Integration of Mental and Medical Healthcare in Rural Areas of Tennessee

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What does integration of mental (behavioral health) and Medical (physical health) healthcare mean?

- **Integrated behavioral health** care blends care in one setting for medical conditions and related behavioral health factors that affect health and well-being. Integrated behavioral health care, a part of “whole-person care,” is a rapidly emerging shift in the practice of high-quality health care. It is a core function of the “advanced patient-centered medical home.”

- Integrated behavioral health care is sometimes called “behavioral health integration,” “integrated care,” “collaborative care,” or “primary care behavioral health.” No matter what one calls it, the goal is the same: better care and health for the whole person.

- Care is delivered by these integrated teams in the primary care setting unless patients request or require specialty services. The advantage is better coordination and communication, while working toward one set of overall health goals.

What are the goals of integration?

1. **Addressing physical and mental health needs:** Providing comprehensive care that addresses physical health conditions and mental health needs is an aim of an integrated behavioral health model. These services can result in improved health outcomes and lower healthcare costs.
2. **Additional access to mental and behavioral health services:** Improving the accessibility of care regardless of geographic location.
3. **Enhancing coordination of care:** Integrating mental health services within existing care settings through a behavioral health model can enhance care coordination between acute care and mental health professionals, resulting in more effective treatment and improved patient outcomes.
4. **Reducing stigma:** Normalizing mental health services and making them more widely available through integrated behavioral health models can help reduce the stigma associated with seeking mental health care.
5. **Patient-centered care:** An integrated behavioral health model focuses on promoting patient-centered care, considering each patient's unique healthcare needs and preferences.
6. **Improving overall quality of care:** Providing comprehensive and coordinated care that addresses physical and mental health needs through a behavioral health model can improve patient outcomes and the overall quality of care.

Understanding the Rural Community

- **It is important to understand that many areas of rural Tennessee can be vastly different than their urban counterparts in the State.**
  - There is a strong sense of “family”
  - Many families rely on agriculture as their employment
  - Often continuing education may not be a priority
  - With the lack of industry, many rural Tennesseans have Government funded health insurance such as TennCare or Marketplace plans
    - This lack of industry can also lead to lower socio-economic status as most of the top paying jobs are in the urban areas.
  - Travel to and from more urban areas can be a time-consuming challenge
  - Many have very strong Religious beliefs

What are the barriers?

Distance

- *Rural communities often have worse health outcomes related to SUD compared to urban communities.*
- *Urban areas see about 31.4% of all treatment admissions compared to the most rural areas, which see 7.2% of admissions.*

Stigma

- *The sense that something is shameful, may be felt more acutely in small rural towns because of the relative lack of anonymity.*
- *In a small town it is more likely that people will know that a person visited a certain provider for help.*
- *Some people believe that treating addiction with these drugs simply substitutes one substance for another.*

Insurance Coverage

Without industry, there is little opportunity for "commercial coverage plans", so Government funded plans are much more prevalent and with lower reimbursement not all facilities will accept those plans.

Education Level

"Stigma will fade in the face of education about the negative impacts of untreated addiction on families and communities".

What are some of the disparities faced in the rural communities?

- Overdose rates in rural counties increased from 4.0 to 19.6 per 100,000 people between 1999 and 2019.
- Per capita, the opioid overdose rate in rural communities is 45% higher than in cities.
- Around 9.2% of people aged 12-20 living in rural areas binge-drink alcohol (5 or more drinks for males or 4 or more for females) in the past moth, compared to 8% of those living in big cities.
- 3.5% of people aged 12 and older in rural areas misuse opioids, compared to 3.1% in big cities.
- Young adults aged 18-25 who live in remote rural areas misuse methamphetamine at almost twice the rate as those who live in urban areas.
- 9% of young adults living in rural communities misused prescription pain relievers in the past year, compared to 8% of those living in urban areas.
- Around 14% of behavioral health treatment facilities in the U.S. are in rural communities, and less than half of these specialize in addiction treatment.

So why is integration important?

Integrating physical and behavioral health services can improve patient health and well-being, and can also reduce costs and improve the patient experience:

- **Improved patient outcomes:** Patients experience better symptoms, functioning, and well-being. They also have improved management of chronic conditions.
- **Reduced hospitalizations and ER visits:** Patients are less likely to be hospitalized or visit the emergency room.
- **Improved patient experience:** Patients feel more comfortable and have a better experience when behavioral health care is integrated into their routine primary care visits.
- **Reduced costs:** There are fewer unnecessary costs in time, money, and delays.
- **Improved diagnosis:** Patients receive mental health evaluations, diagnoses, and treatment plans more quickly.
- **Improved provider satisfaction:** Primary care providers can see more patients and have improved professional life.
- **Holistic care:** Providers can address how physical and mental health conditions intersect. For example, if depression is preventing a patient from exercising, a care manager can help them get the medication or therapy they need.
- **Reduced stigma:** Patients don't have to go outside of their primary/acute care practice to seek behavioral health care

What does integration of mental (behavioral health) and Medical (physical health) healthcare mean?

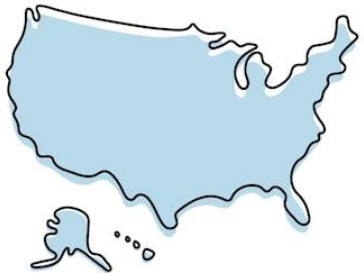
- **Integrate primary care with behavioral health**
  - This can help reduce disparities in care and address the mental health crisis.
- **Use technology**
  - Telehealth, integrated electronic health records, and digital tools can help improve patient access, clinician workflow, and the quality and coordination of care.
- **Co-locate behavioral health clinicians**
  - Embedding behavioral health clinicians in primary care clinics allows for in-person handoffs between care team members.
- **Educate the community**
  - Informing the community about the new services can help lessen the stigma of seeking behavioral health services.
- **Build collaborative relationships**
  - Prioritize team building, role and discipline definition, and communication among providers, staff, and interdepartmental administration.
- **Develop a change management plan**
  - This includes recruiting stakeholders, engaging administrators, providers, and staff early, and communicating shared values, mission, and goals.
- **Use a variety of payment strategies**
  - Primary care practices can use a variety of payment strategies, such as fee-for-service, pay-for-performance incentives, and grants.
- **Build welcoming patient environments**
  - Create collaborative care team models and systems for improved patient communication.

Critical Access Hospitals Serve As The Health Care "Hub" In Rural Communities

- It isn't difficult to find a rural region in the United States—over 70% of the country is categorized as a non-metropolitan area. But only between **15%** and **20%** of the U.S. population (approximately 42 to 57 million people) lives in a rural county.

- Rural populations are also older on average than urban populations and are more likely to suffer from illnesses associated with age, tobacco use, and cancer.

- Opioid-related deaths are 45% higher in rural regions than in urban regions.



What Are Some Of The Challenges For CAHs?

- Of the **1,165** critical access hospitals reporting in 2024, **nearly 373 of them claimed a debt-to-equity ratio of 0.5 or above**, with an average rate of 3.35—a marked change from the average rate of 1.59 reported by CAHs in 2018.

- Approximately **25%** of acute care hospitals are designated critical-access hospitals. Because of this designation and the areas in which they are located, CAHs frequently have *less access to funding, employ fewer physicians, and lack care specialists* compared to other acute care hospitals.

- Additionally, due to the limitations of their critical-access status, CAHs are less likely than other acute care hospitals to have an on-site intensive care unit (ICU), offer cardiac catheterization, and have sufficient (if any) designated surgical facilities.

Why Would Integration With CAH Make Sense?

- Mental health (MH) services provided by Critical Access Hospital (CAH) can be financially sustainable, particularly when considering their impact on system performance rather than as a standalone “profit center.”
- Although study participants reported that MH services were sustainable, only 9 percent of all CAH-based RHCs provide them.
  - There is even a smaller number of CAH’s that provide inpatient care for behavioral health
- RHC providers are satisfied with MH services provided in their clinics and believe they help to overcome stigma and other barriers that discourage patients from accessing needed services.
- It is important that CAH understand third-party MH payment policies and regulations prior to developing these services.
- As previously noted, rural populations are lacking an adequate volume of mental health providers. As more rural hospitals, clinicians, and case managers are relied upon to be the frontline of behavioral health support, access to the latest evidence-based practices becomes integral.

What Are The Benefits?

- Rural areas suffer from chronic shortages of Substance Use (SU) treatment services, with only 20% of SU facilities located in rural areas, and low numbers of inpatient and residential treatment beds (27.9 per 100,000 compared to 42.8 in urban areas).

- As a result, rural residents have *limited access* to SU treatment, must travel farther to access care, and have less choice when selecting providers.

- Reflecting these concerns, the American Hospital Association's (AHA's) Task Force on Ensuring Access in Vulnerable Communities identified **psychiatric and SU treatment as essential services** that should be maintained locally.

What Service Lines Would Be Most Appropriate?

Given the multiple ways in which practices have sought to integrate MH services, it is clear that no one model fits all practice settings. An extensive body of literature on integrated care suggests several questions that can help providers to work through the process of deciding which approach to the delivery of MH services makes the most sense for their practices. These questions include:

- What are the goals for developing MH services? To address the unmet MH needs of the practice's patients or to expand access more broadly within the general community?
- What is the target population? Adults, children, and/or geriatric patients?
- What are the practice's clinical capacity, administrative resources, and space availability?
- What are the needs of the practice's patients?
- What MH resources and referral options exist in the community?

How would integration affect your rural community?

- Rural residents in the USA disproportionately suffer the negative effects of living with unmet or under-met mental health needs.
- Rural Americans have been experiencing a mental health crisis at higher rates with limited access to mental health resources.
- When treatment is unavailable, people will look to other means to cope or self-medicate.

Synergy between MRCI & BSFMC

- Both organizations occupy the single building, MRCI refurbished the unused section of BSFMC. This has greatly enhanced the synergy between the organizations including a “trust factor” that can sometimes be difficult to achieve if the organizations were geographically separate.

- For MRCI, having a fully operation Emergency Department approximately 50 feet from their front door allows acceptance of a much more medically fragile patient needing SUD services.

- For BSFMC, having not only a SUD treatment center readily willing to accept patients from both their ED and inpatient unit, but also having the ability to request consultation from the MRCI providers on psychiatric patients has expedited appropriate placement of those patients.

What are some of the challenges that may occur?

- Recruitment and retention of mental health staff:
  - Where do you find staff?
  - Who will train the staff?
- Medicare coverage limitations:
  - Extending or establishing network contracts
  - Establishing TennCare contracts
- Reimbursement issues:
  - Lag time in network status and actual reimbursement
  - Will the service line support itself
  - Are there additional funding sources (Local/State/Federal grants)
- Patient access issues:
  - Where should patients enter the facility
    - We can help reduce the stigma, by allowing patient to enter the same “front door” that all patient and visitors enter the CAH.

Anecdotal Occurrences In 2024

Examples of **Actual** Myrtle Patients

- 34 YO male presented with HX of opiate usage.
  - Total length of stay 8 days (6 in MRCI and 2 in BSFMC)
  - Initially had a “normal” elevated Clinical Opiate Withdrawal Scale (COWS)
  - Initial blood work with slight decrease in Hemoglobin and Hematocrit
  - By day 4 patient continued to have what we considered a “larger than life COWS score
    - Provider ordered repeat lab work that revealed a significant decrease in Hemoglobin and Hematocrit levels.
    - Symptomology of Anemia can be similar to opiate withdrawal symptoms
  - MRCI provider spoke to BSFMC hospitalist and patient transferred to acute care where he receive (2) units of blood. BSFMC case management arranged GI follow up.
  - Patient returned to MRCI to complete withdrawal.

Anecdotal Occurrences In 2024

Examples of **Actual** Myrtle Patients

- 40 YO male presented with HX of methamphetamine usage.
  - Total length of stay 22 days
  - Patient admitted secondary to request from a large well established residential treatment center.
  - Patient had been in other treatment center for (3) days and had required (4) trips to an emergency department secondary to uncontrolled insulin dependent diabetes.
  - Upon admission patient blood glucose was 765 ml/dl
  - MRCI provider contacted BSFMC emergency department physician to develop and implement treatment plan.
    - Once developed, MRCI provider followed up with BSFMC hospitalist to make any adjustments as patient began to gain control of his blood glucose levels
    - Patient remained in treatment at MRCI for the next 22 days without elevation of his blood glucose

Anecdotal Occurrences In 2024

Examples of **Actual** Myrtle Patients

- 57 YO female with HX of multi substance usage.
  - Total length of stay 15 days (10 in MRCI and 5 in BSFMC)
  - Patient presented with “normal” symptoms of opiate and alcohol withdrawal.
  - Blood work resulted with elevated LFT’s (as would be expected with ETOH)
  - Patient continued with significant COWS scores (mostly based upon N/V and pain)
  - Repeat lab work shows increasing LFT’s on day 8
  - MRCI provider discussed with BSFMC ED provider and patient was transferred for evaluation and TX.
    - ED provider began ABX for treatment of UTI
  - Repeat lab work on day 10 continued to show LFT’s trending upward.
  - MRCI provider discussed with BSFMC hospitalist and agreed patient would be admitted to BSFMC.
  - Complete acute care work up yielded nodules on patients' liver, and GI tract.
  - Patient then transferred to Tertiary care center for treatment of possible CA.

Anecdotal Occurrences In 2024

Examples of **Actual** Myrtle Patients

- 44 YO female with HX of multi substance usage.
  - Total length of stay 28 days (18 in MRCI and 10 in BSFMC)
  - Patient presented with symptoms of withdrawal.
  - As she became “clearer", she began to complain of leg pain
    - Upon assessment a small unstageable wound appeared on her left lower leg.
    - The following day, the wound began to enlarge, and a purulent drainage was noted.
    - In consult with hospitalist from BSFMC, wound was cultured, and it was determined that patient would need IV ABX treatment.
  - Patient was admitted to BSFMC for treatment for 10 days (this included a swing bed admission)
    - During hospitalization @ BSFMC patient would be brought to MRCI for group therapy and MRCI therapist visited her in her hospital room.
  - Patient’s progress warranted D/C from BSFMC, and patient was re-admitted to MRCI where she successfully completed the residential treatment program and was transitioned to supportive living where she remains.

Myrtle Recovery Centers

Overall Conclusions


Myrtle
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Questions?

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If you have any questions or need assistance with a referral, you can contact our Senior Business Development Specialist:

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