

POLICY BRIEF

Characteristics of the Rural Behavioral Health Workforce: A Survey of Medicaid/Medicare Reimbursed Providers



Project Team

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Background

The Behavioral Health Workforce Research Center (BHWRC) conducted a study to better understand the characteristics of the behavioral health workforce in rural areas, the services offered by rural provider organizations, and the barriers these organizations face to providing services. Thirty-five rural of 454 behavioral health provider organizations in the study population completed an online survey, with responses primarily from support staff, behavioral health specialists, case managers, and mental health counselors. These organizations showed signs of not fully integrating behavioral health and primary care services. Policy recommendations include funding more integrated care sites, empowering physician assistants and nurse practitioners to work to their full education/training, and developing rural America's telehealth infrastructure.

Rural areas cover 97% of the United States and contain 19% of the population.¹ Almost 60% of the 5,035 mental health provider shortage areas (HPSAs) designated by HRSA are in rural or partially rural areas.² Rural residents are a vulnerable population due to their limited access to behavioral health and higher rates of depression, substance use disorder, and suicide than urban counterparts.^{3,4} This study aims to better characterize the workforce in rural areas, the services they are providing, the organizations they practice within, and the barriers these organizations face in providing care.

Methods

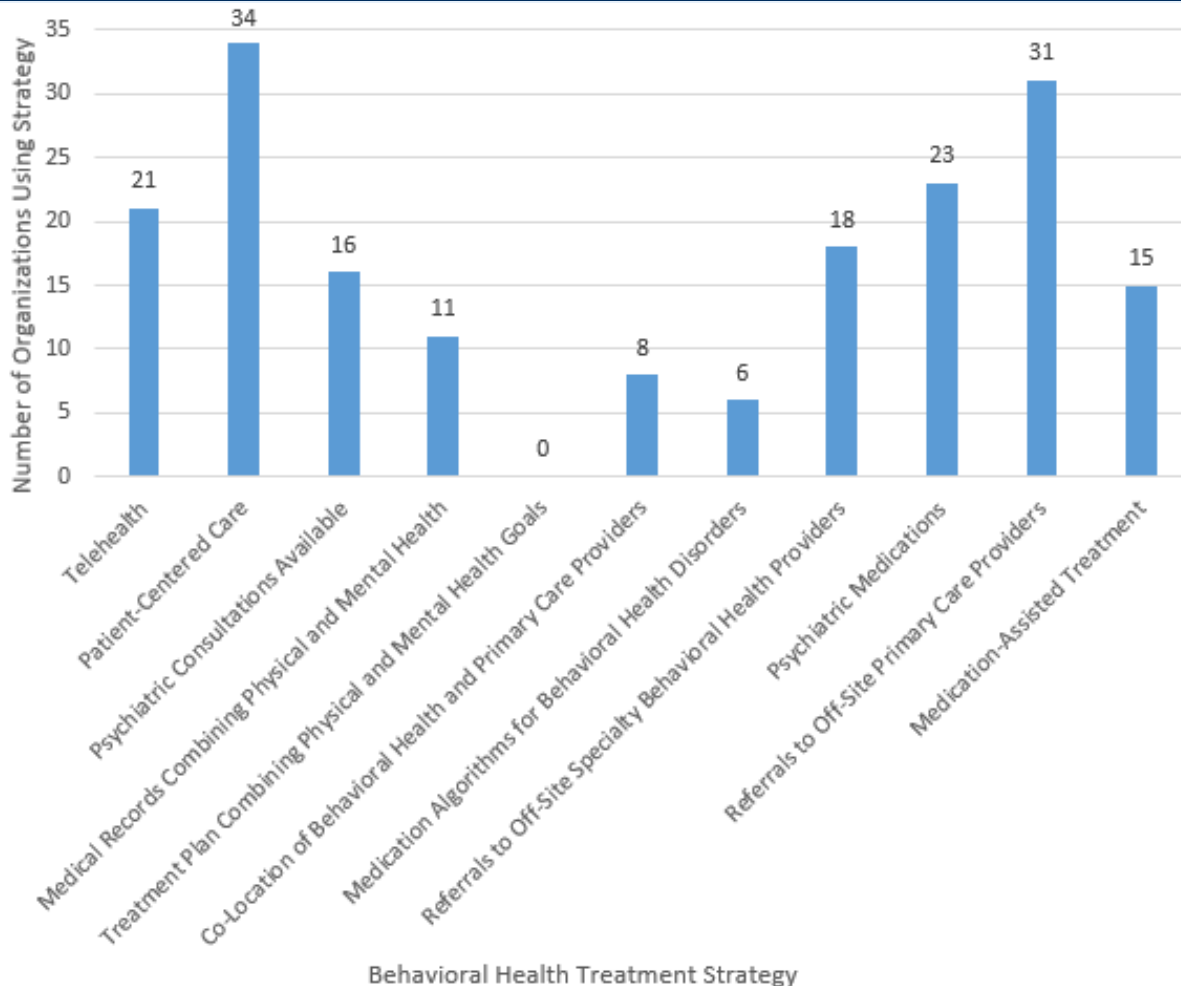
The Centers for Medicare & Medicaid Services (CMS) released a Durable Medical Equipment, Prosthetics, Orthotics and Supplies file containing ZIP codes for areas that CMS designated as rural in the 4th Quarter of 2015.⁵ The National Council for Behavioral Health (National Council) compared these rural ZIP codes to ZIP codes of its 2,900 behavioral health member organizations. This resulted in 454 unique rural behavioral health organizations, all of which received an invitation to complete an online survey. Descriptive statistics of survey responses are presented in this report.

Key Findings

Fifty-seven behavioral health organizations participated in the study (13%). The most frequent respondents were community mental health agencies (n=21, 60.0%) or non-profit organizations (n=10, 28.6%). The median organization served between 500 and 2,499 patients a year, and a community of between 20,000 and 49,999 residents.

The average organization had about 144 total employees (115 full-time equivalent), and the most common occupations were support staff (26.2), behavioral health specialists (13.7), case managers (12.7), and mental health counselors (10.3). Administrators, managers, and non-master’s addiction counselors were identified as the lowest priority new hires, while occupational therapists, pharmacists, and advanced practice nurse practitioners (NPs) were of highest hiring priority. Almost all organizations offered patient-centered care (34) and referrals to off-site primary care providers (31), but few had co-located behavioral health and primary care providers (8) and none had treatment plans with both physical and behavioral health goals, suggesting these organizations were not fully integrated (Figure 1).

Figure 1. Organizations’ Behavioral Health Treatment Strategies (n=35)



Conclusions & Policy Implications

Key findings of this study suggest the rural behavioral health workforce could benefit from:

Incentivizing behavioral health and primary care integration. States could utilize Section 2033 of the Affordable Care Act, make use of federal financial incentives, and establish Medicaid Health Homes which would offer comprehensive treatment for patients with chronic conditions.

Empowering physician assistants (PAs) and nurse practitioners. PAs and NPs are more likely to work in rural locations than physicians, and cost less to hire. By amending scope of practice regulations for PAs and NPs, state policymakers could authorize these occupations to work to the full extent of their education/training, increasing rural access to the services they provide.

Developing telehealth infrastructure. Expanding access to broadband technology and authorizing telehealth through statutes and Medicaid plans may help rural patients connect with providers remotely and gain access to behavioral health services.

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