

## **Integrated Primary Care and Mental Health Project Needs Assessment Results of Physician Surveys and Interviews**

### I Introduction

In September 2003, the Maine Center for Public Health, in collaboration with the State Department of Behavioral and Developmental Services, the Bureau of Medical Services and the Bureau of Health, began implementation of the Integrated Primary Care and Mental Health Project, an effort to develop and test integrated practice models which would enhance treatment of Maine children (aged Birth – 18) who have mental health needs. The project was funded by a planning grant awarded by the Maine Health Access Foundation.

A key project activity during the first quarter was the design and conduct of a needs assessment. Both quantitative and qualitative strategies were identified. The goal of these strategies was the identification of key needs in practices throughout Maine, which would help us develop both practice models to be tested as well as a research design. The needs assessments' components were informed by significant antecedent literature review and provider input prior to the project's formal inception and in its first quarter.

### II The survey

With the help of members of our practitioner group and under consultation with our Research Consultant, Beth Molnar, Sc.D., of Harvard School of Public Health, a brief survey was designed and sent out to over 700 Maine primary care (family medicine and pediatric) physicians. 109 surveys were returned. The survey encompassed the following:

- Basic demographic information regarding the practice, including the name of the physician, the practice and the office manager;
- The type of practice, including its status as a hospital-based or residency clinic/health center/solo practice or group practice;
- Information regarding the frequency of mental health service provision to children;
- Willingness to participate in an applied research project whose goal was to improve the delivery of and funding for mental health services in primary care sites.

Most (97) of the respondents did provide such services, with about two-thirds having frequent contact with these children. About three-quarters of the respondents (76 vs. 27) were interested in participating in the study.

Several additional questions were asked of those who were interested in study participation. These questions dealt with the realities of project practice. The physicians were asked who provided mental health services and through what practice model. It was found that, of the total:

- 44 of the primary care physicians provided diagnosis, management and prescription services without involving psychiatrists or other mental health professionals.
- 22 of them usually referred to psychiatrists or other mental health professional at other sites.
- 7 respondents reported that mental health professionals shared space in their site. Of these, half worked at the practice from 10-29 hours weekly and half, less than that.
- 8 respondents reported that primary care practitioners shared space as well as patient management. Half of the mental health professionals in this arrangement worked with the primary providers more than thirty hours weekly, half less than that.
- In none of the practice sites were the mental health providers fully integrated in the team, with responsibility for all patients in the practice.

The final survey question related to compensation. Two thirds of the respondents stated that compensation was problematic when patients were provided care by a physician (44 vs. 22) and the proportion was about the same when respondents were asked if compensation was a problem when mental health professionals provided care.

In summary, there appears to be interest in the study (since practitioners were identified individually, rather than by practice, the number of physicians interested may represent other providers involved in their practice). Many physicians continue to attempt to provide mental health services, which is probably a response to a lack of available mental health resources. Very few practices provide co-located services and no one provides an integrated practice model. Finally, compensation is an issue for physicians and mental health providers alike.

### III The Interviews

Following conduct of the surveys, twelve clinicians around the state were interviewed, mainly by phone. Each in-depth interview lasted 45-60 minutes. The provider locations included: Presque Isle, Portland, Lewiston/Auburn, Augusta, Cooper's Mills, Millinocket, Patten and Winthrop. Interviewees included pediatricians, family practitioners, family nurse practitioners and behavioral health providers. Names of interviewee subjects were obtained from the Maine Primary Care Association, which works with the federally qualified health centers around the state, the Maine Medical

Association, the Maine Osteopathic Association and members of the project's practitioner group.

The in-depth interview guide covered a variety of topics, which included:

- General information about the respondent, centering on educational background relating to psychiatry, especially training concerning psychotropic medications.
- General information about the primary care practice (solo vs. group setting, urban vs. rural, etc., number of patients seen in the practice and on a typical day by the practitioner
- Information concerning children with behavioral health needs, including diagnostic information, waiting times for consultation and treatment, available treatment resources and issues concerning diagnosis and prescription of medications.
- Information about the availability of resources, whether, clinical or service-oriented.
- Family and community issues, including communication issues, diagnosis and referral, family support
- Opinions on the various permutations of primary care/mental health practice models, including integrated care, co-located services, training models and enhanced consultation models.
- Other comments on training, needed resources and practice models.

#### *A note on methodology*

The insights gleaned in the interviews serve as a contemporary snapshot of what it is to be a Maine primary care provider who deals with children's mental health issues. While qualitative methodology yields many insights into the realities of practice (which quantitative methodologies can overlook), these interviews were conducted—due to staffing and monetary limitations—with a very small sample of providers. While attempts were made to ensure a geographic distribution, some regions of Maine were not represented. The sample may have had elements of self-selection as well, since providers had to agree to an interview which took up, for them, a substantial amount of time.

However, the chance to learn about key concerns from providers themselves was invaluable. It is striking how many common themes emerged in the components of diverse providers. The often unsolicited, additional comments of providers also gave valuable information, which would not always be possible in the more rigid structure of a survey. In-depth interviews or focus groups conducted with a larger and geographically representative sample of providers (including more mental health providers) would also contribute valuable insights in an expanded study.

### Profile of the respondents

A number of questions were asked about physician background and training. Most of the clinicians, whether pediatricians or family practitioners, had not received any further formal training in psychiatry other than a rotation during their residency. Most clinicians had been long in practice; the average was slightly over twenty years.

Most of these seasoned providers had taken advantage of continuing medical education on children's mental health and behavioral topics, sometimes on psychopharmacology issues. However, there was no trend noted in the kind of brief education the physicians had received, which often took place in conjunction with specialty society meetings. The nurse practitioner interviewed had gone back to school to receive post-graduate psychiatric nursing certification (in response to the number of children with behavioral or psychiatric disorders whom she had encountered).

Most of the clinicians practiced in a group setting, with practice patient loads of from 2,00-10,000 patients noted (the average was about 4,000). Six of the practices were largely rural, with the remainder serving practices roughly divided into one-third urban, one-third suburban and one-third rural. Three of the providers practiced in federally qualified health centers or in "look-alike" centers.

These were busy practitioners; most saw from 20-25 patients daily. The age range of patients differed according to the provider practice specialty and other characteristics of the practice. Some family practices reported that only 20% of their patients were under 18; while the vast majority of patients for pediatricians obviously fell in this category. The interviews revealed that practice patterns differed in other ways; it appeared that some practices became the provider of choice for children with special mental health needs. This occurred because of the provider's interest and then word of mouth referral. As a following section on patient characteristics will reveal, these practice characteristics are evidenced in the number of children who are identified as in need of services and then numbers in receipt of such services.

### Financing issues

Financing issues were central for all providers. While these will be discussed in more detail in the context of services, the following issues emerged as central;

- Most providers had a substantial child patient population whose care was reimbursed by Medicaid. Estimates ranged from 35% of the practice to 80%.
- Providers noted that many critical aspects of care for children with mental health issues were not reimbursed. Care management, consultation and referral were all marked as central.
- Both primary care providers and mental health providers evidenced this reimbursement concern.
- Many mental health and/or psychiatric providers do not accept Medicaid. This is an important concern everywhere but becomes crucial in rural areas.

- Even if a patient is covered by private insurance, referral (and approval thereof) can hold up treatment for very substantial periods. In some cases, it is easier to have treatment approved by Medicaid than it is by an insurance company.
- Providers often mentioned home visiting services as a critical area of concern, but these services are either not available or not covered by some carriers.

### The children

Providers were then asked about their practice's dealings with children with behavioral and mental health needs and how they attempted to meet those needs. The picture that emerged was that of an enormous increase in the number of children experiencing behavioral health problems and of a system ill equipped to deal with these challenges.

In the interviews, providers were first asked about estimated percentages of children: who had behavioral or psychiatric problems, regardless of whether or not they had a specific psychiatric diagnosis; percentages of those who had a specific diagnosis, including ADHD, major depression, PDD or Asperger's; and for what proportion of the latter group the services of mental health clinician or child psychiatrist were utilized.

The results were striking. Great variance existed in the estimates of children with such problems; the estimates ranged from 5% to 60% (five providers estimated anywhere from 5-25%"; 5 "20-30%" and one --who was known as a provider of choice for such issues), 60%. One could not estimate.) These were estimates, however, not based on a complex and careful record review. Because, later in the interview, clinicians expressed great variation in diagnostic knowledge as well as ability to treat such disorders, these great variations in numerical estimates are unsurprising.

Similarly, physicians varied in their estimates of children who had a DSM-IV diagnosis, including (but not limited to) ADHD, major depression, PDD or Asperger's. Again, the figures ranged widely, from 5% to 50%, with the mean being about 25% among these providers. The providers were then asked how many of the latter identified group necessitated access to a mental health clinician/child psychiatrist. (This question was occasionally greeted with some mirth, since there is a dearth of services in almost every case). While responses again ranged across the board, from 5% to 50%, the mean was usually about 30-50%, again based on rough estimates. Every case is different, the clinicians noted and the availability of services is equally problematic.

### Stories about access

The question which invariably provoked the most spirited (and often frustrated) discussion was one in this section. It asked, "How do you typically access mental health and child psychiatry services?" A sample of responses speak for themselves:

- We had a child psychiatrist, but he left the area after a dispute with the hospital over compensation. It can take six months for a child to be seen by a child

- psychiatrist. In emergencies, the child can usually be seen right away. It can take a week or two to several months for kids to be seen for non-emergency care.
- We send them to behavioral and developmental services for an evaluation and treatment recommendations. It's very difficult. We are using a child psychiatrist outside of the area on an ad hoc basis. There is an adult psychiatrist, but he is not available all the time. It's difficult because the private providers don't always have hospital privileges. They are not that interested in multiproblem kids; they want to see the worried well. This is an issue for a kid who has been admitted. For non-emergency issues, it used to take days for them to be seen. Now it takes weeks or months.
  - For emergencies, for issues where the child is exhibiting a thought disorder or really bizarre behavior, we are not able to admit them to the (medical center's) Ped unit because they are often homicidal or suicidal. They should have a system, as with other kinds of care, where we know where the beds are. (This provider was not aware that the statewide Crisis and Counseling hotline, which provides such services, was still available; he thought it had gone out of business because of the end of grant funding). Another big issue is home visiting. The state had this, but my sense was that their (home visiting team) caseload was very small; that each accessed about six families. The need for this is really huge.
  - (From a provider in the same county). I do admit kids to the peds unit if they are in crisis. We do have to use an adult psychiatrist because there is no child psychiatrist. There are huge problems for kids who need non-emergency care. They have to wait one to three months for their first appointment, between doing an assessment, figuring out the coverage and finally getting the appointment. Sometimes after all that there are no shows, which frustrates the mental health center.
  - A lot of the issues—most of the issues—are family systems issues (*note: this was echoed by most providers*). It is rare that the problems just involve the child. There are often class issues, poverty, substance abuse, and mental health problems on the part of one or both parents. We need to address these issues or treatment will not work.
  - I use Kennebec Valley Mental Health Center for non-emergency care, Spurwink for evaluations (which can take a couple of months) and now we have started to use a new provider in the area. It is hard to access the pediatric unit for the really sick kids. They go to Acadia and other places.
  - There is no access here in the County. We need everything—counselors, social workers, and child psychiatrists. I need someone to talk to about medications especially; because there are so few services available, medication prescription by the PCP is pretty common. We do have access for kids at the local mental health center, but it takes months for evaluation and treatment. We can only get

evaluation in Bangor (facility name unavailable), not therapy. And Bangor is over two hours way. We have no access to a child psychiatrist. I need phone access to someone who can advise me about medications, especially.

- It takes 2-3 months for a child to be evaluated at EMMC.
- We need access to some sort of central phone advice re assessment and management, especially concerning ADHD. We need help with how to help families, not just kids,
- The child psychiatrist here is totally booked and has closed his practice to new patients. It can take 2-3 months for a child to be seen by a counselor. The developmental services in Bangor have a three-month wait.
- The wait for services is very frustrating. We work some with the schools, with KVMHC, and Tri-City. It can take up to a week for a kid to be seen on an emergency basis. We need more availability of therapy and psychological testing as well as home-based therapy. Another big problem is that a lot of providers don't accept Medicaid.
- Access to psychiatrists is terrible as it is to other providers. Another issue is credentialing. There is no way to know how good a mental health provider is and whether he/she is actually skilled at the specialty. It is all through word of mouth, catch as catch can.
- We need other things, like health promotion activities—information and resources in pediatric practices. There is lack of coordination and access.

Summary of themes about access:

- In the absence of a coordinated system, it appears that each provider has developed his/her own way of dealing with lack of resources, cobbling together a way of providing some minimal level of helping.
- Every provider is frustrated by long waiting lists and delays in accessing services. While emergency services are generally available, providers report different levels of access to non-specialized pediatric units in their areas. As we will see, the delays impact providers' prescription practices and other aspects of their provision of care.
- Mental health providers who do not accept Medicaid or are uninterested in children's issues are a source of frustration. Providers report a need for more information about the expertise of providers and how to evaluate this expertise.
- Providers report a lack of knowledge of community/family-based services available either in their area or statewide, such as the Crisis and Counseling hotline.

- Providers stress that children’s problems need to be looked at in a family and community context. They frequently mention home visiting as a needed service.
- In general, providers did not appear to be knowledgeable about community resources in their area. Only two of the providers mentioned that they worked frequently with the schools.
- Similarly, providers report different styles of diagnosis and mechanisms that they utilize in order to come to a diagnosis and treatment plan. Some providers have themselves developed expertise in diagnosing one or two areas; often, another provider who has different skills in the practice is consulted. Some providers, especially in the more rural areas, attempt to diagnose as much as they can, in the absence of resources; others limit their expertise to one or two areas and phone or in person contact for the rest.
- Providers in more rural areas are impacted by all of these issues, with a greater degree of severity.

### More on the children

Providers were then asked several specific questions about waiting times to see mental health or psychiatric providers. Unsurprisingly, these answers echoed the comments made during their “stories”. In general, children in an emergency situation would be seen immediately or within days.

Whether or not a child could be seen on an urgent, non-emergency basis was more problematic. In a few, more urban areas, the child could be seen within a week or two, but waiting was often much longer in rural areas and transportation to a specialized center or provider was often difficult.

Interestingly, most providers felt access for Medicaid patients was often better for them than those covered by private insurance—but again, the dearth of providers who take Medicaid impacted this.

All providers concurred on the extreme waits for more routine care and evaluation, which ranged from 1-3 months.

Few of the providers encountered kept formal listing of providers with their areas of expertise. Only two had a listing of local counselors, with their specialties, credentials and practice characteristics. Nor did providers appear to have much knowledge of community services (if they existed). Not every provider worked with the schools, nor were they aware of school services. The extent of liaison with the community seemed to depend largely on the personal bent of the staff; if a staff member had a good relationship with community providers or the schools, then the practice worked with them. But this was hardly true for all of these busy practices in economically underserved areas.

### Medications

Providers were asked a few questions about medications. When asked the percentage of children under 18 who were prescribed psychotropic medications, most practices estimated about 10% (with the exception of one provider, who was seen as the “local provider of choice” for children with severe behavioral and mental health needs; that individual estimated 40%). Most providers did not state that they were providing medication due to absence of services, except for one provider in a very rural area. However, half of the interviewees stated that they were regularly providing medications initiated by another provider, as in case of psychiatric sessions or after a hospitalization.

Providers exhibited different levels of comfort and knowledge concerning diagnosis. They were asked about levels of comfort with the following diagnoses: ADHD, Depression, Anxiety Disorders, Autistic Spectrum Disorders, Bipolar Disorder; PTSD; Eating Disorders and Tourette’s Syndrome.

While providers varied considerably in their comfort levels, in general, they were more comfortable with diagnosis of the first three disorders than the latter five. In order to establish diagnosis when they were unsure how to proceed, the providers frequently referred out for an evaluation or turned to another member of the practice who had developed an informal specialty in the diagnosis. In some situations, providers themselves had become specialists; one, in ADHD and another, in depression. Providers noted the complexity of diagnosis, especially with younger children.

Most providers agreed that there was enough information in the literature about diagnosis; they simply felt more comfortable turning to a more seasoned and educated professional for the more complex issues. About half the providers used rating scales and other mechanisms to monitor response to medications.

Almost every provider agreed that access to child psychiatrists for advice about medications or other issues was difficult, whether formal or informal consultation was attempted. Reasons advanced included lack of availability; the child psychiatrists’ fear of liability and reimbursement concerns (these issues, the clinicians noted, were true of most behavioral health and mental health providers). Practice styles were also cited; mental health providers could not be reached because they did not interrupt sessions with patients. There was a sense that mental health providers did not understand or appreciate the busy, sometimes chaotic workday of the primary care clinicians. Providers noted that they would like to see a quick phone call (within an hour) back from a mental health/psychiatric provider. One noted that the recent telephone network established as a cooperative project of the Maine Academy of Family Physicians and the Maine Psychiatric Association could be a model, though his understanding was that this was oriented toward adult psychiatry.

Another question, which elicited much humor, was one, which asked whether or not the PCP received communication back from either a psychiatrist or psychologist after they saw a patient. Rarely did this occur, which the PCP’s attributed to the reasons alluded to

above. PCP's noted that they would like to see faxed admission and progress notes, and/or a treatment plan, with parent authorization if necessary. They also noted that lack of communication from a mental health provider could be especially problematic with private pay patients, since the PCP sometimes had to reauthorize treatment.

### Family and community issues

Most of the time, providers communicated with the child's mother and father about a diagnosis, although, again, it depended on the case. The schools were most frequently mentioned as recipient of communication. Providers generally arrived at the diagnosis themselves and/or with a mental health professional.

Strikingly, although most providers referred to the need for a family systems approach in examining children with mental health needs, only two practices provided family support services (sometimes provided by a nurse who visited families) and both providers acknowledged that it had been difficult to involve families in the support services. Only one practice referred families to organizations, which might provide support/information, such as the National Alliance for the Mentally Ill, parent education programs or the Maine Association of Infant Mental Health.

Because so few services are offered directly by the practice (although they occasionally were through a referral agency or hospital), it is difficult to assess whether families are problematic in part because they are disempowered, isolated and uninformed about the resources available to them. Unfortunately, the interview did not ask about dissemination of low-literacy educational materials concerning children's mental health needs; such an assessment would yield valuable information about a public health approach to these issues.

### The models

The providers interviewed were asked about preferences for practice models that would help to address the many concerns that they evidenced. The following models were briefly explained: *an integrated model* (a team approach with shared services and practice employment), *co-location* (where a MH provider is co-located, but employed by a mental health center, although there could be shared billing or record-keeping), *case management* (where a case manager, perhaps a nurse, is located in the practice and provides assessment and triage, with referral to a MH provider within or outside the practice), *training models*, especially those oriented toward better PCP assessment and brief intervention and *enhanced consultation and referral*.

The answers were of much interest. They included the following:

- All providers were very enthusiastic about the idea of enhanced consultation with a child psychiatrist, most likely through phone contact.
- All providers were extremely enthusiastic about care management through the addition of a practice care manager who is familiar with local resources.

- Reimbursement for referral, consultation and case management were first in providers' minds.
- Providers were interested in an integrated practice model in theory, but seemed to most often mention elements of co-location as most doable—perhaps because of the time, energy, disruption and monetary concerns involved in an integrated model.
- Providers tended to think of co-location as adding a mental health provider for a specific period of time, which could be reimbursed. This happens already in some practices, through the visit of a mental health provider one or two days weekly.
- PCP's want mental health providers to better understand their needs (and probably vice versa), but they are unclear on how this should occur.
- Providers want education to occur in a manner which is again, not disruptive of their current arrangements, perhaps through brief education allied with specialty society meetings or through rounds sponsored by several practices.
- All providers would like access to evidence-based best practices in treating children with mental health needs, but they were unclear on how they would like that to proceed.
- Two providers directly noted that they would like to see a *public health* approach to all of these issues, where a provider works with an approach that is community based and oriented to children's health in the fullest sense—not as the absence of “pathology”, but health in its largest physical, psychological, social and spiritual sense.

### III Summary and conclusions

Both the survey and the interviews present a sobering picture of children's mental health services in Maine. Access to both routine and emergency care for these children is riddled with challenges. Many of the primary care providers interviewed face difficulties in directing children to the proper care, in determining how they should be diagnosed and treated, in working with their parents and community resources, in dealing with a cobbled-together system which appears to change drastically with the departure of a single provider or the loss of even one service. These difficulties are colored by reimbursement problems—by the refusal of providers to take Medicaid, by the delays associated with approvals by other carriers and many other issues.

Many challenges exist in creating a system that works. Great gaps exist in provider knowledge of best evidence-based practices and resources as well as increased availability of resources. While financing is a critical concern, providers need to be educated that financing alone will not solve all problems, for they are systemic, not simply clinical issues.

A solution would entail education of providers and families concerning diagnosis and treatment as well as a system that not only coordinates resources, but also provides information and education to providers, families and the entire community. The foundation of such a system may already be here. The disparate solutions providers have

created to solve—if even momentarily—the lack of a coordinated system express their enormous energy and commitment to children. The following observations may help form some strategic recommendations for a demonstration project:

- Providers need reimbursement for care management, consultation and referral as well as better education on how to access existing reimbursement systems.
- A care manager for each practice is essential. This individual should be knowledgeable about local or statewide resources.
- Psychiatric phone consultation for providers is also essential. Videoconferencing might also be an option, although the lack of DSL lines in Maine can make this challenging.
- Consultation oriented toward psychopharmacology would also be useful.
- In any developing practice model, user-friendly practice education needs to be designed on specific clinical topics as well as family/community resources.
- If an integrated model is proposed, a service manual (see Patty Robinson's work) should be designed on both clinical and operational issues.
- Clinicians and practice representatives need information about community/family resources in Maine, perhaps through a web-based or hard copy resource manual (materials associated with the Institute for Health Improvement's chronic care model could be a resource).
- Health education materials, which are designed specifically for families, should also be disseminated. Wherever possible, these should be provided through low-literacy materials (UNECOM has a nationally-known center which creates such materials.)
- These materials should take a public health approach which de-stigmatizes families and emphasizes all children's mental health strengths as well as needs.
- Wherever possible, we should use physician champions who can help practices buy into this approach. A reliance on evidence-based best practices will further help us gain credibility with this project.
- In selecting potential practice sites, it will be important to consider that physicians themselves appeared to need education about not only services, but also the potential effectiveness of practice models, which require complex system change. Therefore, a research-based demonstration project should include very specific information about each practice model and its components—only if potential practice sites understand model requirements and the project's goals and objectives can a viable research project be designed and funded.