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Lost in the Rush to National Reform: Recommendations to Improve Impact on Behavioral Health Providers in Rural Areas

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Abstract

As the United States embarks on the most ambitious national health reform since the 1960s, this article highlights the challenges faced by behavioral health agencies, providers, and clients in rural areas and presents recommendations to improve access to and quality of services. Lessons learned from five years of research on a major systems-change initiative in New Mexico illuminate potential problem areas for rural agencies under national health reform, including insufficient financial resources, shortages of trained staff, particularly clinicians with advanced credentials, and delays in adopting the latest information technology. We recommend that rural states: (1) undertake careful planning for smooth transitions; (2) provide financial resources and technical assistance to expand rural safety-net services and capacity; (3) modify the health home model for the rural context; and (4) engage in ongoing evaluation, which can help ensure the early identification and rectification of unanticipated implementation issues.

Keywords

Medicaid; rural health services; mental health; health reform; United States

In 2010, the U.S. Congress enacted the Patient Protection and Affordable Care Act, referred to as national health reform in this commentary, to be implemented over an eight-year period.¹ We argue that this comprehensive reform must address the challenges of enhancing fragile rural behavioral health care systems that deliver preventive and treatment services for mental, emotional, and substance use disorders. Historically, policymakers have designed such reforms with more populous urban areas in mind and have not adequately considered rural contexts.²

Rural areas differ from urban regions in terms of population density and geographical and topographical barriers that can hinder access to services.^{3,4} Many are characterized by unmet service needs and limited resources for treatment and administration, making them susceptible to the effects of large-scale reform.^{5–7} Rural behavioral health agencies rely on public insurance. They generally have fewer clinical and support staff and less advanced information technology (IT) systems, which can make it difficult to adjust to the demands of a nationwide comprehensive reform.² Rapid turnover leads to higher recruitment costs in rural areas. Such turnover further diminishes financial resources and intensifies problems of maintaining a well-trained workforce to deliver high-quality services, including evidence-based treatment.⁸ Primary care providers fill service gaps by diagnosing less serious psychiatric disorders, managing medications, and counseling clients.^{9–11}

National reform will dramatically affect rural behavioral health providers in resource-poor environments by increasing requirements for access, covered services, and coordination with medical providers. By 2014, the reform will also afford health coverage to 32 million previously uninsured individuals. Adults without children (currently ineligible) will be able to enroll in Medicaid, with the maximum qualifying income raised to 133% of the Federal

poverty level. Other low-income citizens will receive subsidies for insurance offered by newly created state health insurance exchanges. Adults with moderate mental illness who lack insurance as a result of unemployment or declining employer-based insurance (due to high premiums and co-pays) will likely represent disproportionate numbers of individuals to gain coverage.¹² To optimally serve these individuals, behavioral health providers will have to learn how to navigate uncharted territories of changing Medicaid payment approaches for promoting high quality care and state-selected essential benefit packages that will determine the amount, duration, and scope of covered services.¹³ These factors have the potential to strain the already-limited time and financial resources of rural providers, which, in turn, can affect the quality and availability of services for clients.¹⁴

Public attention has focused on increasing the number of people with insurance, financing services, and improving quality and efficiency under national health reform, rather than on providers generally or behavioral health providers practicing in rural states more specifically. Hearings held in the U.S. Senate and the House of Representatives included little to no discussion of the potential impact on rural areas of reform provisions related to behavioral health care, and there has been little targeted funding for rural community-based behavioral health services.

Lessons from New Mexico

In this commentary, we describe the experience of a major systems change in New Mexico to explore possible effects of the national reform on behavioral health providers in states with large rural areas. In 2005, New Mexico overhauled its approach to organizing and financing behavioral health care by implementing a statewide managed care carve-out for all publicly-funded services, including inpatient, residential, and outpatient treatment for youth and adults.^{15,16} Legislative action mandated that the state agencies that traditionally managed or funded behavioral health care create a purchasing collaborative, which then contracted with a single for-profit corporation to administer services.¹⁷ This initiative was intended to achieve several goals now promoted under Improving impact on behavioral health providers national reform: maximize client access to care and enhance quality, increase use of evidence-based treatment, improve efficient use of disparate public funds for services, and incorporate client and family voice into system operations.

The initiative also piloted a version of the health home, a delivery model now encouraged under national reform. The Centers for Medicare and Medicaid Services (CMS) is funding a large-scale demonstration project to study implementation and impact of health homes, or single clinical entities responsible for coordinating and overseeing care for individuals with chronic conditions to improve service quality and efficiency. Psychiatric practices, community mental health centers, and behavioral health providers that are able to deliver a range of services can be designated as health homes for individuals who either have serious persistent mental illness, or a mental health or substance use disorder coupled with another specified chronic medical condition (such as asthma, diabetes, heart disease, and obesity). With an enhanced Federal Medicaid match of 90% during the first two years of implementation, 31 states have expressed an interest in participating in this demonstration project.¹⁸

In this commentary, we draw upon lessons learned from two studies we undertook on recent systems-change efforts in New Mexico. The first study examined how implementation of behavioral health reform affected provider agencies serving adults with serious mental illness (e.g., bi-polar disorder, major depression, and schizophrenia) over a five-year period. This long-term assessment consisted of participant observation in provider settings, document review, and repeated structured and semi-structured interviews with providers,

clients, families, advocates, policymakers, and state officials.^{14,19–20} Two statewide surveys were also conducted with the directors of behavioral health agencies.^{21–22} The second study comprised a short-term evaluation of a health home program for youth with serious emotional disturbances. This study was based on individual interviews and focus groups with persons either involved in or affected by implementation, and an analysis of administrative data to assess client outcomes.²³

New Mexico serves as a useful case for anticipating problems that may emerge during the national reform, because it is predominantly rural (15 people per square mile) and all but one of its counties is a health professional shortage area or medically underserved area.²⁴ The state has recently ranked 43rd in personal income per capita,²⁵ 5th in people living below poverty level,²⁶ and 2nd in individuals lacking health insurance.²⁷ A 2006 study estimates that of a total state population of 1,915,213, there were 1,138,082 individuals (358,003 children and adolescents and 780,079 adults) living in low-income households under 300% of the Federal Poverty Level who qualified for some level of support for publicly-funded services. Rates of serious emotional disturbance reached 7.4% for low-income children and adolescents. Approximately 6.6% of low-income adults had a serious mental illness, 5.3% had a substance use disorder, and 1.2% had both.²⁸ In Fiscal Year 2009, per capita state mental health spending was \$93.51 in New Mexico, in contrast to the U.S. average of \$122.90.²⁹ In Fiscal Year 2011 (July 2010–June 2011), \$172,103,600 were spent on inpatient, residential, and outpatient behavioral health services for 41,303 children and adolescents under the New Mexico reform, while \$74,672,806 were spent on adults.³⁰ The state's mental health budget currently ranks 43rd in the nation,²⁹ while its alcohol- and drug-induced death rates rank first and second highest, respectively, and the age-adjusted suicide rate ranks second.³¹ Community mental health centers and non-profit agencies are the dominant providers of behavioral health services to New Mexico's rural population.²²

This case study of New Mexico's statewide behavioral health initiative highlights four issues relevant to the national reform that will adversely affect care in rural areas without concerted efforts to address them. These lessons underscore: (1) the importance of well-planned transitions; (2) the need to support the rural safety net; (3) the modification of health homes for local contexts; and (4) the benefits of ongoing evaluation of reform effects on providers and clients. We conclude by proposing solutions that can be adopted by the Federal government and states to improve the performance of national reform in the rural behavioral health arena.

Importance of Well-Planned and Smooth Transitions for Rural Providers

Under national reform, states will become more involved in both public and private insurance markets, playing critical decision-making roles in eligibility determination, essential benefit package development, oversight of Medicaid expansion, and operation of health insurance exchanges. This involvement necessitates that direct service agencies have technological infrastructure in order to interface easily with electronic billing systems, comply with complex eligibility and enrollment processes, and demonstrate delivery of high-quality care.

Service delivery in rural settings often requires significant modifications in requirements, processes, and funding strategies. The incorporation of provider and client perspectives into the earliest stages of planning is critical to shape reform initiatives, because needed modifications may not be obvious to outside observers or easily anticipated in advance.

Financial considerations hampered several initiatives under the New Mexico reform, ranging from community input into design and transition issues to service provision. Input from rural areas was impeded by insufficient allocation of resources to undertake outreach and address

structural barriers to participation in planning activities, such as transportation to public meetings.²⁰ Rural providers in understaffed agencies had to weigh the costs of cancelling appointments with clients or taking time off from work without pay to attend these events.³² State officials also set professional billing limits of four hours a day without first consulting these providers. This decision unintentionally led to the denial of claims for neuropsychological evaluations conducted in longer sessions to minimize travel time and expense for rural clients. This example is one of many in which the incorporation of local feedback in the design of initiatives would have reduced negative effects on providers.

The ambitious statewide IT system introduced under the New Mexico reform experienced unanticipated problems in internally reconciling claims for services funded by Medicaid and Departments of Children, Youth and Families, Corrections, and Health. In particular, the web of overlapping funding streams, client eligibility categories, and service requirements led to complexity and subsequent IT system failures.³³ As a result, providers were frequently unable to access reliable and accurate reimbursement through this IT system.

States and insurers need to establish clear policies and ensure that enrollment and claims processing IT systems are fully operational from the beginning. The state and managed care organization responsible for daily operations in the New Mexico reform fell short on both counts.^{14,34} Manuals explaining new processes and detailing billing codes were unavailable until months into the reform. Ambiguous requirements for submitting claims also delayed payment for months at a time, causing serious cash flow troubles for providers in rural areas. Despite repeated attempts to resubmit claims and confirm eligibility, many providers learned that they had delivered services to people ineligible for public funding, and therefore lost money. These IT difficulties underscore the need to offer rural providers financial and technical assistance for developing infrastructure to meet national reform's expectations of widespread adoption of electronic medical records and communication to improve service delivery efficiency.

To avoid implementation delays and undue strain on resource-strapped providers, the national goals for funding mechanisms must be logistically realistic. This can be accomplished through early input from rural providers, especially in developing time-lines for reform changes that provide sufficient preparation time to train employees, redesign office processes, revise record-keeping practices, and adjust staffing patterns within agencies.

Pressure on Safety-Net Services and Capacity

Under national reform, rural behavioral health providers will face the combined pressure of (1) increased demand for services from the newly insured; (2) Federal mental health and substance use parity requirements; and (3) expanded behavioral health coverage in state exchange plans. In New Mexico, for example, an estimated 200,000 individuals will become eligible for Medicaid under the national reform by 2014, a 40% increase over 2010 enrollment.^{35–36}

Twenty percent of all Americans grapple with a mental illness during their lifetimes, but only one-third receive professional treatment, often because they have no way to pay for care.³⁷ Twenty-five percent of all uninsured adults have experienced serious psychological distress or substance use problems in the past year, and over 6% suffer from a serious mental illness.^{13,37} Individuals with a mental illness are twice as likely to be uninsured than those without such an illness.³⁸ Partly owing to insurance disparities, people in rural areas are less likely than urban residents to receive “any type” of treatment, let alone specialized treatment, to ameliorate their behavioral health concerns.⁶ The Mental Health Parity and Addiction Equity Act, signed into law in 2008, will help ensure that coverage for mental

health and substance use disorders provided through Medicaid and health insurance exchanges is no more restrictive than for physical health conditions.³⁷ Thus, the demand for services can be expected to increase once rural residents gain access to affordable coverage,³⁷ and/or as more newly insured people are identified as having moderate disorders when seeking primary care, a major portal to mental health diagnosis.³⁹ We predict that rural behavioral health agencies in New Mexico and other rural states will be forced to maintain long waiting lists or to triage services to those individuals with the highest need, especially in the early years of national reform. This greater demand, along with administrative and system shifts, may disrupt the ability of these agencies to maintain adequate provision of care for those individuals already receiving services.

We found that the earlier New Mexico reform did little to improve the situation of the rural behavioral health workforce, which has historically struggled to meet the needs of clients with complicated mental health problems. In fact, implementation problems created financial hardship for rural agencies. This hardship contributed to low employee morale, turnover, and agency decisions to reduce or cut services, potentially undermining their ability to treat newly insured individuals with psychiatric disorders who are likely to seek help at their doorsteps.^{19,33}

Based on this experience, we predict that if rural providers are to adequately care for both new and existing clients, they will have to recruit specialty clinicians, particularly psychiatrists, and support the existing workforce through web-based continuing education and intensive training and supervision. Remote technical assistance centers, performance assessment teams, and consultants can play an important role in this effort.^{40–42} Provider and staff development will become a central issue for agencies offering substance use services. These agencies have typically relied on block grants to fund counselors whose credentials do not meet the minimum standards to participate in public and private insurance. National reform will pressure agencies with staffing constraints to upgrade counselor credentials and undertake greater administrative work to process claims. Unless credentialing requirements under managed care are changed or further Federal and state assistance is granted to train this workforce and attract new clinicians, many rural agencies will be unable to compete for providers with those in urban and suburban areas that offer higher compensation and a different quality of life.

Telemedicine has potential for improving access through video-conferencing and other types of electronic communications and reducing emergency room visits and other high-cost services. Some characteristics of behavioral health care lend themselves to telemedicine, including psychiatry, consultation, and brief intervention, but it is less applicable to services such as case management or traditional psychotherapy, especially in rural areas where appointment attendance may be poor and local knowledge is critical. The use of telemedicine in rural areas has also been constrained by technological requirements and insurance reimbursement limitations.^{43–44}

Our research revealed little change in the proportion of New Mexico providers with telemedicine capacity in the first three years of the earlier reform. In 2007, 30% of agencies had this capacity. Since then, the state has made some progress in investing in telemedicine and improving reimbursement. Between 2008 and 2009, the number of individuals treated for behavioral health conditions through telemedicine nearly doubled from 660 to 1,242 (although most of this increase was attributable to one large provider network).^{45–46}

Modifying Health Homes for the Rural Context

The national demonstration project for health homes offers a promising role for behavioral health providers. According to CMS, the range of services to be delivered through health

homes includes comprehensive care management, health promotion, transitional care and follow up, individual and family support, and referral to natural Improving impact on behavioral health providers community supports (e.g., family, religious and nonclinical resources). Health homes are also to deploy health technology such as electronic medical records to better link and coordinate services.

New Mexico had piloted a similar clinical-home project for behavioral health providers in 2007–2008, hastily initiated in response to an attempt on the part of the managed care contractor to reduce utilization of residential care for adolescents with serious emotional disturbance. Our evaluation uncovered several process issues that influenced the overall effectiveness of New Mexico's clinical homes, particularly inadequate planning and preparation.²³ At the project's start, for example, the state government failed to train providers and to clearly define the expectations of participating agencies, leading to confusion about roles, responsibilities, and basic processes. Both providers and the evaluation team also struggled, for different reasons, with fluctuating definitions of the target population and intended outcomes. The providers received no consistent directions for how to implement the intervention and the evaluation team did not know the yardstick being used to measure clinical home effectiveness.

On a pragmatic level, many participating agencies lacked support staff and infrastructure to operate successfully as clinical homes. Payment rates insufficiently compensated agencies for added responsibilities and legal liabilities. Early in the demonstration project, providers also voiced concerns about the increased costs associated with participation, particularly expenses incurred through evolving administrative and oversight functions and not well-specified requirements for serving clients with no identified insurance or funding source. These problems were never completely resolved during the pilot. Several providers stated that participation in the demonstration project consumed limited monetary resources and resulted in financial losses.

The New Mexico demonstration project focused on implementation in urban environments, thus placing rural providers at a disadvantage. The state typically held training sessions to facilitate roll out of clinical homes in urban and suburban areas. Rural providers faced the added obstacle of finding coverage so they could take part in these trainings. Clinical home requirements for intervention did not consider difficulties in transportation and timely response encountered by rural providers. Concurrent changes to reimbursement strategies that limited their ability to assist clients with transportation needs also created special access problems in rural areas.

Clinical homes were brought to an end in 2010. However, New Mexico is now implementing a larger-scale behavioral health home model for both adults and youth with greater attention to defining target populations, and addressing funding limitations and program requirements. Consistent with national reform, the state government has promoted this initiative as a first step toward integrating behavioral health and primary care.⁴⁷ So far, however, this intention remains merely a goal and an undefined expectation placed upon providers, because the state government has again implemented this initiative with scant attention devoted to logistical, legal, and financial issues.

National reform can avoid these problems by recognizing that health home models require tailoring if they are to strengthen the rural safety net. In urban areas, policy-makers have seen the benefits of health homes in promoting a holistic, coordinated approach to the treatment of complex conditions that require interdisciplinary intervention.^{48–50} However, there is also evidence that transforming a practice into a health home can be a lengthy and complex process, especially for solo and small group providers (such as often found in rural

areas) who have fewer staff and less resources.⁵⁰ They may need additional support and incentives in implementing these changes and to explore innovative ways to share case managers and other resources.^{51–52}

Finally, health home providers will have the option of rendering services themselves or referring clients to non-affiliated agencies. Accordingly, providers offering comprehensive services will have incentives to direct clients to their health homes, thus maximizing their financial compensation. The question remains whether this approach will promote the merging of independent practitioners and small agencies into full-service organizations or result in monopolies that can deteriorate the rural safety net. States in the national demonstration project are allowed considerable flexibility in creating payment methodologies that take into account the capability of the team of providers serving as the health home. Strategies to ameliorate inherent disadvantages faced by rural providers include technical assistance, training through webinars, infrastructure grants for improved IT systems, and policies to facilitate collaboration with non-health home providers.⁵³

The Benefits of Ongoing Evaluation

Our New Mexico case study also highlights the importance of incorporating real-time evaluation into the national reform process. First of all, such an evaluation will keep the government and health insurers in touch with the lived experience of providers, staff, and clients. Though start-up difficulties are anticipated during the first months of major reform, an assessment of provider and client perspectives in these early stages can identify unforeseen issues and adverse events. Second, ongoing evaluation provides an evidence base to design mid-course corrections before long-term damage to the rural safety net has occurred.

The New Mexico reform would have benefited from an ongoing system-wide evaluation that emphasized process and outcomes to identify unintended consequences. For example, we uncovered problems providers had when attempting to comply with requirements for comprehensive community support services (CCSS). This intervention model was designed to assist clients in developing and implementing skills and resources to improve their life functioning, without the need for frequent involvement from providers. CCSS is widely touted as a centerpiece service of the New Mexico reform, and is characterized as a process of doing with a client, rather than doing for him or her. Shortly after activating this service within the Medicaid and publicly-funded service array, the state government and its managed care contractor implemented an unusual pre-authorization requirement to control the costs of this outpatient service. We found that many providers lacked the IT systems to track the number of visits for each client and were faced with situations of having delivered CCSS without an authorization. In some cases, a prior authorization was retroactive and, in others, providers were never reimbursed for the unauthorized service. A flexible monitoring effort on the part of the state government and its managed care contractor would have made it possible to assess the early impact of new policies, such as this prior authorization requirement, on behavioral health agencies and to develop alternatives compatible with provider capabilities.³⁴

We also argue for a mixed-method approach to evaluation that can provide a more robust, multi-faceted understanding of national reform's effects on rural agencies, providers, and clients, which quantitative and qualitative research methods cannot produce on their own when deployed separately.⁵⁴ Evaluation that depends only on surveys and other quantitative research tools may present special challenges to rural states, because there are fewer agencies, solo providers, and widely dispersed clients from which to generate samples large enough to determine statistical differences and trends. The addition of qualitative research

methods can improve the relevance of survey questions and facilitate the contextualization and interpretation of quantitative findings. These methods are particularly useful for identifying important local variables, and yielding useful descriptive, in-depth knowledge of how various national reform policies are being enacted in rural behavioral health care settings.⁵⁵

Finally, evaluation requires resources and states are facing severe budget pressures for the next few years. Nevertheless, there may be creative ways of including rural behavioral health providers in such evaluation efforts. One approach is to collaborate with local researchers and apply for grant funding to support evaluation. Second, providers can work with legislators to request that state-level committees or executive agencies, which have funds allocated for such purposes, conduct needed studies. Third, providers can conduct their own studies, using interview and focus group methods, in addition to the collection and analysis of basic outcome measures to understand the impact of reform-related issues on clients and agencies in rural communities. Many providers lack confidence and expertise in program evaluation, but respond positively and effectively when offered resources and support in implementing evaluation strategies. As research on evidence-based practice demonstrates, engagement of clients, families, provider agencies, and other relevant stakeholders improves evaluation and increases the possibility that results will inform reform efforts.^{56–57}

Conclusion

With careful planning and continuous evaluation, national reform could present opportunities to address long-standing disadvantages that rural providers and clients face. The importance of low population density, greater dispersion, and geographic isolation cannot be underestimated in both anticipating and addressing potentially unfavorable impacts of national reform on the rural safety net. Medicaid will play a pivotal role in the reform by allowing a rapid expansion of coverage within existing enrollment, billing, and oversight systems.

We urge policymakers to not lose sight of unmet needs for behavioral health treatment in rural areas and consider ways the reform can enhance community-based services. Thirty-two million dollars for rural areas in U.S. Department of Health and Human Services funding under national reform overemphasizes hospitals as a key source of care.⁵⁸ The expansion of funding for the National Health Service Corps is limited to primary care practitioners. These efforts will not help behavioral health providers nurture their workforce.

We offer four recommendations for policymakers at the Federal and state levels. First, we urge them to apply the lessons learned from our New Mexico research and other demonstrations to improve implementation of health homes for behavioral health providers in rural areas.^{59–60} Clients will doubtlessly benefit from health homes, which should make it easier to find providers who understand co-morbid conditions, decrease fragmentation of behavioral health treatment, and improve coordination with primary care.^{61–63} To be successful, however, adaptations of health homes for rural areas must consider: (1) the limited numbers of psychiatrists and other specialty providers in rural areas; (2) technical assistance and ongoing training for agencies; (3) evaluation of implementation; (4) incentives for inter-agency collaboration to avoid monopolies; and (5) enhanced capitation to cover the increased costs of delivering services in rural areas.^{60–64}

Second, states and the Federal government should monitor the impact of insurance coverage and benefits expansions on the stretched capacity of the rural safety net.⁷ Findings pertinent to services and financing should be shared with the public on a regular basis. Rural

providers will be challenged to improve capacity given existing constraints on transportation, recruitment, and training. In the past, their concerns were overshadowed in evaluations of Medicaid and public sector state reforms.² Without monitoring, the potential for unintended consequences persists. The integration of quantitative and qualitative studies will allow for holistic assessments of reform-related implementation process and impacts on rural agencies.

Third, only a long-term commitment to improving access to specialty services in rural areas will prevent disruptions in care for both existing clients and those who are recently insured. For New Mexico and other states with plans to phase-in national health reform over an extended period of five to ten years, this commitment will need to weather changes in elected leadership. New governors and appointed state officials who espouse priorities regarding health and behavioral health care that differ from those of their predecessors can abruptly alter the path of reform processes, which can then engender even greater stress for rural providers. One strategy to promote such commitment is to create plans that begin with short-term goals and objectives, and to iteratively build upon each achievement. By celebrating these achievements, it may be possible to build political support and public momentum over the long haul.

Finally, evaluation of New Mexico's experiences with statewide reform underscores the importance of providing sufficient resources to effectively implement new policies and programs. This is critical in rural areas where there is a significant population living in poverty that relies on a fragile public health system. Several facets of national reform will be implemented at the state level, at a time when many states are facing major budget crises and are instituting harsh cuts in assistance to their most vulnerable populations, despite high levels of unemployment and unprecedented need.^{37,65} Inadequate funding not only increases the risk of reform failure, but may further undermine an already-weakened safety net.

Community input can play a crucial role in raising awareness of potential and/or negative ramifications of the national reform that may end up costing states more money to rectify while decreasing access to services and increasing suffering. For the planning and oversight of behavioral health reform in New Mexico, the state government frequently convened public meetings across the state and even created special advisory boards or committees. However, these boards and committees did not have decision-making authority and thus their ability to influence systems-change processes was limited at best. Under national reform, it is imperative for state officials to become more responsive to community input, i.e., regularly communicating with the public and offering concrete examples of how local perspectives shape implementation.

Short- and long-term consequences of national health reform on rural behavioral health services promise to be extremely complicated and may require that state and regional regulatory, funding, and service-provision systems undergo substantial changes in practice, infrastructure, and goals. Past reform efforts in New Mexico have demonstrated the degree to which the complexity of rural behavioral health systems can be underestimated, and how important it is to fully assess these systems. Rural providers, clients, and other stakeholders must be included as participants in planning, implementation, and evaluation. A diversity of views must be solicited and respected. While efforts to include the voices of multiple constituents may seem too labor-intensive to employ when state government officials and leadership have a time-sensitive “hot-iron opportunity,”⁶⁶ the New Mexico record underscores the advantages of involving stakeholders in efforts to tailor-fit reform strategies to the unique needs of rural behavioral health systems.

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