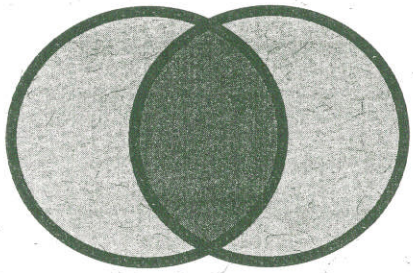
Integrating Primary Care and Mental Health Services



Current Practices in Rural Areas

David Lambert, PhD
Donna C. Bird, MS, MA
David Hartley, PhD
Noel Genova, PA-C, MA

The National Rural Health Association
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The National Rural Health Association

Headquartered in Kansas City, Mo., with an office in Washington, D.C., the NRHA is a nonprofit association composed of individual and organization members who share a common interest in rural health. Its primary mission is to provide leadership for improving the health and health care of rural Americans through education, communications, research and advocacy.

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National Rural Health Association
Publications Department
One West Armour Blvd., Suite 301
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Introduction

Rural primary care providers have strong incentives to form linkages with mental health providers. With a large, diverse caseload and severe time constraints, the typical rural primary care provider often has difficulty keeping up with new mental health treatment modalities and medications. Specialty mental health providers, where available, are a crucial resource for consultation and referral. Changes in Medicare and Medicaid have expanded the range of mental health providers who may be reimbursed and increased the amount they may be paid. Most recently, the development and growth of vertically integrated health networks have increased the incentives and opportunities to link primary care and mental health (Note 1).

Interest in linking rural primary care and mental health services is not new. Federal efforts to promote these linkages can be traced back to the creation of community and migrant health centers (1967) and federally qualified health maintenance organizations (HMOs) (1973). These programs were required to include basic mental health services as part of a comprehensive primary health care package. During the 1970s, Rural Health Initiative and Health Underserved Rural Area grants and the Linkage Initiative program provided additional incentives for linking primary care and mental health services in rural areas (Note 2).

Despite past and current interest in linking rural primary care and mental health services, relatively little is known or widely disseminated about viable linkages between primary care and mental health providers. Lacking this information, providers may find forming such linkages a daunting task. This publication offers help by describing how some rural primary care providers have created and sustained linkages with mental health providers using different resources and responding to different circumstances.

A study conducted by the Maine Rural Health Research Center in 1994 identified 53 organizations in 22 states that had integrated mental health and primary care services in rural communities (Bird & Lambert, 1995). That study focused on identifying different models of integration.

This publication highlights five cases from that study, outlining the circumstances that gave rise to the integration of primary care and mental health, the way the integration works and the lessons other rural providers may learn about linking the two services.

Integrated programs come in all shapes and sizes and have taken advantage of a variety of opportunities. For these reasons, this publication refers to "current practices" rather than "best practices." While these programs may serve as examples for others, the approaches taken and mechanisms used must ultimately suit a program's own circumstances and the needs of the community it serves.

Integration has been defined and discussed elsewhere (Bird, Lambert, Hartley, Beeson & Coburn, 1995). For these purposes, integration refers to a range of inter- and intra-organizational strategies aimed at increasing functional coordination with the intent of improving performance in areas such as access, comprehensiveness, continuity and cost-effectiveness of care.

This publication includes background information, the selection process used, program descriptions and a summary of the lessons learned.

Note: A directory of the 53 integrated programs identified in an earlier study is available from the Maine Rural Health Research Center, Muskie Institute, University of Southern Maine, 96 Falmouth St., Portland, ME 04103.

This publication offers help by describing how some rural primary care providers have created and sustained linkages with mental health providers using different resources and responding to different circumstances.

Background

Differences in treatment philosophy, which may well be the most pervasive barrier, arise from differences in the professional cultures of biomedicine and mental health. The lack of a shared language and divergent healing paradigms may hinder the ability of practitioners to work together.

Since the 1960s, policy-makers have promoted integrating mental health services into primary care as a means to improve access, quality and cost-effectiveness. Integration may be especially desirable in rural areas, given the shortage of mental health providers and the reluctance of rural residents to seek specialty care because of the stigma associated with mental illness and concerns about confidentiality.

Despite the persistence of integration as a policy preference, information on the success or failure of efforts to integrate rural primary care and mental health services and the lessons learned from these efforts has been limited. In part, this may be because most studies were coupled with the initiative itself. When program funding ended, often so did interest in what the programs accomplished (Note 3). Expectations for what primary care and mental health integration might accomplish may have been unrealistically high given the barriers to accomplishing and sustaining such integration. A sense of unfulfilled expectation may have constrained discussion and dissemination of information about these efforts.

Significant barriers to integration arise, among other reasons, from differences between primary care and mental health providers in sources of reimbursement, populations served and treatment philosophy. In rural areas, these barriers are further compounded by the low density of the populations in need of mental health care and the scarcity of specialty providers.

Primary care and mental health agencies often differ in terms of their patients, services and types of providers eligible for reimbursement. Differences in treatment philosophy, which may well be the most pervasive barrier, arise from differences in the professional cultures of biomedicine and mental health. The lack of a shared language and divergent healing paradigms may hinder the ability of practitioners to work together (Note 4). Rural primary care and mental health providers with limited resources often are asked to serve persons residing across vast service areas. While these circumstances provide a strong incentive for integration, they may also severely constrain integration efforts.

Given the limited and dated information about rural integrated programs currently available, the Maine Rural Health Research Center sought to identify and describe models for integrating primary care and mental health services in rural areas. A nomination and screening process was used to obtain the names of provider agencies that: served a rural population, were organizations rather than solo practitioners, and had established linkages with mental health and/or substance abuse treatment services or that integrated these services into the existing primary care program. Research center staff conducted telephone interviews with clinical and administrative staff members of 53 integrated programs.

This study found that primary care providers rely on a combination of four approaches for integrating mental health services:

1. Diversification—coordination of primary care and mental health services within a single organization.
2. Linkage—a specialty mental health provider or practitioner offers ser-

Note: In this publication, the word "providers" refers to provider organizations and the word "practitioner" refers to the individuals who provide services.

Substance abuse is included under the general rubric of mental health.

vices at the primary care site through a formal, ongoing relationship.
3. Referral—using various formal and informal arrangements to obtain off-site mental health services as needed.
4. Enhancement—training primary care practitioners to improve their ability to provide mental health services to their patients directly.

More than one-half of the programs contacted were community health centers. All used referrals, and most used at least one other integration approach. Programs were as likely to treat patients with chronic or severe mental illnesses directly as they were to refer them to specialty mental health services. Many programs had been in operation for at least a decade, although the configuration of services often had changed during that time.

Approach

This study was designed to provide more detailed descriptive information about selected programs that integrate primary care and mental health services. Given that viable integrated programs exist in rural areas, policy-makers, rural practitioners and consumers need to know more about the context in which they develop, how they function and what features they have adopted that may be particularly innovative. Five programs were selected and supplied additional information for this report:

- Family Medicine Center, Amarillo, Texas,
- Isabel Community Clinic and Professional Consultation Services; Eagle Butte, Lemmon and Isabel, S.D.,
- Laurel Health System, Wellsboro, Pa.,
- Monroe Health Center and FMRS Mental Health Council, Union, W.V., and
- Tri-County Community Health Center and Migrant Benevolent Association, Newton Grove, N.C.

These programs are not intended to be representative of all rural integrated programs around the country, nor are they necessarily the "best" according to a specific set of criteria. They were chosen because they are geographically diverse and demonstrate different approaches to integrating primary care and mental health services. Case studies of many more programs could be developed with additional time and resources.

For this study, each organization first was contacted to verify that the program was operational and to confirm that it coordinated or integrated services in the manner reported earlier. The intent was to determine that the program's activities were sufficiently established and ongoing to justify its inclusion in this study.

In-depth telephone interviews with lead primary care and mental health staff and other individuals explored how the program developed and functioned. The interviews focused on the incentives for and barriers to integration, how integration came about and how it works. The interviews also sought to assess how satisfied respondents were with the integration and what their future plans were.

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Case Studies

The integration of primary care and mental health within the center has succeeded because of the continued support for behavioral health training within the family practice residency program.

Family Medicine Center Amarillo, Texas

The Family Medicine Center oversees four satellite family practice residency sites affiliated with Texas Tech University Health Services Center at Amarillo. The center is based in Amarillo but serves a large geographic area, including much of the 26-county Texas-Oklahoma panhandle area. The four satellite sites are located 45 to 60 minutes from Amarillo by car. Physicians treat their own patients within the center, as well as train residents in family practice.

The program trains 18 residents at a time, six in each of three classes. Recognition and treatment of behavioral health problems is a core part of each resident's training and includes a rotation in behavioral health care, as well as ongoing training and responsibility for providing behavioral health care in both hospital and community settings.

The residency program has a long-term contractual agreement with local schools to treat attention deficit disorders and has had contracts with other community partners, including the Texas Department of Criminal Justice.

A central tenet of this program is the key role of rural family physicians in recognizing and treating behavioral health problems. This orientation reflects the reality that in many rural areas the primary care physician may well be the only clinician available to identify and treat mental health and substance abuse problems. The center's regional chair brought this orientation to the practice after spending seven years as a family physician in a remote rural area before moving to the Health Services Center six years ago. He developed the behavioral health component and integrated it into the family practice residency program in collaboration with a psychologist who now holds an associate professor rank and the position of associate regional chair of the Family Medicine Center.

The integration of primary care and mental health within the center has succeeded because of the continued support for behavioral health training within the family practice residency program. The close working relationship between the regional and associate regional chairs has been instrumental in maintaining this support. The Department of Psychiatry at Texas Tech University Health Services Center at Amarillo and the Amarillo Public School System supported the idea of developing this program.

An ongoing effort is necessary to promote and maintain this support among family practice residents. Typically, first-year residents are more interested in procedure-based than behavioral medicine. Prospective family practice residents are screened carefully to assess their willingness to learn about and provide behavioral health care. Second- and third-year residents work closely with first-year residents to ensure that these tasks are completed. The psychologist closely monitors the training of residents and discusses problems with individual residents or within or among clinical departments.

Service Arrangements

Behavioral health training for residents starts with the medical exam. Residents are trained to screen for and diagnose patients' mental health and substance abuse problems. This training is reinforced at weekly department or preceptorship sessions, which include reviews of cases and discussion of relevant medical literature. The month-long be-

havioral science rotation during the first year of residency at the satellite site in Borger, Texas, is funded by a grant from the Phillips Petroleum Corporation. Residents work on an inpatient psychiatric unit, at Alcoholics Anonymous meetings and at a domestic violence shelter, as well as in an emergency room and in general clinic settings. Residents spent substantially less time at the other three satellite sites. Supplemental behavioral health training is provided every six months throughout the residency.

While training is provided in psychiatric settings, the emphasis is on detection and diagnosis in general health care settings where residents encounter patients with behavioral health problems. Special training is provided to enable residents to recognize patients with borderline personality disorders whose problems are often overlooked or referred elsewhere. In addition, residents have responsibility for working with children diagnosed with attention deficit disorder through a contract between the Family Medicine Center and the Amarillo Public School System. Residents provide care to persons who are HIV positive, treating their emotional and behavioral as well as their physical health needs.

Residents receive and make referrals as they would be expected to do during the course of non-resident practice. However, they are not able to maintain ongoing treatment relationships with particular patients. Client information is usually transferred through telephone consultation and case review. Clients have a common identification number, which is used for common billing, for both mental and general health care. Chart transfers between mental and general health care occur only when specifically requested.

Reimbursement Sources

Approximately 20 percent of patients treated at the Family Medicine Center have Medicare reimbursement. Roughly 20 percent have private insurance, another 20 percent are self-pay, and 16 percent have Medicaid reimbursement.

Because of the high degree of integration between behavioral and general health care in this program, staff are not easily able to distinguish reimbursement for behavioral health from that for general health.

Future Plans

The chief architects of the behavioral health training program (the regional chair and associate regional chair) are quite satisfied with how the program has evolved. Despite initial reservations among new residents about the need for this training, they come to recognize its usefulness by the completion of their residency training or early in their practice careers. Community agencies are similarly pleased with the behavioral health services. The center plans to add several psychologists to the program, whose tasks are expected to range from conducting neuropsychiatric testing to working with clergy to help them detect and refer parishioners with Alzheimer's Disease.

One area in which greater coordination and mutual benefit might occur is between the family practice residency and other residency programs, including internal medicine and psychiatry. Turf issues and time resource issues have tended to hinder cooperation among these program areas.

A key lesson from the Family Medicine Center is the importance of having a clear understanding of its purpose and keeping to it: training family physicians to recognize and treat behavioral health problems. While the center has thrived because of basic institutional support for what it does, it has largely created and sustained this support, sometimes overcoming resistance from other clinical departments. This approach should be adaptable to other primary care residency programs that train rural practitioners.

A key lesson from the Family Medicine Center is the importance of having a clear understanding of its purpose and keeping to it: training family physicians to recognize and treat behavioral health problems.

Isabel Community Clinic and Professional Consultation Services Isabel, Eagle Butte and Lemmon, South Dakota

During 1994, the mental health therapist served 1,800 individuals, coordinating care with the physician's assistant at the site through frequent telephone and face-to-face conversations.

Isabel Community Clinic is a small community health center located in an isolated area of northwest South Dakota, between the Cheyenne River Indian Reservation and the Standing Rock Indian Reservation. Established in 1976, the clinic employs eight and one-half full-time equivalent persons, including a physician's assistant. He is supervised by members of a primary care physician group practice who work in Hettinger, just over the North Dakota border. Members of the practice take turns flying to the clinic to spend a half-day a week reviewing charts and seeing patients. They also provide telephone consultation on the prescription of psychotherapeutic medications.

During 1993, the clinic handled 2,500 total patient visits. About one-third of the clinic's patients are American Indians.

The clinic's service region is vast and sparsely populated, with an overall population density of fewer than two persons per square mile. Its tiny communities are linked by secondary roads. The nearest settled area of any size is Mobridge (population 3,768), about 50 miles east of Isabel. In 1990, Isabel had just over 300 residents. The local economy depends primarily on ranching and farming. Unemployment is a serious problem among the American Indians living on the reservations. Many off-reservation jobs are low paying and offer no health insurance benefits. About one-half of the region's children younger than age 18 live in households with incomes below the poverty level.

Five years ago, the clinic assumed sponsorship of another primary care facility 40 miles away in Eagle Butte, a town of fewer than 500 persons. This facility also is staffed by a physician's assistant. Different arrangements for providing mental health services are in place at the Isabel and Eagle Butte sites. However, the same specialty provider serves both clinics.

In 1991, Isabel Community Clinic received a three-year Rural Health Outreach Grant that provided funds to pay for specialty mental health and substance abuse treatment services. During the grant period, which ended in September 1994, the clinic had a master's-level mental health therapist and a certified drug and alcohol counselor who were each on site one-half day a week. They were employed by Professional Consultation Services, a community mental health center and certified alcohol/drug core service agency with headquarters in Lemmon, 75 miles north of Isabel. Funds from the grant covered the cost of services as well as staff travel to and from the site. The clinic provided a private room and handled appointments for the two counselors.

Service Arrangements

Since the grant expired, these services have dropped to one day a month, still covered by the mental health therapist. This decline in mental health service capacity is due both to the loss of funds and to limited demand for the service. While clinic staff perceive considerable need for mental health and substance abuse treatment services, area residents aren't always willing to seek this care.

During 1994, the mental health therapist served 1,800 individuals, coordinating care with the physician's assistant at the site through frequent telephone and in-person conversations. Case conferences, which may involve other area social service providers, are conducted as a way of sharing information and solving problems. The therapist takes her patient records back to the central office of Professional Consultation Services at the end of a clinic session to protect confidentiality. Patients from the Isabel area who need to see a therapist between monthly visits travel to Lemmon, Timber Lake (19 miles east) or Eagle Butte.

When the clinic assumed responsibility for the primary care facility in Eagle Butte, Professional Consultation Services already had two full-time mental health therapists and a substance abuse counselor working in town. Their offices were (and remain) in the old city hospital, which was renovated to make room for the primary care services. These practitioners reside in the Eagle Butte area and provide outreach services to the surrounding towns. They receive referrals from the Eagle Butte satellite, the local Indian Health Service clinic, local schools and social service agencies, as well as from concerned clients and family members.

Since July 1990, Professional Consultation Services has actively cultivated relationships with schools and health centers around the region. Eight clinicians provide outreach services for mental health in 14 communities and for substance abuse in eight communities. In addition to the two clinic sites, Professional Consultation Services also provides substance abuse treatment services at another community health center, an Indian Health Service Clinic and a small community hospital. Some of these facilities are located as far as 170 miles from Lemmon.

During 1994, a majority (70 percent) of these mental health clients were children aged 18 and younger. Almost one-third (30 percent) of the substance abuse clients also were 18 years old or younger.

Services offered include case management, as well as individual, group and family therapy. Staff provide some services in clients' homes and in area schools. The executive director, who is also the clinical director, spends more than one-half of his time providing direct services.

South Dakota Medicaid requires physician certification to confirm each client's need for mental health services. This rule creates genuine hardship in an area with no physicians. Professional Consultation Services turns to consulting physicians from the Hettinger group practice and from St. Alexius Hospital in Bismarck, N.D. (about 170 miles north), which has an inpatient psychiatric unit and employs five psychiatrists. St. Alexius Hospital also receives referrals from this region for patients whose needs are too severe or complex to be handled on an outpatient basis.

Bismarck is one of several towns area residents travel to for specialty mental health services. The others are Rapid City (200 miles from Isabel), Pierre (100 miles away) and Aberdeen (150 miles away).

Reimbursement

Patient fees are now the only source of income for the Isabel mental health service, which operates at a loss to Professional Consultation Services. Overall, about two-thirds of Professional Consultation Services' revenues come from Medicaid, while the balance comes from the Alcohol, Drug Abuse and Mental Health block grant, county government and patient fees. South Dakota has historically used the block grant to fund mental health services to individuals not eligible for Medicaid. This revenue source has been steadily declining.

The executive director of Professional Consultation Services also is concerned about the possibility of a reduced availability of Medicaid reimbursement.

Future Plans

American Indian and white residents in this corner of South Dakota suffer from extreme poverty and isolation. Alcoholism, family violence and child sexual abuse are problems of significant proportions.

Recognizing this, the South Dakota Office of Rural Health has actively encouraged the linkage of mental health and substance abuse treatment services with primary care. Staff members at Isabel Community Clinic and Professional Consultation Services continue to look for cost-effective ways to make these linkages work.

Eight clinicians provide outreach services for mental health in 14 communities and for substance abuse in eight communities.

The Laurel Health System Wellsboro, Pennsylvania

Following recent capital improvements at the Soldiers and Sailors Memorial Hospital, the outpatient mental health center and the partial hospitalization programs have moved there. This has allowed certain efficiencies in the use of both direct care and administrative staff.

The Laurel Health System, located in north-central Pennsylvania with headquarters in Wellsboro, was formed by the affiliation of Soldiers and Sailors Memorial Hospital and North Penn Comprehensive Health Services in July 1989. North Penn's six federally funded community health centers are located in Blossburg, Elkland, Galeton, Mansfield, Wellsboro and Westfield. These facilities all are federally qualified health centers (FQHCs) with a mission to provide comprehensive primary care using salaried physicians, nurse practitioners and physicians' assistants.

Before its affiliation with Soldiers and Sailors Memorial Hospital, North Penn had a 17-year history of developing a network of primary care and human services. In 1972, the state decided to close the general hospitals that provided free care in regions with large low-income populations.

In Blossburg, a 125-bed hospital with a 25 percent occupancy rate in its last year of operation was one of the first hospitals to be closed. Blossburg is located in the coal mining region of Tioga County. The region's mines have not been functional since World War II, resulting in significant unemployment. When the hospital closed, the state arranged to lease the building to the town of Blossburg for $1 per year, in the hope that the town could use the facility to provide health care for the area's residents. In March 1973, a one-physician health center opened in the building, employing some of the nurses who had worked at the hospital. In 1974, a second health center opened in Mansfield, and the Cowanesque Valley Health Center at Elkland opened in 1975. With the closing of the state hospital, the region qualified as a health professions shortage area and was able to staff these health centers with National Health Services Corps physicians.

Early in its history, North Penn added home and center services (August 1973) and an inpatient drug and alcohol treatment center (August 1974), making use of the former hospital building. The home health agency was added in November 1974, and Northern Tier Youth Services was added in 1976, along with a mental health and mental retardation program that was re-named Laurel Counseling Services after the affiliation.

Service Arrangements

Laurel Counseling Services offers partial hospitalization and outpatient mental health services for adults and adolescents, inpatient mental health services and group housing. These programs all are located in Wellsboro. Until recently, they have been offered at separate sites. Following a recent capital improvement at the Soldiers and Sailors Memorial Hospital, the outpatient mental health center and the partial hospitalization programs have been moved there. This has allowed certain efficiencies in the use of both direct care and administrative staff.

In addition, staff believe that having these services co-located with the hospital affords greater privacy to their patients. Formerly, when a patient's pickup truck was seen parked outside the Laurel Counseling Center, everyone in town knew that the individual was seeking mental health care. Seeing that truck in the much larger hospital parking lot is less problematic for patients.

In the early 1990s, mental health workers also saw patients in the five outlying health centers. Recently, staff turnover has made it impossible to offer these services to outlying centers. North Penn Comprehensive Health Services is actively recruiting psychiatrists and other mental health workers with specific plans to offer outpatient mental health services at the health centers again, starting in early 1996.

The inpatient program has two licensed social workers. When mental health workers are again seeing patients in the outlying centers, an additional licensed social worker hopefully will be added, and these three providers will jointly offer 40 hours per week at the health centers. This will allow them to provide follow-up care and case management to the same patients they treat in the inpatient program.

While the integration of inpatient and outpatient mental health services bodes well for persons with chronic and persistent mental health problems, primary care patients at the Laurel Health Centers with less severe problems, such as depression, face waiting lists for counseling services. Some receive medication from a primary care practitioner without having seen a mental health specialist. Although the recruitment and deployment of new mental health workers should alleviate some of this problem, Laurel Health Services now is pursuing graduate training in psychiatric care for its nurse practitioners as another strategy to address mental health problems encountered in the primary care setting. To assess the extent of the need for such services, Laurel Health Services is compiling a list of all mental health diagnoses from the health centers, including secondary diagnoses. In addition, they anticipate developing protocols for the diagnosis and treatment of mental disorders by primary care staff.

Laurel Health Services has encountered some difficulties integrating the medical records from its mental health services with those from acute and ambulatory care. Because of data restrictions to ensure client privacy, enforced by state licensure requirements, mental health records cannot be made accessible to providers in the hospital or the health centers. A patient who seeks primary care at a health center and also receives mental health care there will have a unified record. However, a patient admitted to the hospital with a psychiatric emergency will have two separate records. A consent form signed by the patient is needed for a provider from one side of this data privacy curtain to view documentation on the other side.

The rule restricting sharing of data assumes that mental health agencies are freestanding entities. The rule allows two providers within the same organization to share information without obtaining a release form. It is this provision that allows a patient receiving primary care and mental health care within the same center to have a unified record.

Laurel Health Services now is pursuing graduate training in psychiatric care for its nurse practitioners as another strategy to address mental health problems encountered in the primary care setting.

Reimbursement

Laurel Counseling Services has a concentrated reimbursement mix that depends heavily on Medicaid. Overall, the Laurel Health System reports that 22 percent of its patients are medically needy, which includes Medicaid-eligible persons and a portion of the uninsured.

However, 79 percent of outpatient mental health services are reimbursed by Medicaid, 7 percent by Medicare and 14 percent by other sources. Forty-one percent of inpatient mental health services are reimbursed by Medicare, 36 percent by Medicaid, 18 percent by other insurance and 4 percent by cash.

Future Plans

The executive director of North Penn Comprehensive Health Services recognizes the value of greater integration of mental health and primary care services, both for increasing access to mental health services and for improving the continuity of care among the primary care setting, mental health specialty care and mental health inpatient care. However, she expects that some of these integration initiatives will meet with some resistance from state and federal agencies. For example, the co-location of outpatient mental health services with the inpatient program has been resisted by the state department of mental health, largely because its definition of partial hospitalization calls for a non-hospital setting. Similarly, state licensure for an outpatient mental health clinic includes

minimum levels of psychiatric time. Based on current levels of service, state licensure requires that almost three full-time equivalent persons provide psychiatry for Laurel Counseling Services. By moving more of its mental health care into the Laurel Health Centers, many of these services can be provided by non-psychiatrists under FQHC reimbursement requirements.

When North Penn affiliated with Soldiers and Sailors Memorial Hospital in 1989, one of the greatest obstacles was the regional office of the federal Bureau of Primary Health Care, which oversees grants to community health centers. The regional office staff feared that the affiliation might compromise the community control required by that program. By modifying its board structure, Laurel Health Services was able to convince the regional office that local autonomy would not be compromised. To prevent a similar incident, Laurel Health Services is communicating its plans to integrate mental health and primary care services with state mental health authorities, as well as the Bureau of Primary Health Care's regional office. While Laurel Health Services' staff do not feel that the regulatory and policy environment is conducive to innovative approaches to service delivery, they are fortunate to have the resources to deal with these bureaucracies.

Monroe Health Center and FMRS Mental Health Council Union, West Virginia

The pediatrician and counselor recognized a largely unmet need for mental health services in the community and realized that concerns about confidentiality kept many people away from their doors.

Monroe Health Center is a community and federally qualified health center not far from the Virginia border. Its mostly white, moderate- to low-income patients come from a region whose economy is dominated by farming and government services.

The center has 22 full-time equivalent staff, including two primary care physicians. It is located in the same multi-purpose building as the local satellite office of FMRS Mental Health Council, a community mental health center serving Fayette, Monroe, Raleigh and Summers counties. The two providers have shared a strong, completely informal referral relationship since they became next-door neighbors in 1977.

Since its establishment in 1972, Monroe Health Center has leased space at a nominal cost in a building owned by the Monroe county government. Funds to construct the building were obtained from the Appalachian Regional Commission as part of a nine-county health services development initiative called Operation Health. Eighteen years ago, the county expanded the size of the building, making room for the FMRS Mental Health Council and the offices of a dentist and an optometrist.

The creation of the multi-purpose facility in Union marked another step in the history of collaborative efforts among area health and human service providers. During the 1950s, the county health officer, a physician in general practice, invited the public health nurses to use his office as a site for their clinics. This set an example that others followed, and the Monroe county government became accustomed to looking for ways to bring services closer together.

A generation later, this physician's son was providing counseling services in Union in a building shared with a pediatrician who provided technical assistance to the Operation Health project. The pediatrician and counselor recognized a largely unmet need for mental health services in the community and realized that concerns about confidentiality kept many people away from their doors. They approached the county government with the idea of building an addition to the Monroe Health Center building. Their proposal was positively received, and the construction began.

Service Arrangements and Reimbursement for Services

Today, that counselor is the mayor of Union and the administrator of the Monroe county office of the FMRS Mental Health Council. His staff includes a psychiatrist one-half day per week, a traveling psychologist who is in town two days a week, a child development worker who holds office hours on Fridays and a case manager who transports patients. He shares a part-time nurse with the health center and still spends much of his own time counseling people.

Referrals come from the health center, private physicians, schools, churches and social service agencies. About 40 percent of the patients are on Medicaid, which reimburses $100 for a counseling visit. Another 40 percent are self-pay and use a sliding-fee scale. The rest are eligible for Medicare or have private insurance.

The central office of the FMRS Mental Health Council is in Raleigh County, one-and-one-half hours away from the Union office. Consequently, the satellite office tries to meet the mental health needs of everyone who comes through the door, regardless of the severity of the condition. Services provided include individual and family counseling and the judicious use of psychotherapeutic medications. The facility avoids using group therapy, which clients in this tightly knit community perceive as a potential threat to confidentiality. When the psychiatrist is not available, the health center physicians write prescriptions for medications and handle the paperwork for commitments to psychiatric inpatient care. Many of the people who need mental health services experience situational depression.

Because the community mental health center is directly across the hall from the health center, patients move back and forth between the two with a minimum of fuss. As a result, patients are more willing to follow through with referrals. The organizations have no formal protocols for handling these referrals but maintain regular communication with each other. The nurse who works for both provides a great deal of continuity. Patient information is shared through a combination of chart transfers, occasional case conferences, written memos and face-to-face conversations. Although the facilities maintain separate waiting rooms, the clinical areas are connected by common interior doors often used by staff members.

Future Plans

Monroe Health Center has historically served as a site to train health professionals. It is now the lead agency in a new consortium, Country Roads, which has received state grant funds to become a more formal teaching site for medical, dental and nursing students from around the state. The purpose of this statewide project, called the Rural Health Initiative, is to enable health professions students to learn about rural health services delivery with the expectation that more will choose to practice in rural areas. Classes and preceptorships started in the fall of 1995. The county is adding another 4,500 square feet to the multi-purpose building to house classrooms and additional offices to meet the needs of this program.

On January 1, 1995, state and county employees in West Virginia became eligible for managed care coverage under a primary care case management model. This program seems to have increased demand for health and mental health services at Monroe Health Center but has not yet significantly changed patterns of service use, since most of its patients were already using their primary care physicians as gatekeepers. During 1996, the state plans to implement a Medicaid managed care program in 12 counties, focusing on the northwest region where some HMO market activity has already occurred. Providers in Union anticipate that Medicaid managed care will take a few more years to take shape in their part of the state. By then, they expect that their interactions will be formalized and will require more paperwork.

The relationship between primary care and mental health providers in Mon-

Because the community mental health center is directly across the hall from the health center, patients move back and forth between the two with a minimum of fuss. As a result, patients are more willing to follow through with referrals.

roe County has been remarkably stable and congenial over time. This reflects the respect and admiration the agency administrators have for each other and the overall culture of mutual aid in the face of hardship and scarce resources that characterize the community. Both administrators hope to maintain this positive feeling as the future brings changes to the local health care system.

Tri-County Community Health Center and Migrant Benevolent Association Newton Grove, North Carolina

The creation of the Migrant Benevolent Association, largely supported with state grants, enabled substance abuse treatment services to be linked with primary care.

The Tri-County Community Health Center has offered clinical services to the residents of Harnett, Johnston and Sampson Counties for nearly two decades. The center started as a night clinic in a storefront in 1976. The center's sister organization, the Migrant Benevolent Association, was started in 1986 to obtain funding for services that cannot be provided directly through the center. The center and the association are integrated, share staff and space, and currently employ 81 full-time equivalent staff.

They offer a wide variety of health care and social services to 7,000 individuals. Seventy percent of their clients are seasonal farm workers, most of whom speak only Spanish, while the rest are year-round community members, most of whom have low incomes. Last year, the agencies provided almost 20,000 medical visits and 6,000 off-site encounters. One fourth of these encounters were for mental health, while 3,500 were for educational or social services. In addition, the agencies provided 920 on-site mental health visits last year.

From the beginning, the center employed a clinical social worker obtained through the National Health Service Corps. Her presence enabled mental health services to be offered along with primary care and dental services. New services have been added as need arose and funding became available.

The creation of the Migrant Benevolent Association, largely supported with state grants, enabled substance abuse treatment services to be linked with primary care. These services are run through the association since they do not fall under the center's federal mandate as a migrant health center.

A substance abuse treatment center opened in the fall of 1994, providing intensive outpatient services. This is the only bilingual substance abuse center in the state. Services are offered in Spanish for those patients who do not speak English. Counseling, social service and substance abuse treatment services are offered on site.

Service Arrangements

Tri-County Community Health Center provides social services, outreach programs and counseling. Severely or chronically mentally ill patients receive psychiatric services at the mental health center in the county in which they reside. The services may be up to a two-hour drive away from a patient's home. Insufficient transportation and a shortage of Spanish-speaking staff members compound this distance barrier. To address these problems, Tri-County provides transportation and translation services, making a critical link to mental health services not offered on site.

A list of the substance abuse treatment services provided by the association suggests the breadth of activities in the agencies: counseling and prevention, training outreach workers to identify substance abusers, perinatal intervention through a high-risk maternity care coordinator, intensive outpatient treatment and consultation to other programs

in the state. Some services are offered in the clinic, while outreach and educational services are offered in the migrant camps.

Close networking among providers and outreach into the camps enhance education and screening for HIV. HIV screening is critical because of the high-risk status of intravenous drug users and HIV's association with tuberculosis, a condition of special concern to the high-risk maternity care coordinator.

The overwhelming motive for merging primary care and mental health services at the center is to better serve patients. Language, culture and transience hinder serving migrant farm workers. Keeping the clients in focus is the driving force for all of Tri-County's and the Migrant Benevolent Association's programs.

From the outset, mental health and primary care providers have given direction and leadership to the center. Substantial internal resistance to providing mental health and substance abuse services has rarely occurred. Major functions of governance, budgeting, quality assurance and peer review are shared by primary care and mental health administrators and practitioners.

Specific examples of client care illustrate how closely the primary care, mental health and substance abuse treatment staffs work. Patients have the same chart number for all departments. Until recently, all information was kept in a common chart. Because the patients typically have limited transportation, every effort is made to have all services offered on the same day and in the same building. This practice excludes services requiring a psychiatrist, which are arranged by referral to the county mental health center. The primary care, mental health and substance abuse treatment practitioners simply walk the patients between their separate offices, sharing needed information as they transfer individual patients.

Written protocols are usually not used to refer clients to the county mental health centers and are never used for internal referrals. The policy and procedures manual has written protocols regarding situations in which patients are a threat to themselves or others. These protocols are especially needed in those rare instances when the director of community services is unavailable to handle a situation personally.

Reimbursement

As a community and migrant health center, Tri-County receives the majority of its funding for primary medical and dental services from a federal 330 grant. Much of the funding for mental health and substance abuse treatment also is federal, with the funds flowing through the state. Although services are well coordinated, there are five separate grants for substance abuse treatment alone. There is a sliding-fee scale for primary care services and some small amount of revenue from self-pay patients.

However, the clinic receives almost no reimbursement for any services from Medicare, Medicaid or private insurers. This is partly because many migrant workers are reluctant to apply for state assistance, whether or not they are undocumented immigrants.

Future Plans

The spirit of cooperation and mutual respect is continually bolstered by the benefits realized by the clinical staff, as well as by the patients. Primary care providers benefit by improved treatment compliance and lower costs of medical work ups when their patients' mental health problems are being treated concurrently. Mental health and substance abuse providers benefit because they do not have to struggle with assessment of their patients' medical problems; they simply ask the primary care provider to walk over and see the patient.

The spirit of cooperation and mutual respect is continually bolstered by the benefits realized by the clinical staff, as well as by the patients.

Discussion

Organizations must first recognize the benefits of integration and perceive that they will gain more by integrating services than they will lose by sharing clients or staff or changing the way they do business.

The five cases described here show that rural primary care and mental health services can be integrated and suggest that the medical and behavioral health needs of rural people may be better served as a result. These cases also illustrate that integration is an ongoing process in which organizations must be strategic, opportunistic and flexible.

It is tempting to try to present a short list of steps primary care and mental health providers should pursue to integrate their services to better meet the needs of rural communities. However, given the diversity of circumstances and needs that rural organizations face, such a list might not be particularly helpful and could be misleading.

Rather than implying a cookbook list, the preceding cases illustrate issues that are important in initiating, maintaining and improving integration of primary care and mental health services.

Motives for Integrating Services

Organizations cooperate with each other when it is in their best interest to do so. They must first recognize the benefits of integration and perceive that they will gain more by integrating services than they will lose by sharing clients or staff or changing the way they do business. Integration involves each organization losing some autonomy. Motivation for integration cannot be mandated, nor is the availability of funding alone sufficient to provide this motivation.

For the Family Medicine Center and Tri-County Community Health Center/ Migrant Benevolent Association, recognition of a specific problem established a compelling reason to integrate. The driving force for the Family Medicine Center was the realization that in most of the Texas and Oklahoma panhandles, the family physician is likely to be the only clinician available to detect and treat behavioral health problems. Rural family physicians must be trained to accept and meet this responsibility competently.

Staff at Tri-County recognized that language, culture and lack of transportation pose major barriers to meeting the behavioral health needs of seasonal farm workers. This population is not likely to be served by traditional, separate service providers.

The evolution of motivation to integrate services was more gradual for Isabel Community Clinic and Laurel Health System. Isabel had recognized a need for on-site mental health services since its inception. In 1991, a Rural Health Outreach Grant enabled a linkage arrangement to be established.

Integration of primary care and mental health services within the Laurel Health System has not been a response to a specific need as much as it has been part of the systematic integration of the various components of the health care delivery system in Tioga County. This integration culminated with the formation of the Laurel Health System in 1989. Laurel Health System was able to build on a 17-year history of agency cooperation, during which time additional services were added. Efficiencies in service delivery and reduced administrative costs provided incentives for various organizations to integrate within a larger health network. Current personnel problems have temporarily required removing mental health providers from the outlying health centers, diminishing the opportunities for integration. Because of its affiliation with Laurel Health System, the North Penn Comprehensive Health Services and Laurel Counseling Services staff believe the integration initiatives will be back within the coming year. Integration of budgeting, reimbursement and

record keeping is proceeding as part of Laurel Health System's strategic plan for information systems development.

Access to Services

Lack of access to mental health services in rural areas is a long-standing and pervasive problem. Few if any specialty mental health providers are available in many areas, and it is difficult to coordinate those services available with primary care services across large geographic areas. This is a generic barrier to meeting the mental health needs of rural residents. The specific supply problems encountered in a rural area often shape a program's efforts to coordinate and integrate services.

Lack of specialty mental health providers and the resulting reliance on primary care were central to the inception of the Family Medicine Center's focus on behavioral health. Rural family physicians must screen, detect and often treat behavioral health problems. Residents are trained to refer when necessary and feasible, but they also are taught that this will not always be possible.

The large, sparsely populated region served by Professional Consultation Services is central in understanding how and why it developed. Much of the organization's growth has been strategically focused on expanding mental health care across this large area.

Expanding availability of care is only half the task, however. People must be willing to use the services. Cultural beliefs and values and concern about being an identified user of mental health services may prevent rural persons from using available services. Demand has remained unexpectedly low in some remote rural areas, even after mental health and substance abuse treatment services were made available. As Professional Consultation Services discovered in Isabel, in particular, the stigma associated with mental illness and the lack of insurance coverage still present formidable barriers.

With a small part-time staff, FMRS Mental Health Council serves clients from all over Monroe County, W.V., and takes many referrals from its next-door neighbor, the Monroe Health Center. Accommodations are made in light of limited access to other specialty mental health providers. When the psychiatrist is not on site, physicians from the health center write prescriptions for psychotherapeutic medications and handle the paperwork for inpatient commitments. Because the central office of the mental health center is far away, the satellite office in Monroe treats everyone who comes through the door, regardless of the severity of their problems.

The Importance of Leadership in Initiating and Maintaining Integration

Program evaluations and case studies usually find that strong visionary leadership is a crucial factor in creating innovative programs. The longevity of that leadership, or the succession and internalization of that vision within the program are necessary for a program to realize continued success and growth.

At two sites in particular, the shared leadership of the primary care and mental health directors has been instrumental in initiating and maintaining integration. The Family Medicine Center has enjoyed close collaboration between the regional chair (a primary care physician) and the associate regional chair (a psychologist) from the inception of the program. While behavioral training within the primary care residency program has been institutionalized, continued strong leadership is critical.

Collaboration between Monroe Health Center and the FMRS Mental Health Council initially arose from the coincidental co-location of a pediatrician and a mental health counselor. These clinicians both recognized that there was a large unmet need for mental health services and shared a concern about confidentiality in providing services to meet

Cultural beliefs and values and concern about being an identified user of mental health services may prevent rural persons from using available services. Demand has remained unexpectedly low in some remote rural areas, even after mental health services were made available.

All of the programs described here have focused on reducing the stigma of mental illness, which is an especially serious problem in rural communities where most people know each other.

this need. The mutual trust and respect that have grown over the years between the directors have enabled them to work and lead together effectively.

Strong leadership has also been important to the success of the Tri-County Community Health Center and Migrant Benevolent Association programs. From the outset, mental health and primary care practitioners gave direction and leadership to the health center. Substantial internal resistance to providing mental health and substance abuse services rarely occurred.

Similarly, the executive director of the North Penn Comprehensive Health Services recognized the need for continuity of primary and mental health care and is committed to service integration, despite recent problems.

Staff Training and Cultural Sensitivity

Integrating primary care and mental health services requires that staff with different clinical backgrounds modify their attitudes and expand their knowledge and understanding. At the same time, they also need to be sensitive to the cultures of the community residents they serve, recognizing the effect of cultural beliefs and expectations on the therapeutic process.

Changing the attitudes of primary care residents is a crucial element in the success of the Family Medicine Center. Family practice residents learn to value mental health care and to accept responsibility for detecting and treating mental health problems. Efforts to sensitize other residency programs at Texas Tech Health Services Center at Amarillo Medical School to the importance of behavioral health training are ongoing.

The West Virginia Rural Health Initiative provides the opportunity for health professions students around the state to learn more about rural health services delivery by spending time at sites like the Monroe Health Center. The proximity of Monroe Health Center and the FMRS satellite office allows students to observe and participate in a successful model of primary care and mental health integration.

All of the programs described here have focused on reducing the stigma of mental illness, which is an especially serious problem in rural communities where most people know each other. To protect the confidentiality of its patients, FMRS Mental Health Council does not offer group counseling. Discovering that adults were more likely to seek care for their children than for themselves, Professional Consultation Services has developed a specialty in serving the mental health and substance abuse treatment needs of children.

Perhaps the program that best illustrates the practice of cultural sensitivity is Tri-County Community Health Center and Migrant Benevolent Association. Many of the seasonal farm workers served are Hispanic and speak little English. Staff ensure that these patients' needs are met. If patients require services available only at a community mental health center some distance away, transportation and translation services are provided. Because many of the farm workers do not seek care themselves, the association brings its substance abuse prevention services right to the migrant camps.

Reimbursement and Funding

Integration may be difficult to accomplish when organizations are restricted in terms of the patients, services or types of providers eligible for reimbursement. Administrative services necessary to sustain integrated primary care and mental health programs may not be reimbursable, or reimbursement may be capped. Funding for the additional infrastructure development (e.g., transportation, building space) necessary to support integration may not be available.

The availability of reimbursement alone was not the principal factor enabling integration of primary care and mental health services in the five programs profiled. However, the mix of

available reimbursement mechanisms has affected the options programs have pursued and may influence their continued viability.

The Laurel Health System has been able to use its status as a federally qualified health center to maximize its Medicaid reimbursement and also enjoys other funding streams. The integrated programs run by Tri-County Community Health Center and Migrant Benevolent Association are also supported by relatively diverse funding. The association was created to expand the center's funding base and to add substance abuse treatment and other new services. Primary care, mental health and substance abuse treatment services are supported by a combination of federal, state and local grants.

Reliance on relatively concentrated funding has put Professional Consultation Services in a potentially difficult position. After the Rural Health Outreach Grant ended, Professional Consultation Services continued delivering limited mental health services at Isabel Community Clinic, even though the revenues do not entirely cover the costs. The program receives two-thirds of its funding from Medicaid. South Dakota uses block grant funds to support provision of services to low-income individuals not eligible for Medicaid. Consequently, the program is in a precarious fiscal position given proposed and likely cutbacks in that funding source.

The Future

Rural primary care and mental health providers likely will continue to seek ways to link their services. The rush of managed care and integrated networks is likely to accelerate this trend. As federal funding for Medicare and Medicaid continues to become tighter, states, communities and organizations interested in pursuing these linkages will need to justify them in terms of their likely effects on access, quality and cost of care. It is imperative that the rural health community continue to share and discuss practical ways to link primary care and mental health services, as well as be able to demonstrate the cost-effectiveness of this integration.

There are old and new questions to be examined. The long-standing problem of the resistance of many rural residents to access available services must be addressed. A much newer question is how the profound change in moving Medicaid to a block grant that appears, as of this writing, to be imminent will affect funding for organizations like community health centers and community mental health centers. How will it affect the supply of providers in rural areas? Finally, how will managed care, particularly managed behavioral health care, affect the willingness and ability of organizations to integrate primary care and mental health services?

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Notes

1. These networks often rely on managed care and capitation to help control costs. Network developers generally recognize that a broad spectrum of services must be included to manage risk or to establish market power when dealing with third-party payers.

2. Rural Health Initiative and Health Underserved Rural Area grants required recipient agencies to coordinate with area mental health service providers (1975-1980). The Linkage Initiative program (1978-1980) provided funds for community and migrant health centers to hire staff to assess patients and refer them to needed services at nearby community health centers.

3. The evaluation of the federal linkage programs (Broskowski, 1980) identified a number of factors tending to facilitate or inhibit linkages between primary care and mental health. More complete integration occurred when administrative control was shared between mental health and primary care providers and linkage workers spent comparable time in both settings. Factors inhibiting integration at rural sites included lack of space, excessive travel time between the primary care site and the mental health center and difficulties recruiting qualified staff. A more recent survey of linked primary care and mental health programs in four rural midwestern states identified several factors facilitating integration: mutual need and interdependence, combined with the absence of resources to address the need separately; open and ongoing exchange of information; and active support from leadership within each organization (Van Hook & Ford, 1993).

4. While psychiatrists are trained in the biomedical sciences, psychologists, social workers and counselors tend to be schooled in psychotherapeutic or milieu approaches that are unfamiliar to most primary care practitioners (Strauss, Schatzman, Bucher, Ehrlich & Sabshin, 1981). A primary care encounter is often brief in duration and focused on a specific problem or condition for which a relatively straightforward intervention is sufficient. Psychotherapy, on the other hand, often requires longer and more frequent sessions in which the approach is more diffuse and the outcomes much less certain.

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