Small Rural Hospital Transition (SRHT) Project Behavioral Health Care Coordination Summit

Summit Findings

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Preface

With the support of the Federal Office of Rural Health Policy (FORHP), the National Rural Health Resource Center's (the Center) Small Rural Hospital Transition (SRHT) Project held a virtual summit with national leaders in rural health policy, practice, and payment to identify a path for rural healthcare leaders to operationalize the movement to population health management, specifically regarding behavioral health (BH).[1] The summit focused on the role of rural hospitals in addressing BH as part of collaborative community-wide initiatives and identified strengths, barriers, and actionable next steps for implementing and improving care coordination.

This goal of this report is to help hospitals, clinics, and network leaders move forward on their path to care coordination. The report is also intended to assist state Medicare Rural Hospital Flexibility (Flex) programs and state offices of rural health by offering timely information to help them develop tools and educational resources that support hospitals and networks in the transition to value-based payment models. This 2020 Summit and report build upon the knowledge gained from 2019's Rural Care Coordination and Population Health Management Summit.

The information presented in this report provides the reader with general guidance. The materials do not constitute, and should not be treated as, professional advice regarding the use of any technique or the consequences associated with any technique. Every effort has been made to ensure the accuracy of these materials. The Center and the authors do not assume responsibility for any individual's reliance upon the written or oral information provided in this guide. Readers and users should independently verify all statements made before applying them to a situation and should independently determine the correctness of any strategy before recommending the technique to a client or implementing it on a client's behalf.

[1] "Behavioral health" is an umbrella term to describe mental health, resilience, well-being, and recovery.

Executive Summary

The SRHT Project is designed to assist small rural hospitals in transitioning to value-based care and alternative payment models such as patient-centered medical homes and hospital shared saving plans, as well as prepare hospitals for population health management.

In 2020, the Center held a 2-day, virtual national summit in cooperation with the Health Resources and Services Administration's (HRSA) FORHP focused on the rural hospital's role in addressing behavioral health as part of a collaborative, community-wide initiative. This summit convened experts from the field to explore effective care coordination and transitions of care strategies that maximize the use of available resources and new technology. This summit built upon the findings of the 2019 Rural Care Coordination and Population Health Management Summit.

This summary report of summit findings is intended to identify

- The components that lead to effective BH care coordination,
- Best practices and innovative models to address BH in rural settings, and
- Strategies to address barriers to effective BH care coordination.

The report offers tips on how to maximize available resources and new technology to improve efficiency in care management and transitions of care. It identifies some of the greatest barriers to care coordination—stigma and lack of access to providers—and focuses on four areas of opportunity for addressing them, chosen by the summit panelists.

1. Workforce development and innovation
2. Technology and telehealth
3. Coordination and integration among providers and healthcare organizations
4. Community cooperation and coordination

The report also includes resources in each area of opportunity. This report should serve as one of many tools for rural hospitals and communities in expanding and understanding BH care coordination.

The Summit

The Behavioral Health Care Coordination Summit took place on July 8 and 9, 2020, during the COVID-19 pandemic. As such, what was originally planned as an in-person event in Bloomington, Minnesota, was adapted to be held via Zoom videoconference for 2 hours each afternoon. Producers used video, shared screens, and virtual group activities and breakout rooms to deliver an engaging and inclusive event for all attendees.

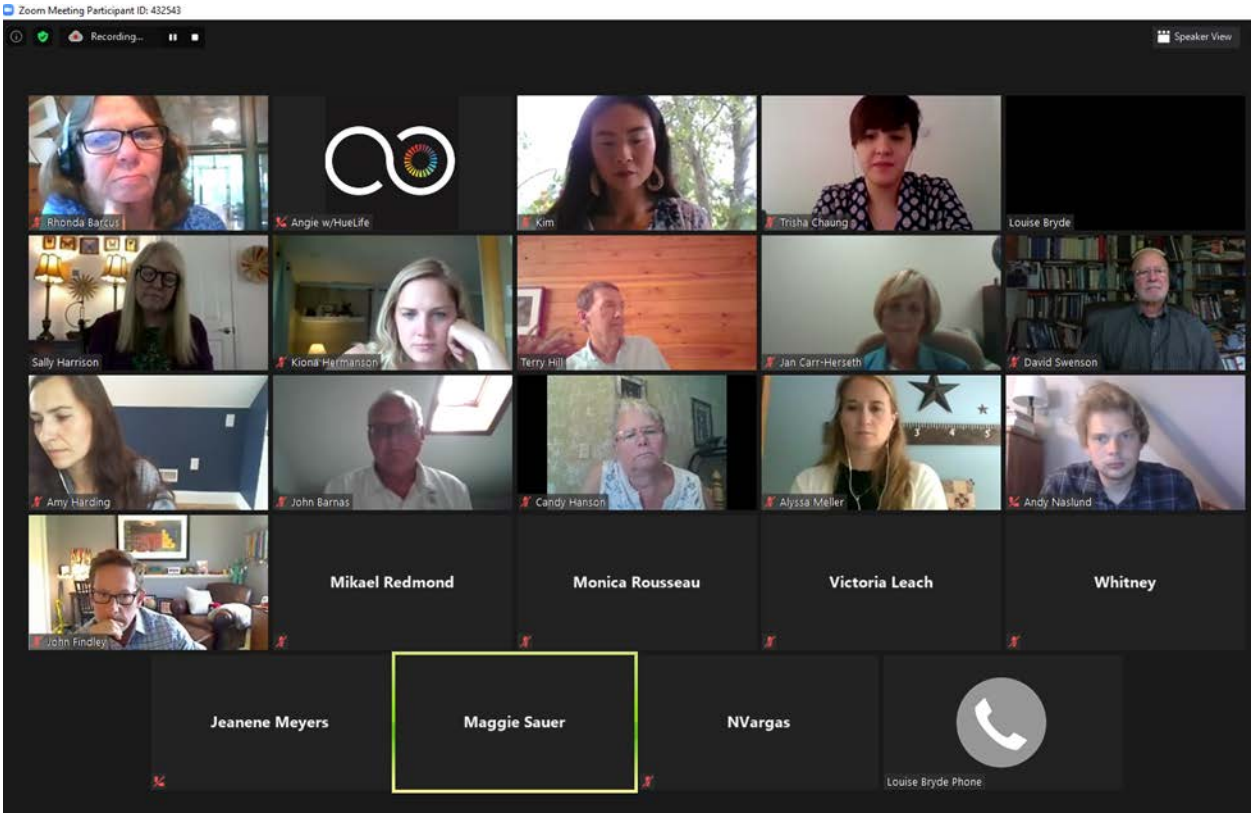
Attendees

The summit was facilitated by Center Program Manager Rhonda Barcus and Senior Advisor Terry Hill, with support from staff Kiona Hermanson, Kim Nordin, and Andy Naslund. Ten experts in rural health policy and practice joined them to discuss how to move BH care coordination forward in rural health care. Panelists included:

- Sally Harrison, Chief Executive Officer, Rural Health Strategies, LLC
- Jan Carr-Herseth, LICSW, Director of Behavioral Health, LifeCare Medical Center
- David X. Swenson, Ph.D., LP, Director, M.B.A. in Rural Health, The College of St. Scholastica, forensic psychologist
- Candy Hanson, B.S.N., PHN, LHIT-HP, Program Manager, Stratis Health
- Alyssa Meller, M.A., Chief Operating Officer, National Rural Health Resource Center
- Louise Bryde, M.H.A., B.S.N., Principal, Stroudwater Associates
- Trisha Chaung, Manager, National Education Programs, National Alliance on Mental Illness (NAMI)
- Maggie Sauer, M.S., M.H.A., Director, North Carolina Office of Rural Health
- John Barnas, Executive Director, Michigan Center for Rural Health
- John Findley, Medical Director of ACO Programs, Caravan Health

Representatives from FORHP joined the summit as observers. They included:

- Jeanene Meyers, Program Officer
- Mike Redmond, State Opioid Response (SOR) Coordinator for Hospital State Division
- Tori Leach, Flex Program Coordinator
- Mike McNeely, Director of Office for the Advancement of Telehealth
- Sara Afayee, Community Based Division
- Marcia Colburn, Rural Strategic Initiatives Division
- Whitney Wiggins, Office for the Advancement of Telehealth
- Monica Rousseau, Rural Communities Opioid Response Program
- Salamatu Barrie, Small Rural Hospital Improvement Program (SHIP)



Summit Objectives

There were four major objectives in convening these experts for the summit:

- Identify the association(s) between rural BH care coordination and healthcare cost and quality.
- Identify service components that lead to effective BH care coordination.
- Identify best practices and innovative models to address BH in rural settings.
- Identify methods by which to disseminate this report and summit findings to Flex programs, hospitals, hospital associations, federal partners, and networks to support implementation findings.

Pre-Planning and Preparation

With the assistance of virtual meeting experts HueLife and with the knowledge of how "Zoom fatigue" is a common challenge during these times, Center facilitators determined that each afternoon's session should not exceed two hours. In order to make the most of the time together, Center staff conducted a series of pre-meeting activities and outreach with panelists, including the distribution of a detailed survey to identify the **trends, drivers, disruptors, and innovations** in BH care coordination in rural settings. The goals of this survey were to:

1. Capture panelists' ideas and input that would normally be brainstormed during a face-to-face session to prepare for more effective facilitation and focus the discussions.

2. Energize survey participants for the virtual workshop, begin "priming the pump" for the topic, and help the participants feel valued for their contribution.

The results of this survey helped drill down on main areas of discussion for the summit breakout rooms and keep the sessions focused and streamlined. The survey questions are listed below.

1. Identify up to five industry trends impacting BH care coordination in rural settings.

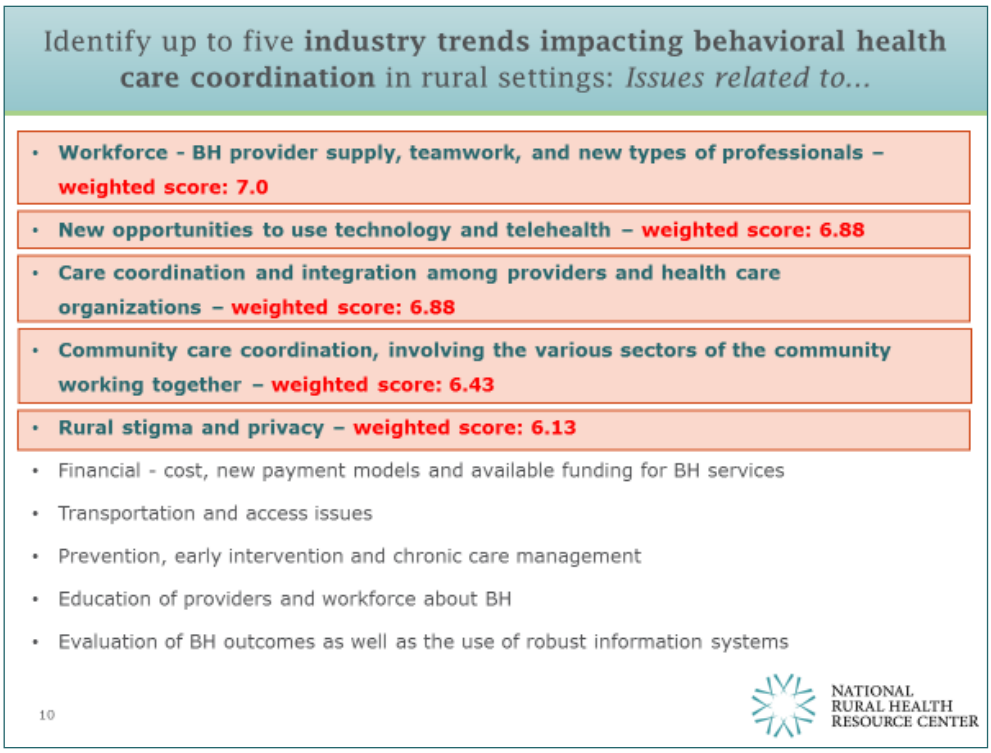
2. Of the industry trends identified in question one, what are forces driving changes that are incentivizing rural providers to include BH in care coordination?

3. Of the industry trends identified in question one, what are the "disruptive" forces that might impact the integration of BH in care coordination and barriers that impede providers from addressing BH with their communities?

4. Given the trends, drivers of change, and "disrupting" forces, what are five ways BH care can be integrated within care coordination in rural settings to improve access to services?

5. Identify up to five ideal practices that lead to effective BH care coordination for rural hospitals.

6. What innovative models are currently in practice or developing as promising models that support rural providers with addressing BH and delivering services to rural areas? If possible, please includes links to information about those models.



Using the survey results, the facilitators built each day's activities to focus on the leading issues identified by panelists.

Rural Behavioral Health Care Coordination

Care coordination is defined as "the extent to which patient care services are coordinated across people, functions, activities, and sites over time so as to maximize the value of services delivered to patients." (Shortell et al., 2000, as cited in Institute of Medicine, 2003). *Community* care coordination, according to Stratis Health's definition, adopted by the Center at its 2019 Summit, is "a partnership among health care professionals, clinics and hospitals, specialists, pharmacists, mental health professionals, community services and other resources working together to provide patient-centered, coordinated care" (Stratis Health, 2020).

To coordinate care effectively, hospitals and other providers must know and meet patients' needs and preferences in a well-organized and targeted manner, leading to better outcomes for patients, providers, and payers. It requires everyone working together in the patient's interest—primary care providers, specialists, community organizations, payers, and other supports.

The drive to increase care coordination has been supported by new payment models, such as value-based reimbursement, that reward providers for coordinating care and achieving better patient outcomes (i.e., "value"), replacing fee-for-service (FFS) payments that pay by procedure and do not account for quality or value of the care provided. Medicare, Medicaid, and private insurance are beginning to pay for prevention and early treatment of mental and BH disorders. Wellness visits, for example, which are being done routinely for Medicare recipients, incorporate multiple questions about BH and refer patients needing help to appropriate services. The result is better care for patients and lower cost for payers. (See Rural Health Value's *Catalog of Value-Based Initiatives for Rural Providers* to learn more.)

In addition, new and increased use of technology is beginning to allow providers to communicate more effectively and efficiently regarding shared patients. The Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access final rule, which will begin to go into effect in late 2020, greatly improves interoperability across providers and

will allow for more seamless data exchange. (Learn more from the CMS Interoperability and Patient Access Fact Sheet.)

There are many challenges to care coordination that cross all geographic and demographic segments of the country and others that are unique to rural areas. Those that are of greatest concern to rural communities include:

- Siloed systems with disjointed processes and procedures;
- Confusing and difficult-to-navigate systems of care (e.g., between primary and specialty care);
- Poor communication, poor sharing of critical information across providers, and cumbersome documentation;
- Minimal research and evaluation data to prove the effectiveness of BH methods and processes, often leading to payer reluctance;
- Shortages of healthcare providers and ancillary workforce;
- Limited access to specialty services and providers;
- Financial barriers (e.g., the cost of implementing health information technology);
- Regulatory barriers (e.g., the Health Insurance Portability and Accountability Act [HIPAA], overlapping documentation requirements, mandated reporting, variation in consent forms);
- Patient noncompliance and missed appointments; and
- Stigma about mental illness and substance use disorder (SUD).

Models of Care Coordination and Integration

Despite the challenges, there has been an effort nationwide to improve care coordination through activities and approaches that help people better understand their care and that help providers better communicate. This has included tactics such as creating networks of care that integrate BH, primary care, and community services; expanding education and knowledge for patients and families; and increasing cooperation across hospitals, providers, and communities, both formally and informally. Government, healthcare groups, and other organizations have established several models of care coordination specifically focused on integration of BH care that rural hospitals may wish to consider. Below is only a small sample of these.

Cross-collaboration between hospitals, behavioral health providers, and other community organizations working to provide education on mental illness and substance use decreases stigma.

—Alyssa Meller

- Collaborative Care Model
- Patient-Centered Medical Home Model
- Primary Care Behavioral Health Model
- Accountable Care Organization (ACO) Model
- Southcentral Foundation (Alaska) Nuka System of Care
- Cherokee Health Systems Model

Maximizing Opportunities and Breaking Down Barriers

Throughout the summit, two recurring themes characterized the discussions of the many opportunities for uptake and expansion of rural BH care coordination: the **stigma** that continues to surround BH in rural America and the ongoing issues with **access** to qualified BH providers.

Roadblocks to Behavioral Health Care Coordination

Stigma. There is more stigma around BH challenges in rural communities, along with less anonymity for people seeking BH care (Mohatt, 2018). Organizations such as the National Alliance on Mental Illness (NAMI) and Mental Health America work to raise awareness of mental illness and SUDs and thereby open the door to discussion and understanding. The COVID-19 pandemic has contributed to a larger national conversation about BH that will hopefully continue to remove the shame and secrecy around this topic.

The effect of open acknowledgement of the importance of individuals' mental wellness was in the national spotlight in 2019, when a simple image of an egg (@world_record_egg) posted on Instagram broke reality TV star Kylie Jenner's record for the most liked image on the social media platform. It turned out that the egg was part of a campaign to decrease stigma around talking about mental health.

Access. Rural Americans struggle with geographic access to primary care providers, specialty providers, and BH and SUD professionals who are well-qualified and practice cultural humility.[2] This leads to increased reliance on emergency departments (EDs) for crisis mental health care, at which point the ED has limited or no community BH service to connect the individual to, thus continuing this cycle.

Opportunities for Advancement of Care Coordination

These barriers—stigma and access—can be addressed via the four major areas of opportunity discussed during the summit. These include the following, which will be explored in more detail later in the report.

Workforce development and integration. Adding to and strengthening the healthcare workforce in rural America is a practical solution to addressing access. But that must come with increased pay, anti-stigma and cultural competence training, and team-based structures for healthcare

[2] Cultural humility is "a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities" (Yeager, 2013).

teams. Some rural hospitals and health systems may consider how alternative or unlicensed staff may fill gaps in their service system.

Technology and telehealth. Telehealth improves access for individuals seeking BH services. The beauty of telehealth is that a provider does not need to be geographically near the person using services. (Although, of course, the provider must be appropriately licensed and credentialed in the state in which the service user resides.) This opens up the opportunity for healthcare organizations to partner with highly qualified providers who practice cultural humility and are a good fit for their patients. Telehealth services also help with privacy concerns among people who do not want to be seen going to the mental health clinic, psychiatrist, or therapist's office in their community. While the panelists noted that some people are concerned about online privacy in telehealth, there is also an anonymity to receiving services online that may be particularly appealing to those who live in small towns.

Coordination and integration among providers and healthcare organizations. The integration of BH and primary care is among the most successful ways to reduce stigma around BH issues. Integration can take a few forms, such as:

Innovation in Rural Care Coordination

The Socio-Economic Approach to Management (SEAM) is an approach to organization development and culture change that is being more widely used in health care, including rural health.

CASE STUDY: A SEAM Intervention in a Rural Health Care System

- Embedding BH care providers directly into a primary care office, with same-day access to these services;
- Hiring or partnering with BH care providers to offer telehealth services via primary care provider; or
- Offering primary care services within a BH care clinic.

Rural communities have a shortage of BH providers, limited specialty services, and long travel times. We need to encourage the integration of BH in primary care [and] acute care services, expanding the use of telehealth and using team-based care.

—John Barnas

Community cooperation and coordination. Engaging the entire community in caring for the whole-person health of its residents is a critical part of successful care coordination. Not only community-based social service or BH agencies, but also churches, schools, police, and other partners can ensure that all residents, including those with BH and SUD challenges, are surrounded by a safety net of resources. Community outreach and stigma reduction requires open and honest communication and discussion of BH in the community.

Opportunity: Workforce Development and Innovation

A robust integrated and coordinated care workforce includes clinical and ancillary BH staff, such as psychiatrists and prescribers, nurses, social workers and counselors, psychologists, community health workers, peers, and others, supported by primary care workers who practice cultural humility and have the skills, knowledge, abilities, and attitudes needed to provide effective, evidence-based services to individuals with BH conditions. This is, of course, dependent on available and appropriately trained professionals.

The shortage of providers in rural health care is an ongoing challenge, but not one without some promising solutions. In this session, panelists discussed the drivers for innovation in the rural care coordination workforce, challenges, and proposed solutions.

DRIVERS

The main driver of this issue is the lack of sufficient BH/SUD providers to meet the needs of rural communities. This is reflected in long appointment wait times, limited access to inpatient BH services, and lack of pediatric and adolescent BH services, according to panelists. Coupled with often inadequate BH and SUD training and experience among primary care providers in the diagnosis and treatment of common BH conditions and SUD, this issue leads many individuals in rural communities to delay seeking services, go without, or seek care at EDs.

BARRIERS AND CHALLENGES

There are several barriers to creating or improving an adequate integrated BH workforce in rural America. These include:

Availability of BH provider workforce. Rural BH providers have historically low salary levels, high caseloads, and low reimbursement rates or limited reimbursement for support services such as care coordination and peer support. There are simply not enough providers to go around.

Provider stigma. From the moment of intake and throughout the care process, panelists noted that individuals with BH concerns are often treated differently by the very people they trust to care for them. As long as stigma exists among providers, there will continue to be resistance to incorporating BH into primary care services and reluctance to engage in the full continuum of care coordination and related services people with BH conditions need.

Siloed services and little incentive to change them. There is a shortage of qualified BH providers in rural communities, and often those who are available are not geographically or contractually connected to primary care practices. When this challenge is combined with limited knowledge and training in BH and SUD among primary care staff, along with resistance from primary care providers to take on patients' BH care, people with BH needs are unable to access providers to help them with their conditions.

Low reimbursement and high costs. Despite the Mental Health Parity and Addiction Equity Act, panelists noted that in many rural areas there is poor reimbursement for BH services. Healthcare organizations are disincentivized

to hire BH staff or use their services if there is not a good financial case for doing so.

SOLUTIONS AND STRATEGIES

Panelists discussed strategies and solutions for addressing workforce issues in rural healthcare coordination. They include the following.

Train and deploy nontraditional staff and new types of professionals. Care coordination activities such as outreach and engagement, follow-up, and connection to community services can often be performed by unlicensed paraprofessionals, such as BH aides, health navigators, care coordination facilitators, and others. These professionals are important resources to enable clinicians to work at the top of their licenses while ensuring individuals are getting the services and supports they need. It is important to note that the inclusion of these new types of paraprofessionals requires buy-in and support from leadership and an outreach and education program to inform existing staff of their importance and contributions to patient care, as well as their roles and responsibilities.

Innovation in Rural BH Care Coordination

The ***Community Paramedic*** model empowers paramedics and EMTs to operate in expanded roles by assisting with public health and primary health care and preventive services for underserved populations in the community.

Broaden the definition of paraprofessionals. In addition to the professionals listed above, some communities have had luck with expanding outside of a traditional definition of who can provide BH support services, such as emergency medical technicians (EMTs, see sidebar), community health workers, and community crisis intervention teams.

Partner with other facilities or providers to share staff and knowledge. Panelists noted that communication with other facilities to share problems and solutions can help reduce silos among professions and professionals. Frequent conferences, webinars, and other sharing of best practices can help increase available staff in geographic areas and expand knowledge of existing providers. One step further involves coordinating

processes, systems, and workflows to create a more efficient system of care that utilizes available providers more efficiently (e.g., reducing repetition or redundancy across providers or provider organizations).

Offer incentives for rural providers. Opportunities such as state and federal loan repayment, free continuing and professional education, and salaries comparable to those in urban areas can incentivize BH professionals to work in rural areas. Value-based reimbursement, in which providers are paid for the quality and value of the care they provide, is a powerful driver in this area.

Provide BH training and education to primary care staff. One of the fundamentals of integrated care is to provide the care that people need when they need it. Primary care teams may have the capacity to provide basic BH services and care but may lack the training and cultural competence to do so. Rural healthcare organizations should invest in anti-stigma education and basic training on providing BH services for their primary care teams. Project ECHO® trainings may be a good opportunity for meeting these needs.

Integrate BH into primary care. By bringing BH services directly into primary care, access to services is improved, and the members of a multidisciplinary team can work most efficiently with the support of ancillary staff. For instance, the Collaborative Care Model is based on a primary care team leader who oversees BH staff such as psychiatrists, social workers, psychologists, and/or peer specialists to provide more accessible BH services.

RESOURCES

Many of the resources below provide more information about the strategies and solutions discussed in this section.

- University of Michigan Behavioral Health Workforce Research Center
- Community Paramedicine (Rural Health Information Hub [RHIhub])
- University of Washington AIMS Center, Advancing Integrated Mental Health Solutions

- The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes (Center for Health Care Strategies, Inc.)
- Care Management Medicare Reimbursement Strategies for Rural Providers (RHIhub)
- University of New Mexico Project ECHO
- Education and Training of the Rural Healthcare Workforce (RHIhub)

Opportunity: Technology and Telehealth

There has been an unprecedented increase in the use of telehealth and telemedicine during the COVID-19 pandemic. According to some resources, private insurance telehealth claims grew by more than 4,000 percent from March 2019 to March 2020 (FAIR Health, n.d.), and Medicare FFS claims for telemedicine rose from 13,000 per week to 1.7 million per week (Verma, 2020).

Innovation in Rural BH Care Coordination

A few of the many artificial intelligence (AI) products (most available as apps) that can address mental health:

BioBase is an app for tracking and managing stress (available in the Apple app store and on Google Play).

Ginger offers on-demand BH coaching, therapy, and skill building.

Woebot offers clinically validated therapy programs via online chat.

Youper is an AI assistant that offers therapy techniques and mindfulness.

This list should not be considered an endorsement of these products.

Research shows that providers and service users alike have mostly positive experiences and expectations from telemedicine. This is especially true for BH providers: according to a 2020 physician survey, among specialties BH providers are most comfortable providing telehealth services (Sage Growth Partners, 2020).

In this session of the summit, panelists talked about how traditional telemedicine can be applied to rural care coordination and how other related technologies may contribute to improving outreach, access, collaboration, and coordination in rural settings.

DRIVERS

Public health crisis. The COVID-19 crisis made it impossible for many Americans to see their healthcare providers in person for non-emergency needs. Accordingly, in March 2020 CMS greatly expanded flexibility and reimbursement for telehealth services through 1135 waivers. Among the many important allowances established are:

- Expansion of types of providers who can bill for telehealth, including the addition of clinical psychologists and licensed clinical social workers;
- Coverage of counseling services via telemedicine; and
- Development of 81 new HCPCS/CPT codes for common telehealth services.

Accessibility. Access to qualified BH care providers is a longstanding issue in rural health care. Telehealth offers an opportunity to bring BH services to rural populations even when a provider is not geographically nearby.

BARRIERS AND CHALLENGES

The panelists discussed the most pressing barriers to using technology to improve rural care coordination. These include:

Interoperability and privacy. Among the greatest challenges to telehealth are concerns with interoperability and privacy, according to panelists. This is consistent with the previously cited physician survey: 82 percent of physicians surveyed said their biggest challenge in providing telehealth was maintaining and explaining privacy, and more than 90 percent of BH providers said lack of integration and interoperability and lack of sufficient data for continuity of care were their biggest practice problems (Sage Growth Partners, 2020).

Lack of access to or understanding of Wi-Fi, smartphones, and computers. Residents of rural communities may not have the same around-the-clock access to the Internet or Internet-enabled devices that urban and suburban populations enjoy. In fact, the COVID-19 crisis and its shift to online education, work, and health care highlighted the inequity of the "digital divide" between those with reliable Internet access and those

without. According to the Federal Communications Commission (FCC), approximately one-fourth of the population of rural America—14.5 million people—lacks access to broadband Internet, and nearly one-third of the U.S. tribal population lacks access (Federal Communications Commission, 2020).

SOLUTIONS AND STRATEGIES

Work with retail clinics. Panelists discussed how retail clinics, such as CVS Minute Clinic®, Walgreens Find Care, Walmart Care Clinic, and others can be partners for helping individuals access BH services. For instance, some Walgreens offer live video calls with board certified physicians from within their retail clinics, along with access to more than 1,000 BH specialists for online therapy. Rural hospitals and healthcare organizations may consider how they can capitalize on these relationships to get needed BH care for their patients, especially those without reliable Internet access in their homes. This may also provide an opportunity for an aging BH workforce to work part time or other nontraditional hours during retirement.

Consider how artificial intelligence (AI) can help. AI tools have a twofold benefit for coordinating BH care: (1) they improve access by automating some of the work that would typically be done by humans—humans who are in short supply in rural areas—and (2) they are completely anonymous, potentially saving people from embarrassment and stigma in sharing their mental health issues. Of course, an app or online tool can never replace a provider, but panelists noted that they may offer important pre-screening, increase access to treatment, and provide accurate diagnoses (Graham et al., 2019).

Keep your eye on FCC technology grants. The FCC's COVID-19 Telehealth Program provided $200 million in funding to help healthcare providers connect with patients at their homes or in other remote locations. While the program stopped accepting new applications in June, there may be a future opportunity for funding to cover the cost of telecommunications and related technology needed to provide telehealth services.

RESOURCES

- Telehealth Assessment (National Rural Health Resource Center, Huron Consulting Group)
- Telehealth in Rural Communities (Centers for Disease Control and Prevention)

- CMS Interoperability and Patient Access final rule (CMS)
- The Promise of EHR Interoperability to Rural Communities (National Rural Health Resource Center)
- Rural Behavioral Health: Telehealth Challenges and Opportunities (Substance Abuse and Mental Health Services Administration, SAMHSA)
- Using Telehealth to Identify and Manage Mental Health and Substance Use Disorder Conditions in Rural Areas (U.S. Department of Health and Human Services [HHS], Office of the Assistant Secretary for Planning and Evaluation [ASPE])

Opportunity: Coordination and Integration Among Providers and Healthcare Organizations

The success of BH care coordination is dependent on healthcare organizations (e.g., hospitals, medical centers, community health centers) working together with BH care providers. This requires practices such as coordination of data sharing and business and referral relationships. This is especially challenging in rural settings, where there is a shortage of community BH care providers and healthcare organizations may be geographically far removed from other providers.

Care management—that is, team-based, patient-centered processes and activities that improve patient care through coordination, elimination of duplication, and empowerment of patients to manage their own care—has emerged as a leading strategy to help healthcare delivery systems and payers ensure they are providing the right care, at the right time, in the right place—including in rural settings.

In this session, panelists discussed how care management and care coordination among providers and healthcare organizations is a critical element of successful care management—and of providing the most comprehensive and meaningful care possible to rural BH patients.

DRIVERS

A main driver of the need for coordination and integration among providers and healthcare organizations is the fact that the current system separates physical health care from BH care and simply does not work for people with BH needs. This has been exacerbated by an increasing demand for acute BH services as a result of the economic shutdown, isolation, and stress that have come from the COVID-19 pandemic (Wan, 2020). This is especially true of the most high-need patients with complex conditions and those who experience multiple comorbidities and social determinants of health (SDOH).

In addition, stigma and shame about the need for BH or SUD services leads many people not to seek them out for fear of being judged. Integrated care helps solve the stigma issue by normalizing BH as part of whole-health primary care and allowing individuals to access services via primary care.

BARRIERS AND CHALLENGES

Siloed systems. In many rural areas, panelists said, services and providers operate in silos, separating primary care from BH care and both from treatment for SUDs. Primary care is often seen as more "legitimate" than BH and SUD services.

Lack of care coordination processes. To effectively work together to integrate care, providers and healthcare organizations need to agree on and document processes and workflows for how they will work together and how they will coordinate care for their shared patients.

Issues with communication and exchange of information. There are often barriers to sharing information and records across providers, especially for individuals with SUD (42 CFR Part 2, HIPAA). These barriers can range from limited or nonexistent interoperability across electronic health records (EHRs) and patient notification systems to apprehension among providers to discuss patients with BH issues because of privacy regulations.

SOLUTIONS AND STRATEGIES

Adopt a team-based model. Put simply, team-based care is the delivery of health services by multiple providers working collaboratively within and across settings to achieve coordinated, high-quality care (Mitchell et al., 2012). Important to a care management approach, team-based care is

based on a group of providers and support staff contributing their expertise to the whole-person care of an individual—for instance, with a physician overseeing medical care, a social worker assessing psychosocial needs, and a nurse coordinating self-management and community supports. A dedicated care coordinator can ensure patients are supported and all engagement and follow-up activities are managed.

Provide screening in primary care and ED. These settings allow providers to "meet people where they are." Outpatient medical practices and EDs can help address BH needs and integrate services by establishing standard mental health and SUD screenings in their practices. (See this list of common screenings from the American Academy of Pediatrics.)

Innovation in Rural BH Care Coordination

North Carolina's Advanced Medical Home (AMH) model requires prepaid health plans to delegate certain care management functions to AMHs at the local level through "clinically integrated networks," a care management vendor, or other population health entity to ensure beneficiaries across the state receive high quality care management no matter where they live.

Develop shared and standardized workflows and processes. The lack of standard care coordination processes can be addressed through a series of approaches, including developing a set of shared workflows and processes across partners (i.e., informal referral partners and/or formal business relationships). Additional steps to standardize processes may include

- Creation of a shared release of information forms for coordinating care across the continuum of care;
- Shared language and terminology; and
- Shared policies and procedures for staff training and competency expectations.

Develop medication-assisted treatment (MAT) programs for SUD within primary care practices. Opioid use disorder and other SUDs are among the most urgent public health crises of our time. Rural communities

are disproportionately affected by SUDs, an issue that is often compounded by stigma and lack of accessible evidence-based MAT. Integrating MAT in primary care, for instance through Drug Addiction Treatment Act of 2000 (DATA) waivered physicians, can help provide the treatment that people need conveniently, accessibly, and confidentially. (There are many models created specifically for rural settings. See the Agency for Healthcare Research and Quality's [AHRQ] Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings for details.) As an extension of this, primary care providers may consider working with local EDs to initiate SUD treatment in ED settings with referrals to community BH or primary care providers for ongoing medical and BH treatment.

Build relationships between hospitals/clinics and BH providers. There are many well-established models for building relationships across providers. Providing BH services within a primary care practice or "medical home" improves overall health outcomes and total cost of care. More advanced systems can also work to build Collaborative Care Models with on-staff psychiatrists or nurse practitioners for those with advanced BH needs. This is also an opportunity to think of the telehealth options discussed previously. The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) has many tools for helping providers build these relationships.

Expand local network of BH providers. Hospitals and healthcare systems should work to actively identify and possibly expand their own local networks of available BH providers, including exploring novel supervision agreements to provide services virtually. See the telehealth section to learn more about how this might be accomplished.

RESOURCES

- A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers (SAMHSA-HRSA CIHS)
- Increasing Access to Medication-Assisted Treatment of Opioid Abuse in Rural Primary Care Practices (AHRQ National Center for Excellence in Primary Care Research)
- Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings *(*AHRQ)
- Patient Centered Medical Home Resource Center (AHRQ)

- Minnesota Integrated Behavioral Health (IBH) Program (National Rural Health Resource Center)
- Foundation for Health Leadership and Innovation Center of Excellence for Integrated Care

Opportunity: Community Cooperation and Coordination

Up to 80 percent of our health is attributable not to medical issues but to the environment and conditions in which we live, work, and play (Manatt, et al., 2019). These SDOH include factors such as poverty, housing, access to healthy food, and education.

In order to "create social and physical environments that promote good health for all"—one of the main priorities of the U.S. government's Healthy People 2020 campaign—the entire community needs to work together to create a system of services and resources to help its members maintain their health and well-being. In this session, panelists discussed how communities can coordinate and collaborate across service systems to best meet the needs of their residents.

> *Rural communities should develop and implement a collaborative planning process among local law enforcement, schools, community-based providers, faith communities, and hospitals to jointly address BH/SUD needs of [the] community.*
>
> *—Louise Bryde*

DRIVERS

SDOH-associated issues such as poverty, drug misuse, and climate change are bringing more awareness to the unique challenges of rural populations.

According to panelists, people are eager to address the lifestyle, social, and behavioral factors that influence physical health in their rural communities, especially during this time of increased economic stress, depression, and related and resulting issues.

However, these needs cannot be handled by the healthcare system alone. A shortage of qualified providers and services necessitates the full engagement and involvement of all available community services, such as faith-based organizations, schools, and police.

Innovation in Rural BH Care Coordination

Community pharmacists can serve as care managers, working with providers and participating in care plans to ensure patients show up for appointments, for instance.

Libraries can commit to helping patrons who are struggling with drug addiction and other SDOH, through training their staff and stocking Narcan or serving as a resource hub for people experiencing homelessness. (See also #LibrariesRespond.)

Regular citizens can support their neighbors with BH concerns through community-wide Mental Health First Aid or NAMI crisis training.

BARRIERS AND CHALLENGES

Silence and stigma. As is the case with nearly every opportunity for BH care coordination, fear of judgement and lack of understanding around BH and SUD is a barrier to engaging the community in partnership. Contributing to this is a lack of communication across systems and potential partners that makes it even harder to understand what types of supports may be available in a community.

Underutilized resources. Panelists noted that many communities have resources that are not well understood or well utilized in helping address the myriad needs of individuals with BH concerns. Remember that schools, churches, or peer- or family-led groups may serve as partners and allies.

SOLUTIONS AND STRATEGIES

Focus on the positive effects community coordination brings to *everyone.* Panelists suggested that creating a community where wellness

and whole-person care are honored as contributors to the well-being of *all* residents can help decrease stigma and resistance to seeing how these services may support people with BH and SUD concerns. For instance, a communitywide mindfulness program helps people understand the connection between mind and body.

Build community support. Mobilizing existing BH organizations like NAMI affiliates can help communities coordinate services and partners, build an information base, and break stigma. Actively seeking out champions and charismatic leaders can help integrate new partners. Communities are full of people with lived experience of mental illness; reach out to them, uplift them, and empower them to be leaders in helping others. Faith leaders are often an underutilized resource. Many rural people trust and rely on their church, so healthcare organizations should think about how local faith-based organizations can support people with BH issues, through support groups or anti-stigma training, for instance.

Consider nontraditional partners. Community BH agencies, social service providers, and human service organizations are important community partners, but they are not the *only* partners. Innovative partnerships may include restaurants or movie theaters trained and committed to supporting patrons with intellectual disabilities or dementia, for example.

Life happens outside of the doctor's office. If I don't have a community that supports me, that affects my ability to grow and to be better.

—Trisha Chaung

Involve employers. Think about where most of your community members work. Factories, farms, construction companies, or whatever your biggest local employers may be can be powerful allies for individuals with BH concerns. Employment is often a critical aspect of recovery and wellness for people with mental health conditions. Local employers may consider participating in the NAMI StigmaFree companies program, for instance, to show their commitment to being open to and supportive of people with mental illness.

Coordinate with law enforcement, courts, and corrections. Many people with BH conditions pass through the justice system. There are numerous models for working with police (e.g., the Memphis Model, or crisis intervention teams), courts (e.g., drug courts), and prisons/jails (community reentry programs). Local jails can establish a pre-release team that works on assessment and care planning. See the resources for more information on many of these programs.

RESOURCES

- Police Mental Health Collaboration (BJA)
- SAMHSA Faith-Based and Community Initiatives (FBCI)
- Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide (SAMHSA)
- Overview of Drug Courts (National Institute of Justice)
- Community Health Workers in Rural Settings (RHIhub)
- Compassion in Action: A Guide for Faith Communities Serving People Experiencing Mental Illness and Their Caregivers (HHS Partnership Center for Faith and Opportunity Initiatives)

Other Considerations

While there was only time during the summit to discuss the four main areas of opportunity, panelists identified other areas that may help or hinder rural BH care coordination. These are listed below with resources for readers to learn more.

Issue	Barriers and Challenges	Proposed Solutions	Resources
Financial issues	Affordability: People in rural communities are more likely to be underinsured or receiving Medicaid. Rural hospitals struggle with costs associated with CMS inpatient psychiatric conditions of	New payment models (e.g., value-based reimbursement) enable teams to deliver comprehensive BH treatment options. Medicare and Medicaid cover BH integration services in primary care practices/clinics.	CMS Innovation Center Medicaid State Waivers list Check your state's SOR program information.

	participation and the necessary build-out cost associated with inpatient BH units.	Some Medicaid 1115 waiver programs (i.e., ACO Model) allow for greater reimbursement for care coordination. SOR funding covers SUD.	
Transportation	Transportation is often not reimbursed with healthcare dollars.	In some cases, Medicaid covers the cost of a ride to and from healthcare appointments. Social service agencies may also fill this need. You can encourage your healthcare system to recognize that early intervention may reduce costs of later care for more serious conditions (e.g., the cost of a ride vs. an ambulance).	Let Medicaid Give You a Ride (fact sheet) Medicare Transportation benefit
Prevention, early intervention, and chronic care management	Lack of funding or understanding that early or ongoing intervention decreases chance of a crisis.	Conduct outreach and education to emphasize that not all BH requires acute visits. Increase knowledge that integrated care leads to prevention. Increase providers' training and education about engagement and early intervention. Teach parents and teachers to recognize early warning signs. Meet your clients where they are. They may scoff at concepts like "mindfulness meditation" but understand when you talk about the way they feel hunting in the quiet woods or fishing on a lake.	Institute for Healthcare Improvement Chronic Care Model Center for Healthcare Strategies, The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes

Appendix A: Summit Panelists

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Appendix B: Resources and References

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