

**Integrated Primary Care and Mental Health Project
Results of Structural Survey
Results of Template Inquiry**

December, 2004

Introduction

In Fall, 2004, the Maine Center for Public Health (MCPH) conducted follow-up activities to its Maine Health Access Foundation (MeHAF)-funded project, the “Integrated Primary Care and Mental Health Project”, a planning grant whose original intent was to create a model integrated primary care and mental health project in the state, which would focus primarily on children’s services and would be replicable. During the course of the project, a needs assessment found that structural, communication, cultural and reimbursement issues all were barriers to the provision of an integrated model, although there was enormous interest in it. The state Department of Health and Human Services (formerly Behavioral and Developmental Services) also determined that the best way to approach the issue was not to pursue grant funding, but permanent solutions to the issues of reimbursement and other structural barriers.

During the course of the project, it was found that a number of such projects had already sprung up around the state. The MCPH was asked to create templates which would provide basic information about these projects. A summary of the results is below.

MCPH was also asked to assess structural barriers from the perspective of the mental health provider, since the project had originally focused on the concerns of primary care physicians (PCP’s). A summary of these results is also below.

Survey Targets and Responses

Structural Barriers

The survey regarding structural barriers was sent to the following: the Maine Psychiatric Association, the Maine Psychological Association, the Maine State Nurses Association, the Maine Nurse Practitioners' Association and the Maine Association of Mental Health Services.

Despite a reminder, only three responses were received and these were all attributable to MAMHS, which sent out the survey to its membership (e.g., of the survey targets identified above, only one organization responded). However, some valuable insights were received. They included the following observations about cultural issues:

- Language and cultural barriers are primary (between primary care providers and mental health providers)
- Cultural barriers are structural, clinical and financial in nature
- Structural barriers include regulatory requirements (see Waterville)
- Ignorance of physical disorders by patients and mental health providers

Solutions proposed include the following:

- Shared vision of all providers
- Care management which is seamless
- Team meetings and education among providers
- Team member role clarification
- Adequate evaluation
- Amendment of licensing regulations and billing mechanisms

Communications and culture were often identified as barriers to adequate care. Solutions included:

- Determination of essential information
- Appropriate confidentiality protocols
- Examine best practices (Waterville Pediatrics)

Respondents were asked about assessment. They identified the following:

- Many primary care providers (PCP's) are not adequately trained in assessment.

- Practice integration should focus on: formal consultation required screening practices and collaboration built into service protocols.
- Brief assessments beginning at birth would be helpful—should minimize paperwork and be easy for parents

Issues regarding treatment planning, progress and coordination included these issues:

- Lack of provider understanding/awareness of services
- Lack of ready access to child psychiatrist for consultation

Proposed solutions:

- Integrated system of care, such as the Four Quadrant Clinical Integration Model which is proposed by Minkoff for co-occurring disorders.
- Decision support should be evidence based, provide training, education patients about guidelines and establish key linkages.
- Video and phone access to psychiatrists.

The survey also asked providers about manpower shortages.

- One respondent (Aroostook) experienced problems in recruiting social workers, psychologists and certified substance abuse professionals. The new OSA licensing regulations have exacerbated the shortage of substance abuse providers in Aroostook.
- One respondent (Motivational Services) responded that it was easier for the agency to recruit registered nurses, as it was a more rewarding environment than hospital-based work.
- Solutions proposed for the more rural areas were: training programs that focused on rural issues and better training of PCP's in diagnosis and treatment of mental health and substance abuse problems. Geriatric training is also needed across disciplines.

Respondents also stated that the system still favored/incentivized a fee-for-service, acute care approach to services, versus a non-acute, holistic, care management approach to services.

Finally, it was suggested that a universal medical record that could be shared across providers would eliminate duplication of services, decrease cost and improve coordination.

Template of Services

A survey whose intent was to detail the characteristics of existing integrated primary care and mental health projects around the state was e –mailed to approximately seventy recipients in November, 2004. The seventy recipients included representatives of the more than twenty projects previously identified by Andy Cook, M.D., of DHHS, as well as individuals on the contact list of the Integrated Primary Care and Mental Health Project.

Response overview

Fifteen surveys were returned. Some surveys contained information about more than one initiative. One survey was returned from an organization which did not meet the criteria of an integrated model; the agency provided mental health services only (these surveys appeared to have been “passed on” by other recipients). The responses ranged as follows:

- Assisted living/apartments with PCP contact 1
- Telpsy psychiatry 1
- Psychiatric consult with hospital
- Therapist integrated into pediatrician offices 3
- New project w/ integration PCP, mental health service and FQHC 4
- Enhanced referral to MH provider by PCP
- Psychiatry/therapy in school health clinic.
- Counselors in primary care site 2
- Psychiatry consult to PCP 4
- Psychiatry consult to outpatient clinic
- Psychiatry consult to virology clinic
- Projects specifically targeting substance abuse as well as mental health 3
- Linked specifically with residency programs 2

Goals of projects:

- Supportive and safe environment

- Personal growth for patients
- Psychiatric consultation readily available
- Counseling offered to families in non-stigmatizing environment (PCP)
- Improvement of service coordination
- Increased accessibility/timeliness of services
- Enhanced quality of services in PCP office
- Evidence-based services
- Enhanced communication between PCP and mental health providers
- Better referral
- Counseling for patients in non-stigmatizing environment (school)
- Better training for providers
- Single point of entry for patients
- Integrated substance abuse, primary care and mental health services
- Better screening
- Model for public policy

Target Population

- Adults with mental health needs 2
- Children and adults 12
- Children under 18 1

Staffing

Because the projects differed in how they approached the issue, there was variation in terms of staffing needs. Following is an overview of staffing configuration information:

- Program coordinator 3
- Psychiatrist 30 (FT and PT)
- Psychologists 1
- Master's level clinician 2
- LCSW 9
- Psychiatric Nurse practitioner 2
- Outreach crisis worker (MHRT II)
- Billing specialist
- PCP 19
- Physician assistant 5

- Nurse 7\
- Administrator 6
- Support 2
- Counselors 3

Note: These are approximate numbers. Although there was usually at least a PCP and consulting psychiatrist involved, the staffing was tailored to the diverse nature of the projects.

Training

Most of the training requirements are described above. All clinical staff expected to be licensed. Training associated explicitly with the project was as follows:

- For telemedicine: 40 hours training support staff/2 hours for psychiatric consults For Master's level clinicians: weekly meetings, ongoing clinical training
- Orientation/ongoing training on integration and clinical issues.
- Attendance at conferences and symposia
- Training from local service providers to promote awareness/access

Most respondents gave little specific information about training configuration/topics.

Financing

- MaineCare
- Negotiations with private payer
- Private contract with hospital to support psychiatrist
- Private insurance
- Self-pay
- Reduced rate self-pay
- Grant from Care Partners (grant program) to pay for psychiatrist
- Grant from Maine Health Access Foundation
- Other grants from foundations
- OSA funding (for co-occurring disorder projects)
- Professional organizations (American Academy of Family Physicians/Maine Psychiatric Association)

Again, financing was tailored to specific project design.

Family Involvement

- Involved in service planning for patient
- “Family-focused” approach
- Formal consultations
- Newspaper articles
- Treatment partners
- Family therapy
- Participation in assessment
- Team meetings
- Invited to educational events
- Involved in care management

Evaluation

- Quality performance plan/measured quarterly
- Service questionnaires
- Service documentation
- Patient/family questionnaires
- Clinical outcome measures
- Phone contact with PCP and patients
- Random mail surveys
- Integration outcomes based on Edward Deming model
- Process outcomes and data examined quarterly
- Telephone consultation and evaluation forms completed by providers

Evaluation plans again tended to be very specific to a diversity of projects.

Indicators

- Medication errors
- Family satisfaction
- Provider satisfaction
- Consumer satisfaction

- Level of need
- Clinical treatment
- Disposition at discharge
- Referral rates
- Clinician productivity
- MaineCare compliance
- Billable hours
- Clinical outcome measures—intake and discharge LOCUS and GAF
- Referral rates of patients referred by PCP to mental health provider who access mental health services
- Length of time from referral to intake
- Clinical outcome—LOS and YOQ
- OSA data measure outcomes for substance abuse treatment
- Increase in staff knowledge
- Understanding of integrated approach
- Refinement of integrated model
- Proportion mental health clients with a medical home
- Proportion of “no show” appointments at mental health provider
- Average monthly number of visits to PCP

Data collection

- Phone interviews
- CALOCUS worksheet
- Surveys
- Annual surveys through QA process
- Progress notes and treatment reports
- Compliance with licensing standards
- Phone follow-up and random mail surveys
- Periodic integration status surveys
- Improved health status measures (patient health questionnaires administered at intervals, goal setting, registries)
- Web based surveys for satisfaction outcomes

Outcomes

- Decrease in medication errors
- Need for new programs identified

- Access to psychiatric consultation
- Higher family functioning
- Better early identification for children Increased demand
- Increased collegial activities/communication
- Better treatment
- More timely services
- Increased utilization
- More provider satisfaction
- Improved cost management
- Enhanced collaboration
- Enhance continuity of care
- Great acknowledge among providers
- Improved quality, especially in rural communities

Staff Reaction

Staff reaction from all providers was uniformly reported as positive or very positive.

Patient reaction

Patient reaction was generally very positive, especially concerning enhanced access and decrease in travel time. Some patients were initially confused by a case management approach, but this eased with more orientation. A number of projects had not yet measured patient satisfaction.

Challenges

- Lack of crisis services for difficult clients
- Emergency Department issues
- Dealing with more than one licensing agency
- Lack of relief staff
- Private payer rates for telepsychiatry
- Licensure for ongoing telepsychiatry
- Lack of back-up for psychiatrist
- Family follow-through
- Transportation and time off for parents to participate in children's treatment

- Communication among providers/coordination of schedules
- Ensuring that medical sites meet mental health licensing standards
- Need for more marketing to PCP's so they understand utility of approach
- Demand outstrips supply regarding psychiatric services
- Lack of understanding of integrated model

Solutions

- Increased funding, especially MaineCare
- Better qualified staff
- Education of ER staff on mental health issues
- Consumer education
- Changes in private pay/licensing/credentialing and privileging (see detail in questionnaires)
- Strategies to increase family involvement (reminder calls, etc.)
- Co-location where possible
- Funding that recognizes issues associated with rural settings
- Case management reimbursement, especially in designated urban areas or rural areas.

Ideas to Improve Services

- Better education of PCP's
- Streamline documentation required for mental health providers
- Payment systems that provide most value, especially for crisis services
- Incentives for PCP's
- Telepsychiatry utilization
- Education both "sides" re integration
- Co-location
- On-site access to psychiatry
- More testing/evaluation
- Proper reimbursement
- Recognition that many services will continue to be provided by PCP's and establishment of a network of behavioral health providers who can be readily accessible to the PCP.

Extensive detail on solutions is provided by a number of respondents.