Rural Health Advisory Committee's Report on
Mental Health and Primary Care

January 2005

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February 17, 2005

Dianne Mandernach
Commissioner of Health
Minnesota Department of Health
85 East Seventh Place
St. Paul, Minnesota 55101

Dear Commissioner Mandernach:

We are pleased to present to you the Rural Health Advisory Committee's report entitled Rural Mental Health and Primary Care. The report is the culmination of work done over the past year and a half by a statewide workgroup including physicians, nurses, mental health professionals, educators, hospitals, consumers and other stakeholders.

For many residents of rural Minnesota, often the only option for mental health care is through their local primary care providers—family physicians, nurse practitioners and physicians' assistants. Primary care providers often face the challenge of being asked to treat mental health conditions without adequate training or support.

Workgroup efforts focused on looking at the current rural Minnesota landscape regarding mental health and primary care, examining promising practices and completing a set of recommendations for you to consider. The recommendations in this report are divided into three areas: health professional education, health systems and state and federal policies.

We hope that this report will be the beginning of a dialogue that can lead to improvements in mental health care on the local, regional and state level, and a document that will coordinate with the work of the Minnesota Mental Health Action Group. We thank you for your continued strong support in improving rural health.

Sincerely,

Mike Mulder   Rhonda Wiering
Chair, Rural Health Advisory Committee   Chair, Mental Health Workgroup
Trimont, Minnesota   Tyler, Minnesota

March 7, 2005

Mike Mulder, Chair
Rural Health Advisory Committee
Farmer's State Bank of Trimont
220 Main Street West
Trimont, Minnesota 56176

Dear Mr. Mulder:

Thank you for the Rural Health Advisory Committee's report, *Rural Mental Health and Primary Care*. We commend you and the entire mental health work group for your efforts over the past year and a half.

Providing adequate mental health care in rural communities is a national problem, and such a thorough examination of the situation in Minnesota was clearly needed. We appreciate that the work group studied access to mental health care by reviewing national data and literature, surveying Minnesota rural primary care providers and Critical Access Hospital providers, searching for promising practices, and of course, using the expertise of a diverse work group.

The group recognized that for many rural residents, the only option for mental health care is often through their primary care providers, who face the challenge of being asked to treat mental health conditions without adequate training or support. In addition, the stigma of seeking help for mental health or chemical dependency issues is heightened in rural communities. The Rural Health Advisory Committee's mental health work group recognized all of these impediments to care and drafted 24 compelling recommendations.

Thank you for your excellent work. The Minnesota Department of Health is committed to finding solutions, and this report, with its clearly stated recommendations, is an important step. We look forward to continuing to work together to ensure that the health of Minnesotans is protected and improved.

Sincerely,

Dianne M. Mandernach
Commissioner
P.O. Box 64882
St. Paul, Minnesota 55164-0882

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1 Executive Summary

Mental health is an integral part of a person's general health and well-being. In rural areas, where specialized mental health services are scarce, accessing mental health professional services can involve long drives and long waits. Primary care is often the only system for delivering mental health services.

Recognizing the important role of primary care in rural mental health care, the Rural Health Advisory Committee (RHAC), a governor appointed committee charged with advising the Commissioner of Health and others on rural health issues, formed a statewide work group to study access to mental health services through the primary care system. Over the past year and a half, the work group examined state and national information on rural mental health and primary care, surveyed rural providers, looked at examples of promising practices for education and care delivery. This report presents these results, along with recommendations for public and private policymakers that will improve care through the rural primary care system.

Key Findings

Work group study, discussion and surveys done over the past year and a half show:
- Rural primary care providers are seeing an increase in mental/behavioral health issues in their clinics.
- The shortage of rural mental health providers results in long waits for appointments and long travel to obtain specialty care.
- The cost of mental health care and the complexity of the payment system are barriers for patients seeking care.
- A stigma about mental/behavioral health problems is a barrier to care, especially in rural areas.
- Rural primary care practitioners would like more education on managing mental/behavioral health.

Integration of mental health into primary care is a key to ensuring the best quality services. Innovations already exist in some rural Minnesota communities,

including integration of mental health professionals within the primary clinic system and use of telecommunication services.

Recommendations

Improving mental health care in the primary care system is dependent on a number of factors including:

- Availability of a trained professional workforce in primary and mental health care

- Adequate funding so health systems are able to provide needed mental health services

- Effective state and federal policies that support mental health care.

Health Professional Education

These first recommendations are targeted at academic health programs that train health professionals who care for patients with mental/behavioral health concerns. These recommendations also apply to health professional organizations and associations responsible for continuing education.

- Enhance and promote mental/behavioral health education and training for all health profession students training in primary practice.

- Enhance mental/behavioral health training for those in family medicine residencies.

- Promote and develop rural site experiences for primary care and mental health practitioners that emphasize collaborative practice within the primary care setting.

- Develop and support rural site experiences for those in psychiatric residency programs.

- Develop and support accessible mental health related continuing education for rural primary care providers.

- Include mental/behavioral health content in conferences and other continuing education opportunities for primary care providers, as well as nontraditional audiences such as pharmacists, dentists, school nurses, counselors and law enforcement personnel.

Health Systems

The second set of recommendations include a variety of entities including health care provider systems and networks, hospitals, clinics and payer systems.

- Promote and support demonstration projects and models of collaborative care between mental health providers and primary care providers.

- Develop a common set of mental health benefits. Support the work being done through the Minnesota Mental Health Action Group to develop a basic set of mental health benefits common to all health plans.

- Advocate for funding streams that promote collaborative and integrated mental health and primary care models.

- Promote and expand telehealth collaborations to strengthen delivery of mental health services in remote and underserved areas.

- Develop quality improvement projects that address mental health bed capacity, appropriate patient transfer and continuing education for emergency room personnel.

- Create an understandable guide to the current payment system for mental health care for rural primary care providers and rural mental health providers.

State and Federal Policies and Programs

The third set of recommendations are meant for policymakers including the legislature, state agencies and the federal government.

- Expand state-funded health professional loan forgiveness programs to include psychologists, social workers and other mental health professionals who agree to work in rural areas

- Support efforts to expand public program coverage of telehealth consultations by mental health professionals.

- Eliminate the funding rule for the Medical Education and Research Costs program that requires small sites to have at least a 0.5 FTE health professional student in any given discipline in order to receive training reimbursement.

- Eliminate the copayments on psychopharmaceuticals for Medicaid and MinnesotaCare.

- Support the Minnesota Mental Health Action Group's efforts to develop best practice and benefit models.

- Provide Medical Assistance reimbursement for care management and coordination of care for patients with complex mental health needs.

- Establish an access-to-care standard that recognizes both distance to services and waiting time.

- Promote development and utilization of electronic records in mental/chemical/behavioral health. Ensure that the rural mental health community is represented in state level discussions on developing and implementing electronic health records.

- Support the development of crisis response teams through collaboration with the Minnesota Department of Human Services, counties and health plans.

- Promote mental health emergency quality improvement projects in Critical Access Hospitals through funding from the Medicare Rural Hospital Flexibility grants.

- Improve Medicare coverage for mental illness and bring it to parity with physical illness coverage. The current Medicare Part B coinsurance rate for mental health services is 50 percent as opposed to 20 percent for physical health services.

- Create a coordinated state data collection and analysis system for mental health incidence, prevalence and treatment data in Minnesota.

Improving mental health service delivery through the rural primary care system involves approaches that recognize the need for a competent and qualified workforce; up-to-date education for primary providers and policy; and funding streams that support the complexity of care.

2 Introduction

We can no longer do business as usual. We must screen, identify and treat in primary care clinics. To do this, collaboration is required, and rural providers must be trained and supported. In addition, funding streams must be redesigned to reimburse and support collaborative models of care.
~Rural Mental Health and Primary Care Work Group

Mental health is an integral part of a person's general health and well-being. Yet, nationwide, the ability of our health care system to respond and treat mental health problems is in question. Inadequate reimbursements for care, shortages of mental health services, lack of a trained professional mental health workforce and a lingering stigma about mental illness contribute to a system that is fragmented, and in some cases, nonexistent.

For residents of rural Minnesota, the ability to access quality professional mental health services is at a critical point. In order to obtain screening, diagnosis and treatment, rural residents often must wait weeks and even months for an appointment with a mental health professional and travel great distances to receive services. For many rural residents, the only option for care is through their local primary care providers—family physicians, nurse practitioners and physicians' assistants. Primary care providers face the challenge of being asked to treat mental health conditions without adequate training or support.

Practical solutions are needed that improve quality and access to mental health services in the context of primary care—and that are welcomed by primary care physicians and clinics, their patients, local communities, mental health professionals and other key health resources. Recognizing this need, the Rural Health Advisory Committee formed a statewide work group to examine rural mental health and primary care in Minnesota. This report presents the results of the work group's efforts over the last year and a half to gather information, discuss the issues and make recommendations for improvement.

3   Rural Mental Health and Primary Care Work Group

Individuals with psychological disorders visit their primary care physician twice as often as individuals without psychological disorder. (www.michpsych.org)

In 2003 and 2004, the Minnesota Department of Health's Office of Rural Health and Primary Care (ORHPC) sought information on critical rural health care problems through a series of citizen health care forums. During these forums, access to mental health services was identified as one of the top four rural health issues in Minnesota. Using the input from these forums, in 2003, the Rural Health Advisory Committee (RHAC), a governor appointed committee charged with advising the Commissioner of Health on rural health issues, formed a statewide work group to study access to mental health services through the primary care system. In the past year, the Rural Mental Health and Primary Care Work Group has examined both national and state information on rural mental health and primary care, surveyed rural providers, looked at examples of promising practices for education and care delivery and issued a set of recommendations.

Mental Health and Primary Care Work Group Charge

The Mental Health and Primary Care Work Group was charged by the Rural Health Advisory Committee to:

- Summarize the current status of rural mental health and primary care in Minnesota.

- Identify promising practices and delivery methods that address mental health through the primary care system.

- Identify potential partners to improve rural mental health services through primary care.

- Create recommendations for public and private policymakers that will improve access and quality of care through rural primary care systems.

Work Group Activities

To address the charge of the Rural Health Advisory Committee, a number of activities occurred between October 2003 and the finalization of this report in January 2005:

Bimonthly meetings. A work group made up of key stakeholders from a variety of backgrounds (see Acknowledgements for the work group membership list) met seven times between October of 2003 and December of 2004. The work group identified:

- Major rural issues on access to mental health care in the primary care system

- Information gaps in evidence-based research

- Promising practices that address the issues

- Recommendations for improving access and quality through the rural primary care system.

Literature search. Work group members and staff conducted an extensive review of literature on the delivery of mental health services in rural areas and primary care settings to better understand the issues and identify promising practices (see appendix D and E for complete results).

Minnesota Rural Mental Health and Primary Care Survey. Because little data specific to the provision of mental health services in Minnesota rural primary care settings was available, the staff of the Office of Rural Health and Primary Care surveyed rural primary care clinics in the spring of 2004 (see appendix B for survey).

Critical Access Hospital Emergency Room Survey. Hospital emergency rooms in rural areas are often the only place to treat mental health crises and emergencies. The Office of Rural Health and Primary Care surveyed all Critical Access Hospitals (rural hospitals in the state with 25 or fewer beds) in the fall of 2004 to better understand mental health emergencies in Minnesota's smallest rural hospitals (see appendix C for survey questions).

Interviews with Providers and Educators. The Office of Rural Health and Primary Care staff interviewed providers and educators in fall 2004 to illustrate examples of work currently underway to address rural mental health issues.

Definitions

For purposes of this work group project, the following definitions were used:

- Primary care is the first point of contact for most general health care, such as a physician clinic or community clinic. Primary care settings are staffed by traditional medical personnel, such as family practice physicians, nurse practitioners, physicians' assistants, nurses and other health care personnel.

- Mental health includes traditionally diagnosed mental conditions as well as chemical health or substance abuse and addictive conditions including alcohol, street drugs and prescription drug abuse.

Work Group Limitations

The issues involved in ensuring the provision of quality mental health services in rural Minnesota are complex and involve many stakeholders. Many ideas, areas and concerns were raised that could not be addressed in this report. Instead the group focused on rural mental health services within the primary care system. Appendix A includes a summary of areas deemed important that could not be included.

4 THE MENTAL AND BEHAVIORAL HEALTH LANDSCAPE

In rural communities, everyone knows if your pickup is at the mental health center. ~ Work group member talking about stigma

The Rural Culture

Any discussion in this report about mental health and rural mental health needs to be prefaced by a note on rural culture. First, "rural" is not readily defined. It could refer to a geographic area, or it could be looked at within a political context or it could simply be a community's self definition. As one work group member commented, "In my part of the state, Mankato is considered urban and all the little towns around it are rural."

Many rural areas in Minnesota are undergoing demographic and social changes. The younger population is leaving for the urban areas and the people who remain are aging. Communities are seeing an increase in immigrant and minority populations. Agricultural-related jobs are changing with the advent of corporate farming.

Delivery of health care services in rural areas can be daunting.
Challenges include:
- Low population

- Transportation and distance to services

- Health care staff recruitment

- Higher unemployment and rates of uninsured.

Delivery of mental health services can be even more challenging because of the added stigma about mental illness. While studies have shown that little difference exists between rural and urban populations regarding the stigma, rural populations are less likely to seek out treatment (Rost et al. 1993).

Yet, rural areas also have these built-in strengths that help communities respond to the problems (Phillips and McLeroy, 2004):

- Dense social networks

- Social ties of long duration

- Ability to collaborate and cooperate

- A high quality of life.

Commitment to community is strong in rural areas and can lead to practical solutions for complex problems.

Mental Health Care a Growing Concern

The notion that rural Americans enjoy a healthier lifestyle and a lower incidence of mental disease is an unfortunate misconception.
~ National Advisory Committee on Rural Health and Human Services

A growing number of commissions, studies and reports are looking at the state of mental and behavioral health in the United States including the President's 2003 New Freedom Commission on Mental Health (www.mentalhealthcommission.gov), which identified specific mental health disparities affecting rural communities:

- Inadequate access to care

- Provider shortages

- Greater social stigma associated with seeking mental health services

- The need to establish models of care that address the unique needs of rural communities.

The subcommittee on rural issues of the New Freedom Commission stated that barriers to care result in "an 'experience of care' for rural Americans that too often includes a delay in care, inconsistent care or no care."

In a 2004 report to the Secretary of Health and Human Services, the National Advisory Committee on Rural Health and Human Services recommended that rural communities would benefit greatly from integrating behavioral health and primary care in rural settings (http://ruralcommittee.hrsa.gov/nacpubs.htm). The report identified barriers to the development of integrated models of care including reimbursement tied to particular types of provider services; institutional resistance toward integration; and lack of integrated training curricula.

Minnesota launched the Minnesota Mental Health Action Group (MMHAG) in 2003. This is a statewide coalition of public and private partners to address the fragmented and often ineffective system of care for those with mental and behavioral health issues (http://www.citizensleague.net/mentalhealth/html/about_mhag.html).

Recognizing the lack of an organized effort to link those working on mental health system reform, MMHAG sought to coordinate statewide activities to achieve common reform objectives and to fill gaps where progress is needed. The action group has concentrated on six general areas:

- Public/private partnership models

- Fiscal frameworks

- Coordination of care and services

- Standardized assessments, performance measures and evidence-based treatments and outcomes

- Prevention and early intervention

- Workforce solutions.

A number of subgroups are working to address issues in these areas. One of the subgroups has developed a "common benefit set," which outlines the basic mental/behavioral health benefits that should be available to all under the current payer system.

National Demographics on Mental Health

Mental health is a leading cause of illness and disability. About 20 percent of the U.S. population is affected by mental illness in a given year (Minnesota Psychiatric Society, 2004). Mental health and illness accounts for 15 percent of the burden of disease in the United States, only less than cancer (National Institute of Mental Health [NIMH] 2001). Healthy People 2010 cites mental health as one of the top 10 health indicators, ranking mental health among such health priorities as obesity, access to care, violence and tobacco use (U.S. Department of Health and Human Services [U.S.DHHS] 2000).

The Surgeon General's report (1999) defines mental health as "the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to change and to cope with adversity." The report also states that mental illnesses are disorders that alter thinking, mood and behavior (1999). Mental illness is one of the most stigmatized illnesses, often associated in the public eye with characteristics such as dangerousness, moral weakness and offensiveness (Johnsen et al. 1997). The Surgeon General's report illustrates how health, government and education officials have increasingly become concerned with the state of mental health in the United States.

The strong link between mental health and behavioral health makes it hard to separate the two. Adults with a substance use disorder in 2002 were almost three times as likely to have a serious mental illness (20.4 percent) as those who did not have a substance use disorder (Epstein, Barker & Murtha, 2004). Substance abuse is also a leading health indicator for Healthy People 2010. In 1995, the economic cost to the United States from alcohol and drug abuse neared $280

billion. These behaviors are associated with motor vehicle crashes, drowning, HIV infection, teen pregnancy, school failure, heart disease, cancer and homelessness (U.S. DHHS, 2000).

Minnesota Demographics on Mental Health

In Minnesota an estimated 950,060 people have mental health problems of some kind and 179,249 have diagnosable serious mental illnesses in any given year. Every year 447 people die from suicide. Suicide is the second leading cause of death in people between the ages of 10 and 34.

According to the Mental Health Association of Minnesota, 950,060 Minnesotans have mental health problems of some kind. That is approximately 19 percent of the state's population. Additionally, 173,249 Minnesotans have a diagnosable serious mental illness in any given year. Some of the more prevalent mental health problems are depression, anxiety, stress, substance abuse, sleep problems, chronic fatigue.

Suicide is one of the most common measurable indicators for assessing mental health status. Each year about 447 Minnesotans die as a result of suicide, three times the number of deaths caused by homicide (Minnesota Center for Health Statistics, 2003). Suicide rates do differ according to gender, race/ethnicity and age. Males account for four of every five persons (83 percent) who die by suicide in Minnesota. American Indians have the highest suicide rate among all racial/ethnic groups in Minnesota. Suicide rates were highest for Minnesotans between the ages of 45-49 and 80-84 (Minnesota Psychiatric Society, 2004). Twenty-one percent of ninth grade students in the 2004 Minnesota Student Survey responded that they had "thoughts of suicide" and 7 percent responded that they have "tried to kill" themselves in the past year. Injury from suicide is more likely to be fatal in rural Minnesota.

Use of Mental Health Services in Rural Minnesota

The U.S. Department of Health and Human Services reports that the supply of specialty physicians decreases as urbanization decreases. While studies have shown that prevalence of mental health distress in rural Minnesota is no greater than that in urban and suburban areas, there is a greater chance that mental health services may be limited or nonexistent. In addition, the area experiencing the greatest growth in mental health volume is rural Minnesota. Analysis of Minnesota's Hospital Discharge Database, reveals a total increase of 19 percent in mental health patient days, with a 25 percent increase in rural hospital patient

days versus 18 percent at urban facilities (Minnesota Health Economics Program, 2004).   See Figure 1.

Figure 1
Change in Minnesota Mental Health Services
Utilization, 1998 vs 2002
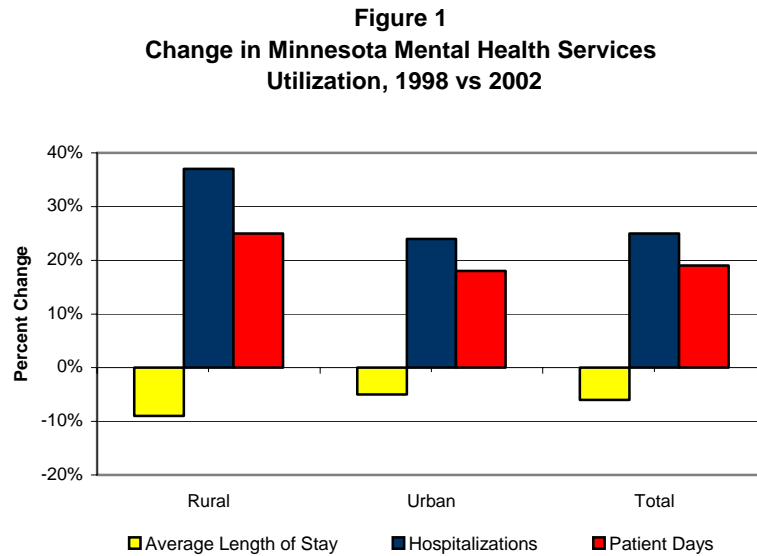
The Minnesota Psychiatric Society (2004) found that the Minnesota Hospital Association recorded a 40 percent increase, from 19,031 to 27,522, in the number of combined urban and rural emergency room acute mental illness outpatient claims between 1997 and 2002. The total claims amount almost tripled in five years from $6,318,292 to $16,182,936. The average charge also increased from $322 to $588 per visit.

While many rural residents seek assistance through their primary care physician for a mental health condition, one study from the Journal of Family Practice estimated that 50 to 80 percent are not diagnosed or are misdiagnosed (Badger L. et al. 1999).

Public Mental Health Care in Minnesota

The following is a condensed overview of mental health services provided to rural Minnesota through public systems. Programs exist on both a state and local level and vary according to the community. The Minnesota Department of Human Services (DHS) works to ensure that mental health services are available. Further information is online at the DHS Web site: http://www.dhs.state.mn.us.

State Operated Services
The Minnesota Department of Human Services' State Operated Services (SOS) are campus and community-based programs serving people with mental illness, developmental disabilities, chemical dependency and traumatic brain injury. It includes regional treatment centers (RTCs) in Anoka, Brainerd, Fergus Falls, St. Peter and Willmar. It also includes Ah-Gwah-Ching, the state nursing home in Walker, Community Support Services, and Minnesota State Operated Community Services. SOS Forensic Services serve the entire state and include the Minnesota Security Hospital in St. Peter, the Minnesota Sex Offender Program in Moose Lake and St. Peter, and the Minnesota Extended Treatment Options program in Cambridge.

Community Mental Health Centers
There are about 115 community mental health centers and clinics in Minnesota serving 120,000 people (Minnesota Psychiatric Society, 2004). These community mental health centers service counties and regions using a combination of public funds, grants and funding from third-party payers. Most are private, nonprofit agencies. They are responsible for providing state mandated mental health services, as well as serving a range of needs including prevention, assessment, outpatient therapy and rehabilitation. Community mental health centers work in collaboration with local public health and human services. Because of funding cuts and shifts, community mental health centers have moved toward serving a more specialized population, concentrating on the chronically mentally ill, the uninsured and those receiving Medicaid or General Assistance Medical Care (GAMC).

Local Public Health
Rural mental health services through local public health programs vary from county to county. Some public health agencies provide direct care including case management, visiting nurse services and psychiatric nurse services. Others focus on screening and assessment and refer to community mental health services as needed. Local public health uses a collaborative model to support mental health services in rural areas.

Mental Health and Primary Care

The most common mental health disorders treated by rural primary care practitioners included depression, anxiety and panic disorders, attention deficit disorder, and dementia among the elderly (Geller, 1999).

Primary care is the "front end" of mental health care delivery for most people. Approximately 70 to 80 percent of patients will make at least one primary care visit annually (Strosahl in Cummings et al.1997). Primary care is where most patients with mental disorders contact care delivery systems. It has been called the "de facto mental health care delivery system," despite the presence of specialty mental health clinics and clinicians.

According to a 2001 survey, 33 percent of respondents would turn first to a primary care physician for a mental health problem. Forty-eight percent of respondents with a mental health disorder said they were first diagnosed by a primary care physician (National Mental Health Association, 2001). Overall, 67 percent of psychopharmacologic drugs are prescribed by primary care physicians. Family practice physicians prescribe more psychotropic medications than psychiatrists in all categories (Pincus, et.al.1998). Other patients with emotional distress, but without a mental health diagnosis, will also present in primary care. It is estimated that 20 to 50 percent of all visits to primary care physicians are due to conditions that are caused or exacerbated by mental or emotional problems (Celluci et al. 2003).

Depressive disorders, especially in the elderly, tend to present with more physical symptoms than cognitive symptoms. Unfortunately, depression often goes unrecognized in primary care. It is frequently found with chronic medical illnesses such as strokes, cardiovascular disease, Parkinson's, rheumatoid arthritis and diabetes (Noel et al. 2004). The prevalence of depression with these medical conditions varies from 10 to 50 percent depending on the study. With multi-system disease, differentiating the symptoms of depression versus the symptoms of the medical illness is a daunting task.

Given the scarcity of mental health specialists in rural areas, primary care has long been considered a way of expanding access. Research has shown that rural physicians already tend to play a greater role in mental health care provision than their urban counterparts. A 1999 survey of rural primary providers revealed that most thought 10 percent of their patients' needs were primarily mental health (Geller, 1999).

Mental Health and Primary Care Workforce

Primary care physicians. Of physicians employed in Minnesota, 43.7 percent report that their first specialty is in primary care. In rural Minnesota, that number rises to 61 percent of the workforce. However, the ratio of primary care

physicians to the population is still lower in rural Minnesota than in urban Minnesota. There are only 70 physicians for every 100,000 rural Minnesotans, compared to 120 physicians for every 100,000 urban Minnesotans. As a result, primary care physicians practicing in rural areas are seeing and treating a wide range of patients (Office of Rural Health and Primary Care, 2004).

The Mayo Clinic College of Medicine and the University of Minnesota, through its Twin Cities and Duluth medical schools, offer the only physician training programs in the state. First and second year medical students attending the University of Minnesota can choose to receive their training at the Duluth campus. The Duluth program emphasizes curriculum in rural primary care. In addition, third year medical students can take the Rural Physician Associate Program (RPAP) as an elective. During the RPAP, medical students live and train in nonmetropolitan communities with physician preceptors. This provides medical students with experiences in rural settings and allows them to become more comfortable diagnosing mental health problems.

Mental health professionals. Federal law and the National Institutes of Health consider psychiatry, psychology, social work, psychiatric nursing and marriage and family counseling as "core" mental health professions. There is limited data describing these health care professions; however, shortages exist in rural areas among certain mental health specialties.

Psychiatrists. In Minnesota, there are only 10 psychiatrists per 100,000 people versus 16 psychiatrists per 100,000 in the United States (Minnesota Psychiatric Society, 2004). This is about 33 percent fewer psychiatrists per capita than the national average. Data collected by the Office of Rural Health and Primary Care shows that many psychiatrists in Minnesota are working part time and are not likely to be practicing in rural areas. In fact, 83 percent of psychiatrists in Minnesota practice primarily in an urban area (seven-county metro, Olmsted, Stearns and St. Louis Counties). In 2003, there was a ratio of 12.3 psychiatrists per 100,000 urban population (seven-county metro and cities of Duluth, Moorhead, Rochester and St. Cloud) compared to approximately 4.5 psychiatrists for every 100,000 rural Minnesotans (Office of Rural Health and Primary Care, Health Workforce Analysis, 2004).

> **Mental Health and Primary Care Workforce**
> - There are 70 primary care physicians for every 100,000 rural Minnesotans, compared to 120 primary care physicians for every 100,000 residents in urban areas.
> - There are 4.5 psychiatrists for every 100,000 people in rural Minnesota.
> - A total of 19 child psychiatrists practice outside the Twin Cities seven-county metro area.
> - The average age of a rural psychiatrist is slightly more than 51.
>
> Minnesota Department of Health's Office of Rural Health and Primary Care—Health Workforce Analysis

Psychiatrists are also aging, like a majority of Minnesota's rural population. While the average age of a psychiatrist in Minnesota is 51, in rural areas it is slightly higher (Office of Rural Health and Primary Care, 2004). The need for psychiatry services in rural areas is likely to increase given the number of expected retirements among psychiatrists.

The University of Minnesota Academic Health Center, Mayo, Hennepin County Medical Center, and Regions Hospital offer psychiatry residency programs. Residency training takes place in metropolitan hospitals and clinics; there is no specific rural psychiatry training through these programs.

Social Workers. The Minnesota Board of Social Work reports 9,199 licensed social workers with Minnesota mailing addresses as of 2003. Of these, 5,215 have a mailing address in the seven-county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington), while 3,984 have mailing addresses in greater Minnesota. Statewide, there are approximately 187 social workers per 100,000 population. This translates to approximately 197.4 per 100,000 in the seven-county metro region and around 174.9 per 100,000 in greater Minnesota. The national estimate of clinically active social workers is 99,341 or 35.3 per 100,000 population (SAMHSA, 2002). The Minnesota Board of Social Work data includes all licensed social workers rather than only those who are clinically active. Similar limitations occur with data on psychologists.

Psychologists. The Minnesota Board of Psychology reports 3,288 licensed psychologists practicing in Minnesota as of 2003. This is approximately 66.8 psychologists per 100,000 population, well above the national average of 31.1 per 100,000 population (SAMHSA, 2002). However, psychologists, like other health professionals, are concentrated in metropolitan areas of Minnesota. Differences in psychologist to population ratios vary widely from zero in 13 rural counties to 123.7 per 100,000 in Hennepin County.

Advanced Practice Nurses. In Minnesota, nurses with advanced training through either a nurse practitioner program or a clinical nurse specialist program can diagnose and treat mental health issues under a collaborative agreement with a physician. Treatment can include prescribing medications. A biennial survey of licensed nurses indicates that, as of 2004, there are 186 advanced practice nurses who specialize in child or adult psychiatry or mental health (Office of Rural Health and Primary Care, 2004). Of those, 34 percent list their primary practice site as outside the Twin Cities seven-county metro area, Duluth or St. Cloud. Minnesota has only two advanced practice nurse training programs with specialization in psychiatry/mental health. The University of Minnesota, Minneapolis has a clinical nurse specialist program and the College of St. Scholastica, Duluth has a nurse practitioner program with mental health content.

Mental Health Professional Shortage Areas

The National Health Services Corps (NHSC) is a federally funded program available through Health Resources and Services Administration's (HRSA) Bureau of Health Professions (BHPR). The program's mission is to recruit health care professionals to deliver care to underserved communities. NHSC has identified psychiatrists, clinical psychologists, psychiatric nurses, clinical social workers and marriage and family counselors as mental health providers eligible for loan repayment in exchange for service in federally designated Mental Health Professional Shortage Areas (MHPSAs). MHPSAs are designated solely on the distribution of psychiatrists providing outpatient treatment. A large majority of Minnesota's counties are designated as a MHPSA (See below)

Data Source: Minnesota Department of Health
Office of Rural Health and Primary Care

5 COVERAGE FOR TREATMENT OF MENTAL/ BEHAVIORAL HEALTH

"Too often help is a car ride away—without gasoline."
~physician in northeastern Minnesota

Treatment for mental and behavioral health problems is covered under private health insurance, Medicare and Medicaid. However, coverage is often fragmented, limited and complicated for both patients and providers. In rural areas with high populations of Medicare, Medicaid and Minnesota Care recipients, restrictions on coverage can have a significant impact on whether patients seek treatment.

Medicare Coverage. The current Medicare Part B coinsurance rate is much higher for mental illness (50 percent copay) than for physical illness (20 percent copay). For older rural residents with limited income, the copays can be prohibitive. Because consumers are more sensitive to prices for mental health services than for physical health, they are less likely to seek mental health services (National Advisory Committee on Rural Health and Human Services, 2004).

Medicaid and Minnesota Care Prescription Drug Coverage
In general, the Minnesota Medical Assistance (MMA) program has good coverage for the treatment of mental health conditions and offers more comprehensive coverage than Medicare. However, in 2003 the state legislature added copays under Medicaid and Minnesota Care coverage affecting most prescription drugs. With the exception of antipsychotic medication, most drugs for the treatment of mental/behavioral health care now require the patient to pay part of the cost.

The prescription drug plan under the new Medicare Modernization Act will change prescription coverage for those who are eligible for both Medicare and Medicaid benefits (also called dually eligible). In January 2006, all dually eligible persons will receive their prescription drug benefits through the Medicare program—not Medicaid. The Medicare benefit is more restrictive on the types of drugs it will cover and could require more out-of-pocket copayments.

Consultation Reimbursement

For many rural primary care providers, the only timely access to psychiatric expertise is through telephone consultation with a psychiatrist located elsewhere. Under current third-party reimbursement policies, telephone consultation is not a covered service. The only way a psychiatrist can bill for consultation time is if the patient is seen. This has been a disincentive for scarce psychiatrists to provide primary care providers with sometimes time-consuming consultations.

Rural Health Clinic Reimbursement

In rural Minnesota, 62 primary care clinics are Medicare certified as Rural Health Clinics. These are specially designated clinics delivering essential medical services to communities that are both "rural" and "underserved." Delivery of mental health services through Rural Health Clinics is problematic because of the Medicare payment system. Under Medicare reimbursement, the clinics are able to recover only about 50 percent of the costs for mental health services. Because of this, there is less of an incentive for rural health clinics to offer mental health services, creating another gap in services.

Conclusion

The President's New Freedom Commission on Mental Health states:

> *Understanding that mental health is essential to overall*
> *health is fundamental for establishing a health system*
> *that treats mental illnesses with the same urgency as it*
> *treats physical illness.*

Rural Minnesota faces a number of challenges in ensuring prompt, responsible and competent treatment for mental disorders. One of the first steps to improvement and to establishing the system envisioned in the President's report is to strengthen care in the rural primary care setting.

6   MENTAL HEALTH SURVEY OF RURAL PRIMARY CARE CLINICS

"Rapid access to mental health services is a challenge. Appointments take one month and we have no crisis center or weekend mental health help."
~ Nurse practitioner in southeast Minnesota

Introduction

The work group identified a need for more information on mental and behavioral health services in the rural primary care setting. Locating and collecting data related to mental health and mental illness is difficult. Also, based on research conducted for this study, it appears that no publicly accessible and comprehensive list of primary care clinics exists in Minnesota. Therefore, an informal survey, developed by the ORHPC with guidance from the work group, was conducted in the spring and summer of 2004 to begin to develop foundational information. Rural Minnesota primary care providers including physicians, advanced practice nurses and physicians' assistants were asked questions regarding the frequency and types of mental/behavioral health issues seen in the clinic, ability to treat within the clinic setting, available resources and support needs. The survey questionnaire is in Appendix B.

Survey Methods and Response

Approximately 300 copies of the survey were distributed to health care providers practicing in rural Minnesota. A total of 110 surveys were returned electronically or by mail, for a response rate of approximately 37 percent. The 110 surveys represent approximately 5.3 percent of the 2,079 primary care providers practicing in rural Minnesota, but are not necessarily a representative sample.

Doctors, nurse practitioners and physicians' assistants practicing in seven regions of Minnesota completed surveys: Central, Northeast, Northwest, South Central, Southeast, Southwest and West Central.   Of the 110 responses, 25 percent came

from the Central region, 18 percent each from the Northeast and Northwest, 12 percent from Southeast, 10 percent from Southwest, 9 percent from South Central, and 8 percent from West Central.

Sixty-one percent of respondents were physicians mainly specializing in family practice medicine, 17 percent were nurse practitioners, 18 percent were physicians' assistants, and four percent were "other" (clinical social workers, psychologists, etc). Due to the somewhat scattered nature of the sample and varying responses among regions, survey results are inconclusive and regional comparisons are not recommended. However, the broad brush picture supports anecdotal reports from work group members and other rural mental health experts consulted throughout this study.
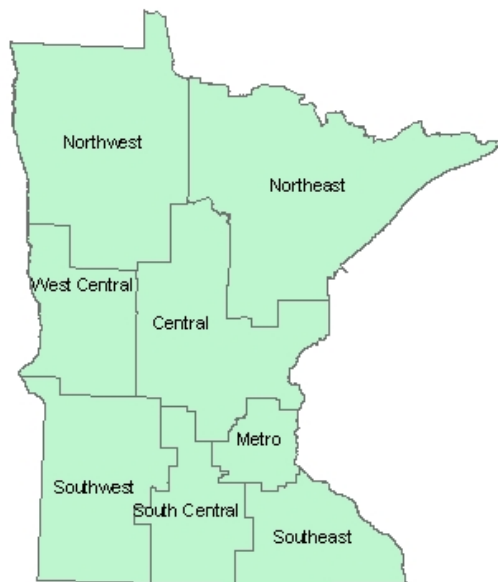
## Survey Results

Summary of main points
- The majority of respondents have observed an increase in mental/behavioral related issues among patients over the past two to three years.
- Most respondents do not routinely screen their patients for mental/behavioral health issues.
- Rural primary care providers are most likely to refer rather than treat patients with complex mental conditions such as schizophrenia, bipolar disorder and substance abuse. They were most likely to treat depression and anxiety.
- Long waits and travel times for appointments, a shortage of emergency services, and mental health professional workforce shortages are barriers to access for rural Minnesotans in need of mental or behavioral health services.
- The majority of respondents would like to receive more education/training in mental/behavioral health.

- Substance abuse was the mental/behavioral issue respondents mentioned most often as a concern.

Discussion
Mental/behavioral issues increasing in frequency. Sixty percent of respondents reported an increase in the proportion of patients presenting with mental/behavioral issues in their clinics over the past two to three years; 35 percent reported that the proportion had stayed the same. No respondent observed a decrease in the number of patients with mental/behavior issues coming to their clinic. (Figure A: "Other" includes providers who were uncomfortable responding to the question.)

Figure A
"Over the last 2-3 years, do you believe the proportion of patients presenting with mental/behavioral issues in your clinic has: "
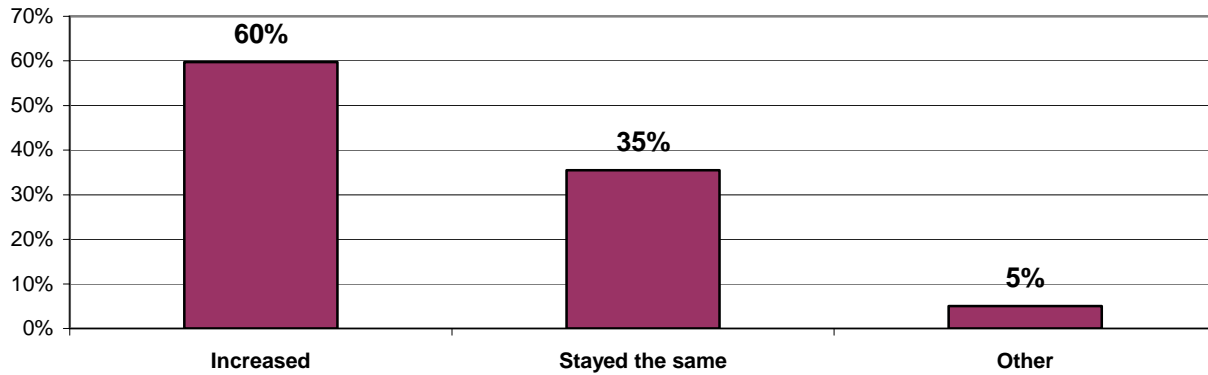

Screening
Most primary care providers who responded to the survey said they did not routinely screen patients for mental/behavioral health issues (64 percent). When providers did screen patients, the condition they screened for most frequently was depression (97 percent of the 36 percent who said they routinely screen).

Treatment vs. referral. In response to a question about what types of mental/behavioral health issues providers were likely to treat themselves, most replied they were more inclined to treat patients for depression, anxiety, Attention-Deficit Hyperactivity Disorder, Alzheimer's disease and dementia. They were more likely to refer patients needing treatment for bipolar disorder, schizophrenia and substance abuse. Thirty-nine percent of respondents said that when they referred patients, they usually referred outside their clinic but within the community (Figure B).

Figure B:
"If you refer patients, where would you most commonly refer the patient?"
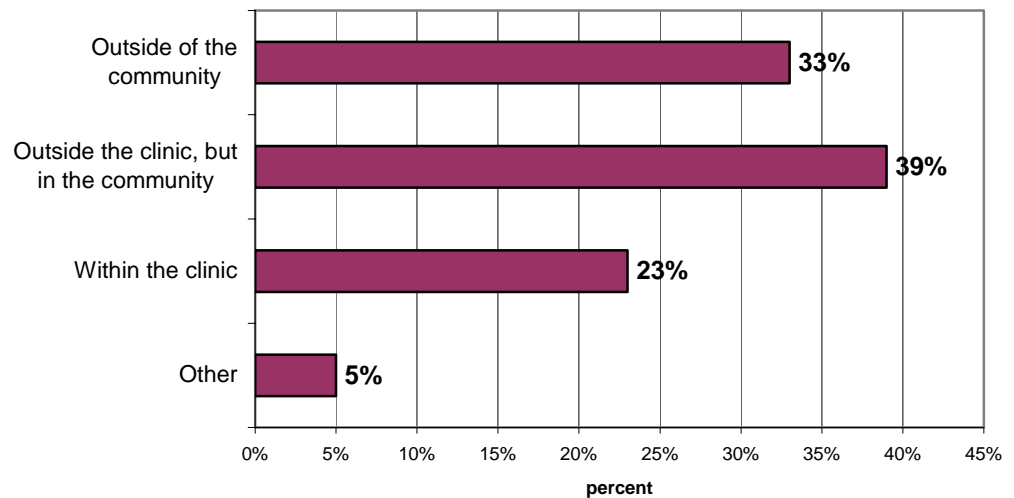
Access to Mental/Behavioral Health Services

Waiting for services. Many providers expressed concern over the length of time patients had to wait to see mental health specialists, ranging from two days to eight months. Respondents noted that the length of time a patient waited often depended on the type of mental health professional and the nature of the problem. For example, patients typically waited longer to see a psychiatrist than a psychologist, while social workers and counselors were available almost immediately. About half of the providers responding to a question about travel distances said patients had to travel, on average, more than 40 miles for treatment.

Emergency mental health services. More than half of the providers (56 percent) said emergency mental/behavioral health services are not available within the community. Where emergency mental health services are unavailable, providers said most patients are transferred outside the community, most frequently to a hospital with inpatient treatment and available space. The demand for inpatient psychiatric beds in rural Minnesota increased 37 percent from 1998 to 2002, driven partly by demand for beds from patients who could not find them in the Twin Cities (Health Economics Program, 2004).

According to the Minnesota Department of Human Services, the lack of access to inpatient psychiatric beds affects all Minnesotans, "but is especially problematic for children and adolescents due in part to a shortage of inpatient capacity."   For residents of greater Minnesota, this may mean traveling 150 miles or more to the state's only 24-hour psychiatric emergency room in Minneapolis to receive appropriate care.

Mental health workforce. While noting the shortage of mental health providers, almost half of respondents (46 percent) said mental/behavioral professionals were available within their clinic, compared to 54 percent who said none were

available. Additionally, 86 percent said mental/behavioral health professionals were available within their communities. These relatively high percentages may indicate a skewed sample; clinics with mental health services readily available may have been more likely to respond to the survey than those without those services. Also, the question of availability of mental health professionals was not followed with a question about the extent to which these professionals are physically present in the clinic and/or community, an important caveat for measuring actual accessibility. Anecdotal information tells us that many mental health professionals work part time in rural areas and their presence in a clinic or community ranges from one day per month to more than once a week. "Long waits for appointments" and "lack of available counseling" were frequently mentioned in the survey as a great challenge for patients in need of mental/behavioral health services.

Psychologists made up a majority of the mental/behavioral health professionals working in the rural clinic or community. Social workers were the second most frequently mentioned professional working in a rural clinic or community. Not mentioned as often were psychiatrists, who ranked third among the five "core" mental health professions.

Mental health support services. A significant majority of providers (85 percent) said support services for people with mental/behavioral health issues were available in their communities. All providers said they encouraged their patients to use these community support services when appropriate. Chemical/alcohol treatment programs, county government human services, and faith-based support groups were the most frequent types of community support services available (Figure C). Community support programs were described as providing group support (84 percent), followed by community outreach and education (44 percent), and transportation (42 percent). Some providers suggested that community organizations could do more in terms of transportation, outreach and raising awareness of their services for community residents.

Figure D:
How frequently do you participate in continuing education related to
mental/behavioral health?"
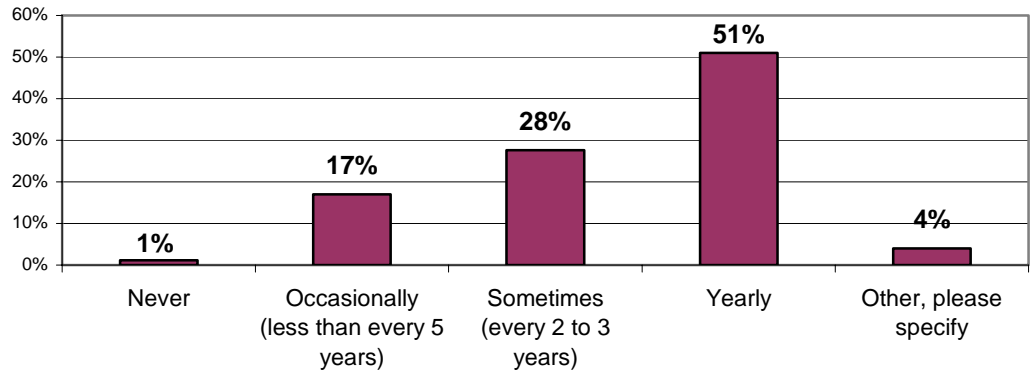
Continuing education. Although 51 percent of respondents participate yearly in continuing education related to mental/behavioral health (Figure D), 79 percent said they needed additional training, and 88 percent said they would attend continuing education courses if they were more readily available. Most providers (94 percent) responding to the survey said they stayed current with the latest diagnosis and treatment advances in mental/behavioral health through continuing education sponsored by colleges and professional organizations. Some reported that they also turn to pharmaceutical companies and/or distance learning/telemedicine programs to keep current.

Additional Mental/Behavioral Health Challenges in Rural Primary Care
In response to the open-ended question "What mental/behavioral health issue that you see in your patients or community are you most concerned about?" substance abuse was listed most frequently. Methamphetamine use also emerged as a specific concern. According to a respondent, "Drug abuse (especially with methamphetamines) is completely and unequivocally uncontrolled throughout Minnesota." Another respondent was most concerned about substance abuse because, "I think many people 'self medicate' for [mental] disorders."

The survey also asked, "What is the greatest challenge for patients from your community in obtaining mental/behavioral health services?" Most of the responses to this question fell into the following categories:
- Wait time for appointments
- Travel distance to receive services and lack of transportation
- Lack of providers
- Cost and insurance coverage issues
- Stigma regarding mental illness.

Wait time. A nurse practitioner from southwestern Minnesota wrote, "Waiting two to three months for these consults is insufficient, unacceptable care. This is my greatest challenge." A pediatrician from south central Minnesota noted "Having parents wait another two to six months when they've already waited two months to get an assessment from me seems cruel." Transportation and travel distances were a consistent challenge to primary care providers. Responses mentioning transportation challenges were often similar to this respondent's comment, "[mental health services] are all located out of town—hard for people who are elderly or have low incomes."

Shortage of mental/behavioral health providers. Respondents identified several problems related to the shortage of providers, including a significant lack of child psychiatrists and psychologists, frequent turnover in providers, and difficulty in finding a mental health provider in a crisis. "No child psychiatrist is easily available who I can work with. The closest is 15 minutes away, but in the wrong county and can't see our patients."

Cost of insurance and coverage issues. A physician from central Minnesota wrote, "Patients have to check on insurance to determine what services they can have. It makes them less likely to seek help or successfully get help." From a physician's assistant in west central Minnesota, "Patients who need a psychiatric service either can't afford it, or refuse to go."

Stigma. A number of providers mentioned the stigma of mental illness as a barrier to patients receiving appropriate care. A nurse practitioner from south central Minnesota wrote, "Stigma still exists that a mental health diagnosis is a sign of weakness." Several providers also noted that the difficulty of keeping mental health issues confidential in small communities contributed to patients not seeking services.

7   CRITICAL ACCESS HOSPITAL SURVEY

"We have become adept at jumping through many administrative and other barriers to find care for our mental health patients. Sometimes we fail...our regional support system fails us every day."
~Survey respondent

Introduction

The Office of Rural Health and Primary Care surveyed Critical Access Hospitals (CAH) in Minnesota in the summer of 2004. The goal was to obtain information for the work group on mental and behavioral health visits in the smallest rural emergency rooms. The survey questions were on the amount and type of mental and behavioral health issues seen in emergency rooms, outcomes of these visits, barriers to providing adequate care, and needs of the CAHs. For the purposes of this survey, behavioral health was defined as pertaining to alcohol, substance or chemical use or abuse.

Survey Response

The survey was sent to all of the 52 Critical Access Hospitals in Minnesota. Since then seven more hospitals, not included in the study, received federal designation. Forty-six CAHs responded to the survey. The response rate of 88 percent gives an accurate picture of the trends in mental and behavioral health in emergency room visits and needs of CAHs as stated by the nurses, physicians and other health care providers who completed the survey.

Critical Access Hospitals

The Critical Access Hospital Program was created by Congress in the Balanced Budget Act of 1997 with the sole purpose of supporting hospitals in rural areas with limited services. These hospitals receive cost-based reimbursement from Medicare and are exempt from inpatient and outpatient prospective payment methods. The federal criteria for CAH designation include:

- Located in a rural area

- Provide 24-hour emergency care services

- Located more than 35 miles from a hospital or certified by the state as a "necessary provider"
- Operate no more than 25 acute beds.

Critical Access Hospitals must respond to the diverse medical needs of the community. Because many of them are so small, emergency room nurses and personnel often also staff other hospital units such as the intensive care units and medical/surgical units. Nursing staff is on site 24 hours a day, but physician coverage can be on call. Most Critical Access Hospital emergency rooms do not staff mental health specialists.

Map 2
Critical Access Hospitals - Minnesota
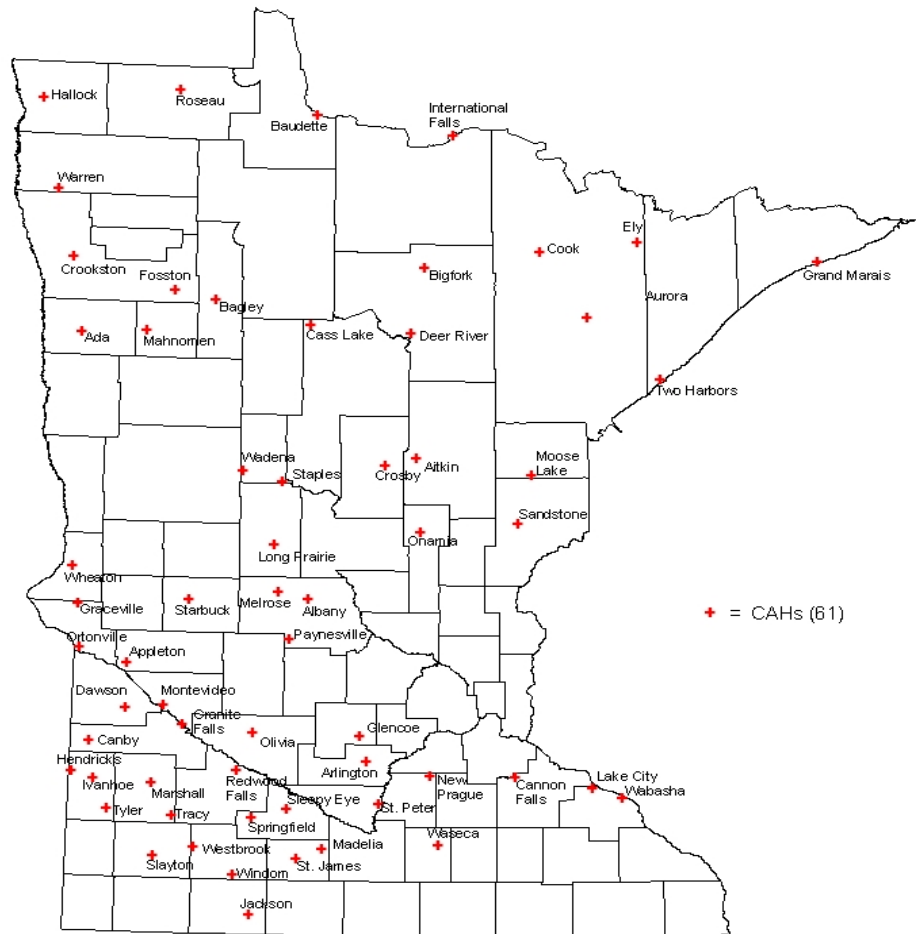
As of 01/07/2005

"We are seeing more chronic medical problem patients…there is always an underlining mental health issue that seems to be forgotten or never addressed."
~Survey respondent

Survey Results

Emergency Room Visits. The hospitals surveyed had an average of 49 emergency room (ER) visits in a typical week with a range of six to 164 visits. The average number of visits involving a mental or behavioral health issue is five with a range of zero to 36. Ten percent of emergency room visits are related to mental or behavioral health with a range of under 1 percent to 22 percent.

**Figure A:
"Over the past 2-3 years, do you believe that the proportion of visits to the ER that involve mental and behavioral health has:"**
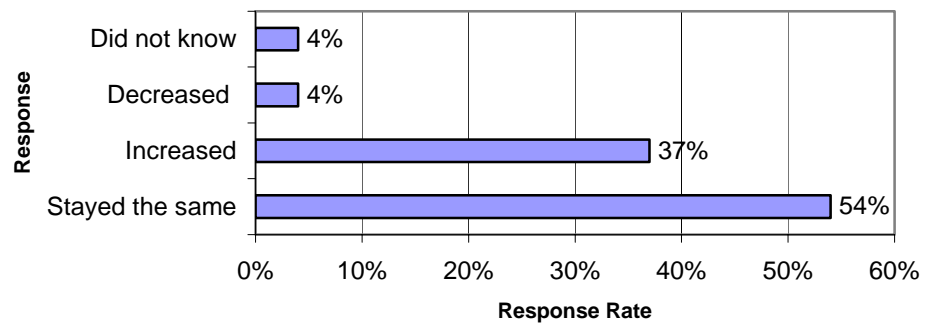
Figure A shows that over half (54 percent) of the respondents felt that the proportion of ER visits involving mental and behavioral health had stayed the same in the past two to three years. Thirty-seven percent indicated they had increased, with 4 percent indicating a decrease. Another 4 percent were unable to answer the question due to lack of information or experience at the facility.

"Treating patients with mental health issues—finding placements and gaining acceptance of the patient by the new facility—is very time consuming."
 ~Survey respondent

Figure B shows the comfort level of CAH staff with mental and behavioral health visits in the emergency room. Sixty-three percent were somewhat or very uncomfortable with these types of visits. This is also reflected in the needs identified section, as many requested more training and education for mental and behavioral health.

Figure B:
The comfort level of CAH staff with mental and
behavioral health visits in the emergency room
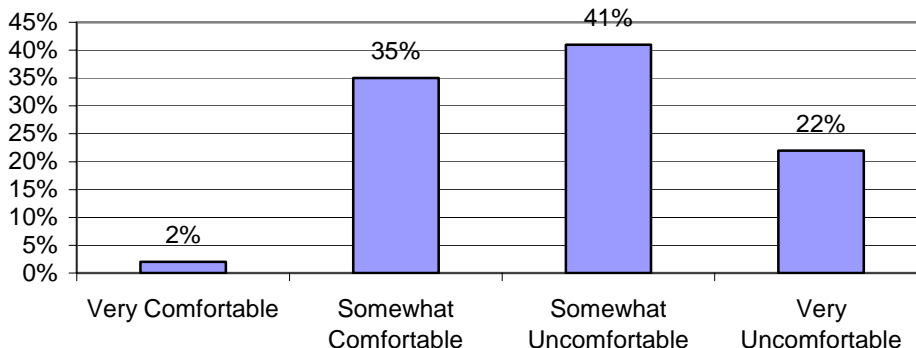
Characteristics of Patients. Thirty-two percent of mental and behavioral visits involved chronic or repeat visits by the same individuals. Respondents stated that 63 percent of visits are patients 19 to 64 years old, 21 percent are 65 years and older, and 16 percent are 18 years and younger (Figure C).

Figure C:
"Please estimate what proportion of visits that involve
mental and behavioral health conditions are
represented by patients in each age category:"
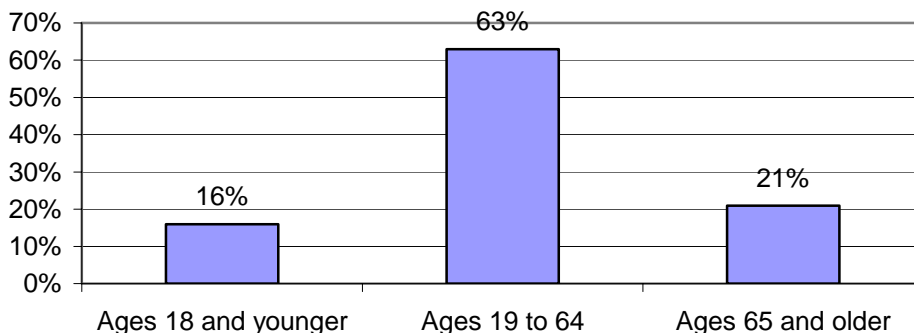
Common Types of Visits. Substance/alcohol abuse and depression/anxiety were the two most common types of mental and behavioral health issues seen in the emergency room. Suicide (attempted or ideation) and dementia are third and fourth respectively.

Length of Visits. The average length of mental and behavioral health visits was two hours. About 33 percent of respondents indicated the visits were less than or equal to one hour and 20 percent have visits that last over two and a half hours. The range was 30 minutes to five hours.

Outcomes of Visits. Overwhelmingly, the survey indicated that, when dealing with mental and behavioral visits, hospitals and emergency rooms "treat patients as transfers" according to one respondent. Eighty-four percent of respondents identified "transfer to detox" as an outcome for patient with alcohol/substance abuse with law enforcement involved in 43 percent of outcomes, not including transportation. For patients without alcohol/substance abuse, 81 percent of the respondents identified "transfer to psychiatric unit" as an outcome. These patients required the involvement of law enforcement 14 percent of the time. Respondents identified "admit for observation" as less than 50 percent of the outcomes for both types of visits. None of the respondents identified telemedicine as a treatment.

Crisis Intervention Services. The average distance to the nearest crisis intervention service was 54 miles or about one hour. The range in distance was 15 to 180 miles and time was 20 minutes to two and a half hours. Twenty-one percent of respondents are unsure of the availability of the nearest or most used crisis intervention service.

Telemedicine in CAHs. Telemedicine capability was present in 15 percent of CAHs with another 35 percent planning to implement in the future. Of the 23 CAHs who have or are going to have telemedicine in the hospital or emergency room, 14 percent use and 48 percent are planning to use it for mental and behavioral health patients in the emergency room.

Nursing Home Placement. Thirty-six percent of respondents experienced no difficulty in placing patients with mental and behavioral health issues in nursing homes. Another 34 percent had experienced difficulty and 30 percent were unsure (see Figure D).

Does your hospital or emergency room have telemedicine?
- 50 percent No, no plans to
- 35 percent No, but planning to
- 15 percent Yes

Is telemedicine used for mental or behavioral health in emergency room?
- 48 percent No, but planning to
- 33 percent No, no plans to
- 14 percent Yes
- 5 percent Unsure

Figure D:
"Do you experience difficulties finding placement in
nursing homes for patients with mental or behavioral
health issues?"
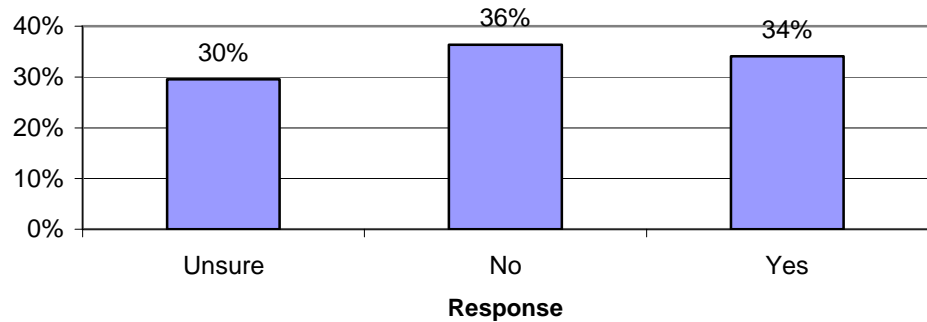
Barriers Identified. The respondents listed many barriers faced by their emergency room in meeting the needs of patients in mental and behavioral health crisis:
- No psychiatric beds available
- Significant use of emergency room's time and resources
- Lack of adequately trained staff
- Lack of resources in the community
- Mental health provider shortage
- Safety and security of both patient and staff
- Transportation
- Lack of appropriate physical space for patients.

Needs Identified. Respondents indicated a desire to provide better care to mental and behavioral health patients. They listed the following ways to improve care:
- Better education and training on mental and behavioral health issues
- More community resources that are easily accessible
- More mental health providers
- Better community knowledge and understanding of mental and behavioral health
- Ease in making referrals
- More referral options.

Steps Taken. Hospitals and emergency rooms are improving the quality of care for mental and behavioral health patients. This includes community collaboration, education and training of staff, and policy and procedure changes.

8   Promising Practices

Begin with the Community

Improving Mental Health Care through the Primary Care System
In order to help rural Minnesota communities look at ways to improve
mental health care through the primary care system, the work group reviewed
the research and literature and added its own expertise to examine models of
care delivery, practices and partnerships that have proven potential to improve
care. A number of common themes emerged that form a framework of
promising practices.

The work group identified some rural Minnesota models that illustrate these
practices. The intent of this section is to provide guidelines that communities
can use to fashion care systems that work in their unique settings, not to endorse
a specific program or project. See appendix E for a discussion of the research
and literature.

Start by Assessing the Needs of the Community
The literature and the research emphasize the importance of understanding a
community and its practical needs before developing specific rural programs.
Every rural community has its own culture and concerns. Community forums
illustrate some of the different areas of concern:
- In a southern Minnesota community, forum participants talked about the need
  for bilingual, culturally competent mental health providers for a growing
  immigrant population.
- In a northwestern Minnesota community, concern centered on adequate
  mental health treatment for the elderly, particularly addressing depression
  and dementia.
- Some central Minnesota forum participants expressed concern
  about methamphetamine use.

Collaboration
One of the great strengths in rural Minnesota communities is the willingness and
ability to work together toward a common goal. In looking at ways to improve
mental health care in the primary care setting, this collaboration will be key.
Collaboration is required at the community level, the health care system level and
the health care professional level. In each case, creating collaborative approaches
to care involves building human community among people who may not know or

understand each other well at the outset. Success is much less likely if a finished product is simply delivered to people who were not part of the process. Dialogue among the interested parties "co-creates" a project.

Work group members noted that even though the focus was on mental health services in primary care, stakeholders interested in improving care were not solely health care providers. Possible partners include law enforcement, clergy, Area Agencies on Aging, schools, pharmacists, ambulance services and other community leaders.

Successful models require community interest, thoughtful collaboration, and a number of practical steps:
- Establish a design team made up of the people needed to make the program a reality. Develop a shared vision and common purpose as well as addressing the clinical, financial and operational realities of the project.
- Make sure all parties understand how the program, project or model meets the needs or addresses what is important to everyone.
- Expect developmental steps to take place over time and set realistic goals for each step.
- Build in evaluation as an ongoing part of the process.

Care Delivery Models

A number of care delivery models have emerged to address mental health services within the primary care setting. The following models were most often identified in the research and by the literature as working within the context of primary care.

Integration of mental health services into primary care clinics
A growing body of research indicates that the quality of mental health care is enhanced through integrating mental health services with primary care. In an integrated model, the mental health professional is part of the clinic team and clinic community. The mental health professional works in the same location as the physicians and other primary care providers. Mental health screening, assessment and treatment becomes part of the continuum of care delivered by the clinic and works especially well for intertwined medical and mental health conditions that do not lend themselves well to referral to separate and often distant mental health clinics.

Co-location of mental health professionals into primary care clinics
In this model, the mental health professionals are not fully integrated into the primary care practice, but they are located in the primary care clinic. They are quickly accessible, and are seen more as on-site specialists than members of the standard primary care medical team. Space and clerical support may be in a separate area of the clinic and may be identified as "mental health." The mental health professional is in routine communication with primary care providers. Protocols regarding information-sharing between the mental health and general

medical practices are very clear to patients. This works very well for "co-provision" of care where coordination and communication is very important but the medical and mental health providers can proceed with their own portions of the care and patients recognize this difference.

Liaison
A liaison figure such as a nurse works with a primary care clinic and mental health clinic to identify patients in need of care—especially coordinated care of some kind—and to assist with referral and follow-up.

Consultation
A psychiatrist or another mental health professional provides consultation services, often related to diagnosis and treatment of mental health conditions, pharmacological interventions, or behavioral/psychosocial aspects to chronic illness care or rehabilitation.

Community-based
The community and its resources becomes the center or organizing level for the care, which could include crisis teams in community or hospital emergency rooms, home-based care, shared services between the community (school, public health, home care) and the primary care clinic. It could also include community collaboratives, case management, and using community members and volunteers for outreach.

Telehealth
Telehealth, the provision of services through video and teleconferencing, is a growing field. Research indicates that telehealth can be an effective tool for diagnosing and treating some mental health conditions. For rural and remote areas, it offers patients the opportunity to see mental health professionals without traveling great distances. Since this is a relatively new field, challenges to this system include finding willing psychiatrists and developing "buy in" from family practice doctors and other primary care providers.

Health Professional Training in Rural and Collaborative Practice

Training in both rural and collaborative practice is critical to creating successful partnerships that support mental health care in the primary care setting. As one work group member commented, "The professional boundaries in rural practice are challenging. I might be playing softball with my neighbor one day and treating his suicidal daughter the next." Rural health care practice involves knowing the community and the relationships.

Most professional training does not emphasize collaboration between medical and mental health professionals and therefore skills in this area are often not developed. The research and literature suggest that training should involve topics such as clinical models, population health, cultural differences and communication.

Because integrated models so often involve mental health professionals entering the world of primary care practice, training also needs to be focused on helping mental health professionals adjust and operate with a new culture and language.

Promising Practices Make a Difference

Measures of Success

In discussing the promising practices that can improve mental health care delivery in the rural primary care setting, the work group felt it was important to also look at the larger health care picture. Through literature review and discussion the group enumerated ways of answering the question, "Are these practices making a difference?" (See Appendix E for more detailed discussion)

- Look at the *quality* and *completeness* of the care process. Are all levels of care—ranging from screening and prevention to an actual intervention— provided?

- Look at the impact on the bigger health picture. Does this improve population health outcomes? For example, does the reduction of depression in the elderly population result in better management of dementia?

- Look for improvements in the big picture or system of rural health care. Does this address larger problems, such as the social stigma around seeking mental health care; the health care workforce shortage; or improvement in chronic illness care?

Examples

The following examples illustrate some of these concepts. They were chosen because of the collaborative nature of their organization, project or work and because they are working models, currently providing services.

Programming in Primary Care Resulting From Community Assessment

Fond du Lac Domestic Abuse Counseling and Education Program

Fond du Lac Human Services Behavioral Health Department in Cloquet assessed a need in the tribal community for a Domestic Abuse Counseling and Education Program. Residents were having difficulty meeting court ordered completion requirements under the existing area programs. Fond du Lac Human Services is a tribal primary care system serving American Indian clients in Carlton and southern St. Louis Counties. In developing the 26-session program, the clinic identified:

- A program that would address the cultural sensitivities and cultural needs of the Fond du Lac tribal community

- A program that would not charge for services

- A program that would meet statutory requirements and also contain follow-up components.

Because of the success of this program, Fond du Lac Human Services Division is developing a training protocol for use and adaptation by other reservations. Additionally, the division is working to integrate mental/behavioral health services into its primary medical care system. Plans include adding a behavioral health specialist to the medical team to assist patients.

Community Collaboration to Create Services
Shared Care Psychiatry
In Shared Care Psychiatry in Detroit Lakes, a patient's primary physician consults and shares in the care with the psychiatrist but continues to be primarily responsible. This program includes Becker County Human Services, Dakota Clinic, MeritCare Clinics, Lakeland Mental Health Center and St. Mary's Regional Hospital. The agencies, some of them competitors, partnered over a common need to enhance psychiatric services. Prior to the launch of the Shared Care model, patients often waited several weeks for a consultation with a psychiatrist. Since implementation, most people are seen within two to three days. The collaboration has worked well because:

- All partners recognized a common need and a common goal

- The right stakeholders came together

- All partners are contributing. Lakeland provides a psychiatrist and does all the billing. The clinics provide space and professional time. Becker County coordinates the grant and St. Mary's Regional Hospital coordinates education and evaluation.

- Adequate grant funding from the local Dakota Medical Foundation helped cover start-up costs. Further grant funding from the Blue/Cross Blue Shield Foundation is helping to cover additional work in developing best practices and evaluating the model and developing a Web site and toolkit.

Integration of Mental Health Services into Primary Care
St. Mary's Health System Duluth Clinic Integrated Program in Ely
In 2004, the Duluth Clinic began a collaborative project to integrate psychiatric services into the primary care clinic. In this model an integrated care team including the primary physician, consulting psychiatrist and licensed therapist work together and use an integrated medical record to provide care. A visiting psychiatrist provides consultation services to evaluate and develop a plan of treatment for the patient—usually in one to two visits. Care is then returned to the primary care physician. The psychiatrist is available to the physician via phone for follow-up questions and consultation. Psychotherapy services from a licensed therapist are provided in the clinic. Currently, the program is supported through the billable services of the psychiatric consultations and the psychotherapy. One of the challenges is finding a funding stream to support care coordination. In the

long-term plan, a nurse or social work care coordinator will be added to the team to provide more intense follow-up and support to the patient.

Integration of Psychology Services into Primary Care

Psychology Integrated into Primary Care

Psychologist Jeff Leichter is located in Merit Care, a primary practice clinic in Detroit Lakes. The clinic includes five family practice doctors, two surgeons, an internist, an optometrist, an obstetrician/gynecologist and physician's assistants. The clinic employs one adult psychologist and one adolescent psychologist and a 3/5 FTE psychiatrist (see Shared Care collaborative model).

Psychology services within the primary care clinic began in 1990. The practice was built through prompt responses to requests and referrals and concise feedback to referring doctors. Because of overwhelming response, Dr. Leichter closed his practice to self-referrals and only takes patients referred by clinic doctors. He consults at the hospital in crisis cases. He also works collaboratively with the other psychologist in the clinic and does case reviews for quality assurance.

Since setting up practice, Dr. Leichter has noted that family doctors have increased their ability and willingness to manage mental health issues with patients. Services are billable and handled through the clinic system. Medical assistance, Blue Cross Blue Shield and private insurers provide coverage for services. Medicare has a 20 percent copay with restrictions.

Collaboration and Co-location

Human Development Center in Duluth/Gateway Clinic in Moose Lake

The co-location model in the Gateway Clinic in Moose Lake has thrived for over a decade. It originally started with the Human Development Center (HDC) supplying a mental health professional a half day per week. A professional is now co-located at the clinic every day. HDC pays rent, maintains a separate medical record and bills separately for services. Primary care providers make 75 percent of the referrals.

> "In order to work, co-location needs to have a defined relationship with the clinic."
> *Glenn Anderson, HDC Director*

Glenn Anderson, HDC Director, explained that co-location provides a good service; but, because of the need for separate medical records and separate billing, the service is not as well integrated into primary care as it could be.

Telemedicine

Center for Rural Mental Health Studies and Scenic River Health Services, Big Fork, Minnesota

This off-site shared care model is a collaboration between the University of Minnesota Medical School in Duluth and the physician clinic in Big Fork. A family practice physician makes an appointment for the patient with a medical

school based psychologist. Consultation is done via video. The psychologist provides consultation, problem-solving and follow up with the family practice physician, usually in one or two visits. There is no long-term relationship with the patient. A similar site is being set up in Cook, Minnesota, and the Human Development Center of Duluth is working via televideo consultation with Grand Marais to provide child psychiatric services. The University of Minnesota is currently doing an evaluation study of the efficacy of this model.

The model is becoming more affordable because cost of equipment is becoming less expensive. The University and the clinic invest approximately $3,000 in equipment per site and must have high-speed Internet access. The telehealth visits are billable under Medicare, Medicaid and third-party payors.

Collaboration to Provide Rural Psychology Training

The Minnesota Consortium for Advanced Rural Psychology Training

This consortium in Detroit Lakes is a collaboration of a number of agencies delivering mental health services in Becker, Mahnomen and Ottertail Counties and the White Earth Indian Reservation. The collaborative effort is dedicated to designing and implementing a rural residency program to train post-doctoral psychologists. In January of 2003, the consortium received grant funding to develop a curriculum for this project. The curriculum includes training opportunities in a number of areas, from primary care clinics to school-based child psychology, chemical dependency, nursing home care, community hospital practice, and consultation with social service and law enforcement agencies representing the spectrum of clinical experiences and challenges unique to practicing in a rural area. The consortium is now seeking funding to support the residency.

9 Summary and Recommendations

Key Findings

Rural Mental Health and Primary Care
In rural areas mental health problems are often treated in the primary care setting. Rural Minnesotans lack access to mental health professional services due to shortages in the mental health workforce, distances people have to travel for services and delays in receiving services. A stigma about receiving mental health services exists and can act as a deterrent to receiving services. Patients in mental health crises presenting in the emergency rooms of small rural hospitals are often transferred to mental health beds a significant distance from home. The complexity of the payment system for mental health creates hardships for both patients and small rural clinics with limited staff and resources.

Education of Students and Practicing Professionals
Training that could prepare mental health providers for the unique needs found in rural areas is sketchy and in some cases nonexistent. Primary practitioners lack the knowledge and expertise to treat many of the mental health disorders.

Promising Practices
Research shows that community collaboration is a key in ensuring quality services. Integrating mental health services into the rural primary care setting can be effective. Models include co-locating mental health services within the primary clinic setting and integrating services. Models of telehealth that extend the use of psychiatrists and other mental health professionals into remote areas exist and have demonstrated effectiveness.

Recommendations

Recommendations are divided into three categories:

A. Health Professional Education

B. Health Systems

C. State and Federal Policies and Programs.

A. Health Professional Education
Recommendations in this section are targeted at academic health programs that train medical students, nurses, mental health professionals and other health professionals who care for patients with mental/behavioral health concerns. These recommendations also apply to health professional organizations and associations responsible for continuing education of their constituents.

A-1. Enhance and promote mental/behavioral health education and training for all health profession students training in primary practice.

A-2. Enhance mental/behavioral health training for those in family medicine residencies. It is critical that family medicine physicians, in particular those planning to practice in rural areas, have an understanding of the interaction between physical and mental health and disease, and are adequately prepared to diagnose, treat and/or refer patients with mental or behavioral conditions. The University of Minnesota and Mayo Medical Schools should seek out practicing rural and family medicine physicians who successfully collaborate with mental health practitioners (either on-site or via telehealth) and develop education and residency programs that highlight the experience of these teams.

A-3. Promote and develop rural site experiences for primary care and mental health practitioners that emphasize collaborative practice within the primary care setting. As a starting point, curriculum developers should tap into lessons learned through the experience of the University of Minnesota Rural Health School, which was recently absorbed into the Minnesota Area Health Education Center (AHEC) program. The overall goal of the Rural Health School was to prepare rural health care providers to practice in interdisciplinary teams. In addition, curriculum/site developers should explore potential on-site training experiences with the successful collaborative teams identified in Recommendation A-2.

A-4. Develop and support rural site experiences for those in psychiatric residency programs. Curriculum/site developers should think creatively about potential on-site residency opportunities, including community mental health centers, state Regional Treatment Centers, correctional facilities and programs, larger regional hospitals and clinics in rural areas of the state (e.g., Marshall, Bemidji, Willmar, Mankato), as well as sites served by the successful teams identified in Recommendation A-1.

A-5. Develop and support mental health related continuing education for rural primary care providers through accessible means such as distance learning (including Web applications), regional conferences and traveling programs. Traveling programs should consider modeling their approach after the Comprehensive Advanced Life Support (CALS) course. CALS is structured to maximize the intensity and volume of material presented, while minimizing the amount of time providers need to take away from their practice or facility. Continuing education opportunities should be developed collaboratively with the

Minnesota Department of Human Services. Existing trainings for mental health professionals could be expanded and adapted to include primary care providers.

A-6. Include mental/behavioral health content in conferences and other continuing education opportunities for primary care physicians, nurses, nurse practitioners, physicians' assistants and nursing assistants, as well as nontraditional audiences such as pharmacists, dentists, school nurses and counselors and law enforcement personnel.

B) Health Systems
Health systems includes a variety of entities including health care provider systems and networks, hospitals, clinics and payer systems.

B-1. Promote and support demonstration projects and models of collaborative care between mental health providers and primary care providers. Successful examples include co-location of services, integration of services within the primary care clinic system, and the "shared care" model. Work group members' experience and the relevant literature point to collaborative models of care as one of the most effective and efficient means of integrating mental health and primary care services to better meet the needs of patients.

B-2. Develop a common set of mental health benefits. Support the work being done through the Minnesota Mental Health Action Group (MMHAG) to develop a basic set of mental health benefits common to all health plans. With the development of this common benefit set, people who change insurance could be assured of continuity of coverage levels for mental and behavioral health services, and providers would benefit from administrative consistency across plans. Even with a common benefit set, it is important to bear in mind that rural Minnesotans are more likely to be uninsured or under-insured than their urban counterparts. Therefore, efforts to promote coverage/service options for rural Minnesotans who lack or have inadequate mental health coverage should continue.

B-3. **Advocate for funding streams** that promote collaborative and integrated mental health and primary care models. Funding should support reimbursement for consultations between the primary care provider and the mental health provider, as well as care management, care coordination and other collaborative models such as co-location. In addition, the work group identified several existing coding and funding mechanisms that create barriers to collaborative care. These mechanisms should be catalogued and brought to the attention of funders and policymakers.

B-4. Promote and expand telehealth collaborations to strengthen delivery of mental health services in remote and underserved areas. Many rural health care providers have begun to use telehealth technology for a number of purposes, including teleradiology, teledermatology, telepharmacy and home health monitoring. In some cases, telemental health applications could be developed

using existing equipment. Equipment does not need to be costly; simple telephone technology can often be used effectively.

Although reimbursement is often assumed to be a barrier to providing telemental health services, Medicare does cover teleconsultations by psychiatrists, clinical nurse specialists, clinical social workers and clinical psychologists for beneficiaries living in rural health professional shortage areas. State efforts to expand this coverage to the Medical Assistance program should be supported.

B-5. Improve delivery of mental health crisis services at small rural hospital emergency rooms through quality improvement projects that address mental health bed capacity, appropriate patient transfer and continuing education for emergency room personnel. Provider networks, Stratis Health (Minnesota's Medicare quality improvement organization), the Minnesota Hospital Association, and other health care organizations and associations should incorporate this goal into their quality improvement plans. The Minnesota Department of Health's Office of Rural Health and Primary Care should add this to its list of federally fundable objectives under the Rural Hospital Flexibility Program.

B-6. Create an understandable guide to the current payment system for mental health care for rural primary care and rural mental health providers.

The current system reflects a complex combination of payment methodologies and has become very difficult to understand and use. As a result, rural providers and administrative staff may not know how to obtain reimbursement for specific mental health services; this can lead to restrictions on patients' access to care. Also, since billing and coding patterns do not always accurately reflect diagnoses and treatment delivered, payment patterns do not accurately reflect actual incidence of certain conditions. Therefore the occurrence of these conditions in the community as a whole is understated.

The payment system guide should include concrete examples of how to access, interpret and blend payment mechanisms and sources to most accurately reflect patient diagnosis and treatment, while simplifying and clarifying billing and coding procedures for providers. The Minnesota Department of Human Services, in cooperation with other payers and representatives of the provider community, should be charged with developing this guide, using information gleaned through the Minnesota Mental Health Action Group.

C) State and Federal Policies and Programs
This set of recommendations is meant for policymakers including the legislature, state agencies and the federal government.

C-1. Expand state-funded health professional loan forgiveness programs to include psychologists, social workers and other mental health professionals who agree to work in rural areas. Currently, the Minnesota Department of Health's Office of Rural Health and Primary Care administers state-funded loan forgiveness for physicians, nurses, mid-level providers and dentists. To address the shortage in rural areas, this program should be expanded to include psychologists, social workers and other mental health professionals. Funding for the overall program should be increased so as not to draw needed funds away from professions already included in the program.

C-2. Support efforts to expand public program coverage of telehealth consultations by mental health professionals. Medicare currently covers teleconsultations by psychiatrists, clinical nurse specialists, clinical social workers and clinical psychologists for beneficiaries living in rural health professional shortages areas. State level efforts to expand this coverage to the Medical Assistance program and other public health care programs should be supported.

C-3. Eliminate the funding rule for the Medical Education and Research Costs (MERC) program that requires small sites to have at least a 0.5 FTE health professional student in any given discipline to receive training reimbursement. Work group members reported—and Minnesota Department of Health data confirmed—that this rule, which was instituted during the 2003 legislative session, has resulted in substantially reduced training reimbursements to many small rural hospitals, clinics, pharmacies and other training sites. While MERC reimbursement does not support mental health training sites per se, it does support primary care training sites, which are needed to promote and develop collaborative, interdisciplinary practice models.

C-4. Eliminate the copayments on psychopharmaceuticals for Medicaid and MinnesotaCare instituted in the 2003 legislative session. Creating financial barriers to care can be risky, particularly in the area of mental and behavioral health. If patients are unable to afford their medications, or if they cut back on doses as a result of financial pressures, their conditions may deteriorate, causing worsening symptoms and even a need for emergency and/or inpatient care.

C-5. Support the Minnesota Mental Health Action Group's (MMHAG) efforts to develop best practice and benefit models that would address rural mental health needs in the primary care setting.

C-6. Provide Medical Assistance reimbursement for care management and coordination of appropriate mental health patients at the primary clinic level. Some rural patients with complex mental health and physical health needs could be helped at the primary clinic level with care management services that could include regular follow-up by nurses or social workers for medication monitoring and counseling. Most primary care clinics do not have the resources to provide this type of service without a reimbursement.

C-7. Establish an access-to-care standard for the Medical Assistance and other public health care programs that recognizes both distance to services and waiting time. Currently, geographic distance to care is defined in statute as an access indicator. Given the long waiting time sometimes required to see a mental health practitioner, these should also be factored into the access standard.

C-8. Promote development and use of electronic health records in mental/chemical/behavioral health. Ensure that the rural mental health community is represented in state level discussions on developing and implementing electronic health records. Electronic health records are especially needed in the areas of mental, behavioral and chemical health because of the fragmentation of the treatment system.

C-9. Support the development of crisis response teams through collaboration among the Minnesota Department of Human Services, counties and health plans. This might include rural regional urgent mental health care clinics, cross-trained crisis response teams or mental health telemedicine networks.

C-10. Promote mental health emergency quality improvement projects in Critical Access Hospitals through funding from the Medicare Rural Hospital Flexibility grants. The Office of Rural Health and Primary Care administers the federally funded Medicare Rural Hospital Flexibility (Flex) Program in Minnesota. In publicizing and distributing Flex mini-grants, the ORHPC should encourage development of quality improvement projects focused on Critical Access Hospitals' mental health emergency response capabilities.

C-11. Improve and bring Medicare coverage for mental illness to parity with physical illness coverage. The current Medicare Part B coinsurance rate for mental health services is 50 percent as opposed to 20 percent for physical health services. This high coinsurance rate creates a barrier to care for Medicare beneficiaries.

C-12. Create a coordinated data collection and analysis system for mental health incidence, prevalence and treatment data in Minnesota. This database should be developed in coordination with the Minnesota Departments of Health, Human Services, and Corrections, health plans, Minnesota Mental Health Action Group and other mental health stakeholder groups representing consumers and providers.

CONCLUSION

Improving mental health service delivery through the rural primary care system involves approaches that recognize the need for a competent and qualified workforce; up-to-date education for primary care providers; and policy and funding streams that support the complexity of care.

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Appendix A:
Areas of Concern
not Included in Report

The scope of the work group task was limited to looking broadly at mental health services within the rural primary care setting. Many aspects of mental health care in rural Minnesota were discussed during the course of the work group project. Some areas, however, were either not pursued or not addressed in depth in order to keep the focus of the group on services in the primary care system. The following is a compilation of topics discussed but not included. All these areas were deemed to be important to the provision of mental health care in rural areas, but beyond the scope of this work group.

Chemical Dependency and Substance Abuse
Rather than address this area as a separate topic, chemical dependency and substance abuse was included in a general definition of mental health. The work group noted that chemical dependency and substance abuse issues are significant challenges in rural areas and could constitute a separate work group to look at treatment and care provision.

Children and Adolescent Mental Health
Services to screen, diagnose and treat children and adolescents for mental health disorders are often scarce. As noted in the body of the report, rural Minnesota has few child psychiatrists, and waiting time and travel distance can be a significant barrier to care. The work group discussed the need for coordinated services between schools, social services, law enforcement, mental health providers and the primary care system.

Mental Health and the Elderly
The population of rural Minnesota is aging. Most mental health services for the elderly are provided through the primary care system. The work group discussed the specific problems of providing mental health services to nursing home residents, which often includes long wait times for mental health assessments.

Other Mental Health or Behavioral Health Topics
Suicide, depression and domestic violence were identified by the work group as areas of concern in rural Minnesota. Additionally, the group commented on the

importance of prevention activities, noting promising practices of pre-school and after-school programming in some communities focused on high-risk children.

Emergency Transportation

Community ambulance services are sometimes called upon to transport people in mental health crises either to the local emergency room or to psychiatric beds in other parts of the state. The work group commented that travel time and distance involved can leave a community without ambulance service for significant amounts of time. In rural communities most ambulances are operated by volunteers who are not always trained in handling mental health emergencies. Emergency transportation, and transportation in general to obtain services outside the community, are problematic and should be a topic for further discussion.

Community Resources Outside the Primary Care System

While primary care was the focus of this work group and report, many rural communities have resources outside the health care system. A number of these resources were mentioned as providing vital formal and informal mental health services to rural populations. These resources include community mental health centers, the school systems, community clergy, community social services and public health, volunteers, and Alcoholics Anonymous. A number of respected programs that illustrate rural community activities developed in response to mental health needs were discussed but not included in the "promising practices" section of the report because they are either in the developmental stage, or not closely connected with primary care. For example, the Development and Behavior Clinics (DBC), through the Minnesota Department of Health's Minnesota Children with Special Health Needs Program are held throughout rural Minnesota to provide multidisciplinary team diagnostic assessment and recommendations for children and adolescents with mental or behavioral health needs.

Law Enforcement and the Corrections System

The work group identified that law enforcement is frequently involved in mental health emergencies and crises. In addition, local law enforcement officers are called upon to transport patients when no other option is available. People convicted of crime and sent to Minnesota jails and prison systems often have co-occuring mental health problems. These are both rural and urban issues and broad enough that the work group felt this should be addressed in a larger forum.

Appendix B:
Primary Care Survey

M I N N E S O T A
MDH
DEPARTMENT OF HEALTH

Survey of Rural Clinics on
Mental/Behavioral Health Issues

The Rural Mental Health and Primary Care Work Group of the state's Rural Health Advisory Committee (RHAC) is conducting a survey of physicians, nurse practitioners, and physician assistants in rural primary care clinics in order to learn how the primary care system works with patients presenting with mental or behavioral health issues. Please complete this survey about your experience treating patients with mental or behavioral health issues. If you have received this survey and are not a direct care provider, please forward it to the appropriate professionals in your clinic. This survey consists of 39 questions and will take 10-15 minutes to complete. Please fill it out and submit it before May 21, 2004. The survey can be completed in one of two ways:

1) Electronically at: www.zoomerang.com/survey.zgi?p=WEB2DQ9APR8

or

2) By paper and mailed to:
Minnesota Department of Health
Office of Rural Health and Primary Care
Attn: Mental Health Survey
P.O. Box 64975
St. Paul, MN 55164

The Rural Health Advisory Committee serves as a statewide forum for rural health concerns and advises the Commissioner of Health and other state agencies on rural health issues. Your feedback is important to us. If you have any questions regarding this survey, contact the Minnesota Department of Health - Office of Rural Health and Primary Care at 1-800-366-5424 or email chs@health.state.mn.us.

Thank you in advance for participating in our survey.

1)   What region of Minnesota is the location of your clinic?

☐   **Central** (Benton, Sherburne, Cass, Todd, Wadena, Morrison, Chisago, Crow Wing, Isanti, Mille Lacs,
       Stearns, Wright, Pine, Kanabec)

☐   **Northeast** (Aitkin, Itasca, Koochiching, Carlton, Cook, Lake, St. Louis)

☐   **Northwest** (Becker, Mahnomen, Norman, Beltrami, Clearwater, Hubbard, Lake of the Woods, Kittson,
       Marshall, Pennington, Red Lake, Roseau, Polk)

☐   **South Central** (Blue Earth, Brown, Nicollet, Faribault, Martin, Le Sueur, Waseca, Meeker, McLeod, Sibley,
       Watonwan)

☐   **Southeast** (Dodge, Steele, Fillmore, Houston, Freeborn, Goodhue, Mower, Olmsted, Rice, Wabasha,
       Winona)

☐   **Southwest** (Big Stone, Chippewa, Lac Qui Parle, Swift, Yellow Medicine, Cottonwood, Jackson, Kandiyohi,
       Lincoln, Lyon, Murray, Pipestone, Nobles, Rock, Redwood, Renville)

☐   **West Central** (Clay, Wilkin, Douglas, Grant, Pope, Stevens, Traverse, Otter Tail)

2)   Of the patients you see, please estimate what proportion have mental/behavioral health issues.

☐   Less than 10%
☐   10% - 20%
☐   21% - 50%
☐   over 50%

**3)   Over the last 2 - 3 years, do you believe the proportion of patients presenting with
        mental/behavioral issues in your clinic has: (select one)**

☐   Increased
☐   Decreased
☐   Stayed the same
☐   Other, please specify_____

**4)   Please estimate what proportion of your patients age <u>18 and younger</u> have mental/behavioral
        health issues.**

☐   Less than 10%
☐   10% - 20%
☐   21% - 50%
☐   over 50%

5) **Please estimate what proportion of your adult patients <u>age 19 to 64</u> have mental/behavioral health issues.**

☐ Less than 10%
☐ 10% - 20%
☐ 21% - 50%
☐ over 50%

6) **Please estimate what proportion of your adult patients <u>age 65 and older</u>, have mental/behavioral issues.**

☐ Less than 10%
☐ 10% - 20%
☐ 21% - 50%
☐ over 50%

7) **Please estimate what proportion of the patients you see are of minority race/ethnicity.**

☐ None
☐ Less than 10%
☐ 10% - 20%
☐ 21% - 50%
☐ over 50%

8) **Of the patients referenced in question 7, please estimate what proportion have mental/behavioral health issues.**

☐ Less than 10%
☐ 10% - 20%
☐ 21% - 50%
☐ over 50%

9) **In your clinic, do you use a routine screening procedure to detect mental/behavioral health issues for your patients? If you answer "no," please skip to question 12.**

☐ Yes ☐ No

10) **If you answered "yes" to question 9, do you screen (please select your choice):**

☐ All patients.
☐ All adult patients.
☐ Children/adolescents.
☐ Only selected patients based on their described symptoms.
☐ Other, please specify_____

11)   If you said "yes" to question 10, what conditions do you screen for? Select all that apply:

☐   Depression
☐   ADHD
☐   Anxiety
☐   Substance Abuse
☐   Dementia/Alzheimer's Disease
☐   Other, please specify

12)   Are there mental/behavioral health professionals available within your clinic? If you answer "no," please skip to question 14.

☐   Yes   ☐   No

13)   If you responded "yes" to question 12, what type(s) of professionals? Select all that apply:

☐   Social Workers
☐   Psychologists
☐   Psychiatrists
☐   Marriage and Family Therapists
☐   Psychiatric Nurses
☐   Other, please specify_____

14)   **Are there mental/behavioral health professionals available outside your clinic, but within your community? If you answer "no," please skip to question 16.**

☐   Yes   ☐   No

15)   If you said "yes" to question 14, what type(s) of professionals? Select all that apply.

☐   Social Workers
☐   Psychologists
☐   Psychiatrists
☐   Marriage and Family Therapists
☐   Psychiatric Nurses
☐   Other, please specify_____

16) **For what types of mental/behavioral issues would you treat a patient yourself? Select all that apply:**

☐ Depression
☐ Anxiety
☐ Substance Abuse
☐ ADHD
☐ Alzheimer's Disease
☐ Dementia
☐ Bi-Polar Disorders
☐ Schizophrenia
☐ Other, please specify_____

17) **For what types of mental/behavioral issues would you refer patients? Select all that apply:**

☐ Depression
☐ Anxiety
☐ Substance Abuse
☐ ADHD
☐ Alzheimer's Disease
☐ Dementia
☐ Bi-Polar Disorders
☐ Schizophrenia
☐ Other, please specify_____

18) **If you refer patients, where would you most commonly refer the patient?**

☐ Within the clinic
☐ Outside the clinic, but in the community
☐ Outside of your community
☐ Other, please specify_____

19) **If a patient has to travel outside the community for treatment, how far on average would he/she have to travel?**

☐ Less than 20 miles
☐ 21 - 40 miles
☐ more than 40 miles

20)   **If a patient is referred outside your clinic for treatment, what level of communication do you typically have with the referral provider? Select one.**

☐   None beyond referral
☐   Some
☐   Frequent or ongoing contact
☐   Other, please specify_____

21)   **How long, on average, do patients you refer have to wait for an appointment?**

_____

22)   **Referring to question 21, is the waiting time different depending on the nature of the mental/behavioral health problem?**

☐   Yes   ☐   No

If yes, explain:

_____

_____

_____

23)   **If a patient needs emergency mental/behavioral health services due to suicidal thoughts or attempts, severe psychiatric incident, etc., are those services available in the community?**

☐   Yes   ☐   No

If not, what do you do?

_____

_____

_____

24)   **Are support services for people with mental/behavioral health issues available in your community? If the answer is no, please skip to question 27.**

☐   Yes   ☐   No

25) **If you answered "yes" to question 24, please describe those support services that are available. Select all that apply:**

☐ Faith-based support groups
☐ Area Agencies on Aging
☐ School programs
☐ Chemical/alcohol treatment programs
☐ County government human services
☐ Other, please specify_____

26) **Referencing question 25, do you as a provider encourage your patients to use these services when appropriate?**

☐ Yes ☐ No

27) **What roles do community organizations (churches, schools, etc.) play in prevention, diagnosis, treatment, and follow-up for patients with mental/behavioral health issues? Select all that apply:**

☐ Support groups (AA, bereavement, etc.)
☐ Volunteer recruitment and coordination
☐ Transportation
☐ Outreach/Community education
☐ Home visitation
☐ Unsure/Don't know
☐ Other, please specify_____

28) **What additional roles could community organizations play?**

_____

_____

_____

29) **Now, please tell us about you and your practice. Are you a:**

☐ Physician
☐ Nurse Practitioner
☐ Physician Assistant
☐ Other, please specify_____

30)   Please list any specialties you have:

Primary: _____

Secondary: _____

31)   What type of continuing education or other supports are available to help you keep current with diagnosis and treatment advances for patients with mental/behavioral health issues? Select all that apply:

☐   Continuing education workshops through colleges & professional organizations
☐   Continuing education by pharmaceutical companies
☐   Distance learning/telemedicine
☐   Self through journals/books
☐   Other, please specify

32)   How frequently do you participate in continuing education related to mental/behavioral health?

☐   Never
☐   Occasionally (less than every 5 years)
☐   Sometimes (every 2 to 3 years)
☐   Yearly
☐   Other, please specify_____

33)   Do you have a need for additional training in mental/behavioral health issues?

☐   Yes   ☐   No

34)   Would you attend continuing education courses for mental/behavioral health if they were more readily available?

☐   Yes   ☐   No

Comments:

_____

_____

_____

35) **How comfortable do you currently feel in providing mental/behavioral health services to your patients? (please select your choice)**

☐   Very comfortable
☐   Somewhat comfortable
☐   Somewhat uncomfortable
☐   Very uncomfortable
☐   Other, please specify_____

36) **Please complete the following: I am <u>most comfortable</u> treating patients with the following mental/behavioral health issues (select all that apply):**

☐   Depression
☐   Anxiety
☐   Substance Abuse
☐   ADHD
☐   Alzheimer's Disease/Dementia
☐   Bi-Polar Disorders
☐   Schizophrenia
☐   Other, please specify_____

37) **Please complete the following: I am <u>least comfortable</u> treating patients with the following mental/behavioral health issues (select all that apply):**

☐   Depression
☐   Anxiety
☐   Substance Abuse
☐   ADHD
☐   Alzheimer's Disease/Dementia
☐   Bi-Polar Disorders
☐   Schizophrenia
☐   Other, please specify_____

38) **What mental/behavioral health issue that you see in your patients or community are you most concerned about?**

_____

_____

_____

39)   What is the greatest challenge for patients from your community in obtaining mental/behavioral health services?

_____

_____

_____

Thank you for your input on mental/behavioral health care in Minnesota!

The information gathered from the surveys will be compiled and used as a resource in developing recommendations for improving Minnesota's mental/behavioral health care system. A full report from the Rural Mental Health and Primary Care Work Group, including the results of this survey, is expected by Spring 2005 and will be posted at the ORHPC website located at: http://www.health.state.mn.us/divs/chs/orh_home.htm

Appendix C:
Critical Access Hospital Survey

M I N N E S O T A
MDH
DEPARTMENT OF HEALTH

Survey of Mental and Behavioral Health Visits in CAH Emergency Rooms

The Rural Mental Health and Primary Care Work of Minnesota's Rural Health Advisory Committee (RHAC) in consultation with the Minnesota Hospital Association is conducting a statewide survey focused on emergency room visits that involve illness or symptoms that may be associated with mental or behavioral health. Behavioral health pertains to alcohol, substance, or chemical use or abuse. **Please complete and return survey by September 16, 2004.**

1. Approximately, how many visits occur in your emergency room in a typical week? _____

2. Approximately, how many visits involve **mental or behavioral health issue(s)** in a typical week (either as the primary presenting problem or as condition that ER personnel become aware of during the course of the visit)? _____

3. Approximately, what proportion of these visits involves chronic or repeat visits by the same individuals? _____%

4. Over the past 2-3 years, do you believe that the proportion of visits to the ER that involve mental or behavioral health issue(s) has: (select one)
    ☐ Increased
    ☐ Decreased
    ☐ Stayed the same
    ☐ Do not know

5. Please estimate what proportion of visits that involve mental or behavioral health conditions are represented by patients in each age category:

    Ages 18 and younger   _____%
    Ages 19 to 64   _____%
    Ages 65 and older   _____%

6. What are the **3 most common** types of mental or behavioral issues seen in emergency room visits: (select 3)
    ☐ Suicide (attempted and/or ideation)
    ☐ Substance/Alcohol Abuse
    ☐ Psychosis

☐   Violence (i.e., youth violence, domestic violence, sexual violence)
☐   Anxiety/Depression
☐   Dementia
☐   Other, please specify_____

7.   What is the average length of a mental or behavioral health visit in the emergency room? _____

8.   Does your hospital offer inpatient psychiatric treatment?
☐   Yes
☐   No, but planning to add in the future
☐   No, and no plans to add in the future

9.   Please complete the following chart, space for comments is available below

Type of mental/ behavioral health professional	Number of providers in the community*	Number of days available per month (add provider hours together)	Do they offer services after regular business hours** (yes or no)?	Do they offer crisis intervention services in the event of mental health crisis (yes or no)?	Do not know
Psychiatrists					
Psychologist					
Social Worker					
Licensed Counselor					
Marriage and Family Therapist					
Psychiatric Nurse					
Other: _____					

* Can be located within hospital or surrounding area
** Weekdays after 5pm and weekends

Comments:
_____
_____
_____

Questions 10-12 refer to the professional or agency that offers crisis intervention services nearest to your hospital.

10.   What type of mental/behavioral health professional or agency is your main resource that offers crisis intervention services nearest to your hospital (inpatient or outpatient)?
☐ Community Mental Health Center
☐ Psychiatric Hospital
☐ Crisis Service
☐ County or Public Health Service
☐ Primary Care Clinic with mental health provider on site
☐ Individual Mental Health Provider (i.e., Psychiatrist, Social Worker)
☐ Urban Emergency Room
☐ Chemical Dependency Treatment Center/Detox
☐ Other, please specify: _____

11.   On average, how long would it take a typical patient to travel from your hospital to the nearest professional or agency that offers crisis intervention services?
Time: _____
Miles: _____

11b. If your answer would depend on the day of the week or bed availability, please explain your situation:
_____

12. Does this professional or agency available offer the crisis intervention service 24 hours a day and 7 days a week?
☐ Yes
☐ No
☐ Unsure

13. What arrangements are available for crisis intervention after hours and weekends for residents of this community? (check all that apply)

☐ Admission to your hospital for observation
☐ Place in an observation bed in your hospital, but not admitted
☐ Transfer to a psychiatric unit in a general hospital
☐ Transfer to a psychiatric hospital
☐ Involvement of a crisis intervention
☐ Consultation with a psychiatrist or psychologist
☐ Referral to a community mental health center
☐ Involvement of law enforcement (for more than just transportation)
☐ Involvement of pastoral counseling
☐ Contact or inform the primary care practitioner (PCP)
☐ Use of telemedicine
☐ Other, please specify_____

14. When a patient presents in your ER with a mental health issue that is **not** substance abuse or alcohol-related, what are the **three most common** scenarios? (select 3)

    ☐   Admission to your hospital for observation
    ☐   Place in an observation bed, but not admitted to your hospital
    ☐   Transfer to a psychiatric unit in a general hospital
    ☐   Transfer to a psychiatric hospital
    ☐   Involvement of a crisis intervention unit
    ☐   Consultation with a psychiatrist or psychologist
    ☐   Referral to a community mental health center
    ☐   Involvement of law enforcement (for more than just transportation)
    ☐   Involvement of pastoral counseling
    ☐   Contact or inform the primary care practitioner (PCP)
    ☐   Use of telemedicine
    ☐   Other, please specify_____

15. When a patient presents in your ER with a substance abuse or an alcohol-related issue what are the **three most common** scenarios? (select 3)
    ☐   Admission to your hospital for observation
    ☐   Place in an observation bed in your hospital, but not admitted
    ☐   Transfer to a psychiatric unit in a general hospital
    ☐   Transfer to a psychiatric hospital
    ☐   Transfer to Detox Unit
    ☐   Involvement of a crisis intervention unit
    ☐   Consultation with a psychiatrist or psychologist
    ☐   Referral to a community mental health center
    ☐   Involvement of law enforcement (for more than just transportation)
    ☐   Involvement of pastoral counseling
    ☐   Contact or inform the primary care practitioner (PCP)
    ☐   Use of telemedicine
    ☐   Other, please specify_____

16. What is your and your staff's comfort level in dealing with mental and behavioral health crises?
    ☐   Very comfortable
    ☐   Somewhat comfortable
    ☐   Somewhat uncomfortable
    ☐   Very uncomfortable
    ☐   Other, please specify_____

17. Do you ever transfer patients out-of-state (e.g., to Sioux Falls, SD, or Fargo, ND)?
    ☐   No, never need to.
    ☐   No, we cannot. Please specify why: _____

    _____
    ☐   Yes.
    ☐   Other, please specify: _____

18. Do you experience difficulties finding placement in nursing homes for patients with mental health or behavioral issues?
   ☐ Yes.
   ☐ No.
   ☐ Unsure.

19. Do you have telemedicine (i.e., video communication technologies for consultation, diagnosis) in your hospital or ER?
   ☐ Yes (go to question 20)
   ☐ No, but planning to use in the future (go to question 20).
   ☐ No, and no plans to use in the future (go to question 21).

20. Do you use or will you use telemedicine in the ER for mental health or behavioral encounters?
   ☐ Yes.
   ☐ No, but planning to use in the future.
   ☐ No, and no plans to use in the future.

21. What are the **top three** barriers your emergency room faces in meeting the needs of persons in mental or behavioral health crisis?

   1.

   2.

   3.

22. What steps (if any) has your emergency room taken to improve the quality of care provided to mental and behavioral health patients in the past two years?

23. What would you need to provide better care for mental and behavioral ER visits?

24. Please share other thoughts or comments

Appendix D: Literature Review

RURAL MENTAL HEALTH
Mental Health and Behavioral Health

The Surgeon General's report (1999) defines mental health as "the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to change and to cope with adversity." The report also states that mental illnesses are disorders that alter thinking, mood and behavior (1999). Throughout most of the world, mental illness is one of the most stigmatized illnesses, often associated in the public eye with such characteristics as dangerousness, moral weakness, and offensiveness (Johnsen et al. 1997). Mental health and illness accounts for 15 percent of the burden of disease in the United States, only less than cancer (NIMH 2001).

The 1999 report illustrates how more and more health, government and education officials have become concerned with the state of mental health in the United States. For example, Healthy People 2010 cites mental health as one of the top 10 health indicators—putting mental health among such health topics as obesity, access to care, violence and tobacco use (U.S. DHSS, 2000).

About 20 percent of the U.S. population is affected by mental illness in a given year (Minnesota Psychiatric Society, 2004). This means that about one million Minnesotans will experience mental illness in a given year. Each year about 447 Minnesotans die as a result of suicide, three times the number of deaths caused by homicide. Suicide rates do differ according to gender, race/ethnicity and age. The highest rates occur in males (gender), the American Indian community (race/ethnicity), and the ages of 45-49 and 80-84 (Minnesota Psychiatric Society, 2004).

The Minnesota Psychiatric Society (2004) found that the Minnesota Hospital Association has recorded a 40 percent increase, from 19,031 to 27,522, in the number of combined urban and rural emergency room acute mental illness outpatient claims between 1997 and 2002. The total claims amount almost tripled in five years from $6,318,292 to $16,182,936. The average charge also increased from $322 to $588 per visit.

People with mental health problems often express risky behaviors such as smoking and alcohol and drug use (Minnesota Psychiatric Society, 2004). The strong link between mental health and behavioral health makes it hard to separate the two. Behavioral health, for this paper, is defined as substance use and abuse. Substance abuse is also a leading health indicator for Healthy People 2010. In 1995, the economic cost to the United States from alcohol and drug abuse neared $280 billion (U.S. DHSS, 2000). These behaviors are associated with motor vehicle crashes, drowning, HIV infection, teen pregnancy, school failure, heart disease, cancer and homelessness (U.S. DHSS, 2000).

Rural Culture

Defining "rural" is a complex task. Rural is a political and geographical term while also being one of self-definition, making the assessment of the rural population difficult. On a national level, there are 55-60 million rural people that constitute between 20 to 25 percent of the population but occupy about 80 percent of the land (Stamm et al. 2003, National Institute of Mental Health, 2000, Mulder et al. 2000).

Characteristics typical of rural communities and individuals include strong family ties, lower levels of education, higher poverty rates, limited tolerance for diversity, low population density, inadequate health services, limited insurance coverage (50 percent of uninsured live in rural areas), higher rates of disability, avoidance of conflicts and discussions about feelings, limited tax base, isolation, and a culture of self-sufficiency (Helbok, 2003, Mulder et al. 2000, Bull et al. 2001, Public Health Reports, 2000).

Slama (2004) discusses how language/terminology, presentation and body language, and demographic factors might be used to determine "rurality." She discusses how using "supper" for the evening dinner meal, directions by location not direction (e.g., turn right at Anderson's grove), and females starting sentences with apologetic language can all be indicators or characteristics of the rural culture. The paper also looks at presentation and body language that are common to the rural community including females being hesitant to shake hands, and males wearing caps, sitting with arms crossed, desiring extra foot space and avoiding eye contact. Slama (2004) also lists five factors making a person more rural: increase in age; less education; live on farm or smaller town or never lived in urban area for any significant time; have parents or grandparents in rural areas; and have not traveled often or far.

Other studies and research have addressed other rural culture issues. Garrison (1998) found that financial matters were the strongest factor of quality of life for rural families. Poverty and substandard housing in rural America are not equivalent to urban America (Mulder et al. 2000), and greatly affect health and health care. These generalizations cannot be applied to each and every rural community because rural communities are heterogeneous both internally and externally.

Being rural is becoming more and more important to health care providers and policymakers as the importance of "place" to health status is becoming increasingly clear. The places in which people work and live have an enormous impact on health, health care and health status. Each is influenced by political, socioeconomic and environmental factors including, air, water, roads, buildings, economy and community infrastructure (IOM, 2003). For example, the outcomes and consequences of severe illness and accidents are more severe for rural populations due to delay in treatment and distance to urban treatment center (Hicks et al. 2001).

Rural Mental Health

About 20 percent of the U.S. population is affected by mental illness in a given year. This means that about one million Minnesotans will experience mental illness (Minnesota Psychiatric Society, 2004). The various definitions of rural place rural Minnesotans at between 25 to 40 percent of the total Minnesota population (Slama, 2004). This suggests that between 250,000 to 400,000 mentally ill people live in the rural areas.

Unfortunately, most rural areas constantly experience a mental health provider shortage. In the 1950s the Eisenhower administration examined the state of rural mental health and found that 60 percent of rural areas suffer from mental health provider shortages. Decades later the Carter administration discovered the same shortage rate (Benson, 2003). This shortage still exists today.

More and more studies are focusing on rural mental health—comparing prevalence, treatment and outcomes between rural and urban areas. Anderson and Estle (2001) found that children living in non-metropolitan counties have a higher rate of inpatient mental health admission than those living in metropolitan counties. Depression prevalence has been found in rural women to be as high as 40 percent with urban rates ranging between 13 to 20 percent (Mulder et al. 2000).

Rost et al. (1999) found that rural patients receiving treatment for depression were three times more likely to be hospitalized for either physical or mental health problems than their urban counterparts. The study showed that rural patients incurred lower annual outpatient expenditures than urban, mostly due to less specialized care. The researchers also found that in rural areas a $1 increase in the cost of depression treatment was associated with a $1.42 reduction in the cost of treating physical problems.

When looking at rural-urban differences in service use and course of illness in bipolar disorder, Rost et al. (1998) found that rural patients had 22 times the odds of receiving services exclusively from a general medicine practitioner and almost six times the odds of using hospital emergency room services, when compared to urban counterparts. The research also found that rural patients had four times the odds of experiencing a manic episode during the year following baseline and 17 percent higher suicide attempt rate when compared to their urban counterparts. The researchers concluded that rural patients have poorer outcomes that lead to higher healthcare costs including hospitalization and emergency rooms visits (Rost et al. 1998).

Johnsen et al. (1997) found that rural community leaders ranked mental health as fourth in their priority list, ranking behind education, health care and economic development. Researchers were uncertain if the ranking comes from a perception as a growing problem or as an area of investment. The study broke down leaders by occupational sector. Educators, health care providers, mental health providers and retired persons ranked mental health as fourth. Those in the sectors of criminal justice, business, social services and clergy ranked mental health as fifth or sixth with farmers ranking mental health as seventh. Johnsen et al. (1997) concluded that there is greater need to look at the history and beliefs of the rural community because without "such contextual understanding, efforts aimed at promoting changes by health and mental health program personnel could be seen as little more than temporary."

Gamm and Hutchison (2003) found correlating results when looking at the priority areas among state and local rural health leaders. The study found that one third or more of the respondents identified "mental health and mental disorders" as a priority. State rural health organizations and rural health clinics/centers considered "mental health and mental disorders" as a high priority. Interestingly, public health organizations were not likely to identify mental health as a priority.

The Johnsen et al. (1997) study also found that the stigma associated with mental illness is about as problematic in rural areas as in urban areas. This confirms what Rost et al. found in 1993 that "all else being equal, rural culture does not attach greater stigma to mental health care treatment than urban culture;

however, stigma in rural communities is a much stronger deterrent to seeking mental health care than in urban areas."

Mulder et al. (2000) found that "public mental health systems are often the only provider in rural areas and primarily serve persons with severe mental illness." This leaves many seeking help from a network of family, friends, ministers and others, which is important, but is often not comprehensive, thorough or adequate (Mulder et al. 2000). The researchers concluded that rural residents prefer an integrated social, mental and physical health and wellness treatment. The research found many barriers that affect both social support and access to mental health services, including isolation, weather, the declining farm economy, unstable income, and financial concerns.

Petterson (2003) found that non-metropolitan persons who obtain specialized mental health treatment have less visits and are more likely to see a medical or primary care doctor for mental health treatment. This correlates with other studies that show rural or non-metropolitan persons as less likely to receive specialty care. The study found that rural/non-metropolitan persons are more likely to be hospitalized for mental health problems than their urban/metropolitan counterparts.

Substance Abuse and Use in Rural Areas

Studies have shown that persons seeking chemical dependency/substance abuse treatment experience the same barriers as those seeking mental health treatment. Studies have suggested that rural high school seniors have a higher rate of binge drinking then their urban counterparts. The Center on Addiction and Substance Abuse released a paper in 2000 that stated that rural eighth graders have a higher rate of use of methamphetamines and cocaine than urban eighth graders but there was no found difference in adult usage. (Cellucci et al. 2003).

Alcohol has been found to be the drug of choice in rural areas. The level of consumption by adults is at or higher than most urban regions. The rural areas and consumption rates can be greatly affected by economic uncertainties and crisis. Alcohol causes or increases the incidence to violence, car accidents, high-risk sexual behaviors, and accidental death (e.g., drowning, hunting accidents) (Kelleher and Robbins 1997).

Rural Primary Care Providers and Health Systems as Mental and Behavioral Health Providers

The following studies, along with others, illustrate the difference of opinion as to which is a better and more efficient practice—more mental health/behavioral health providers or better mental health/behavioral health training for primary care providers.

The lack of mental health providers and systems causes much of the mental health needs of the community to fall on primary care providers and basic medical health systems.
- Geller (1999) found in a focus group of primary care providers that they felt that 10 percent of their patients were primarily mental health and that their patients expected them to "fix" all problems.
- Mulder et al. (2000) found that psychological complaints accounted for more than 40 percent of all patient visits to rural family practitioners.
- Another study focusing on major depression found that rural primary care practitioners diagnosed only 24 percent of cases; their urban counterparts diagnosed 50 percent (Rost et al. 1995).

- Cellucci et al. (2003) states that 20 to 50 percent of primary care providers visits are behavioral health related
- Ferguson et al. (2003) found that physicians underestimate the prevalence of alcohol use.

Studies have shown that brief interventions or physician advice can be very significant to a person's decision to seek behavioral health treatment or decrease in chemical and substance use. Lack of community resources and distance to treatment centers were seen as major barriers by rural physicians.

Hartley et al. (1998) found that symptoms of rural patients with depression are more reduced by increased primary care practitioner mental health training than by better or increased access to mental health providers.

Baldwin and Rowley (1990) found that those practicing family medicine, as graduates, "often express concerns about their lack of expertise in some of the expanding areas of knowledge and skill demanded by modern medical practice" and that "many young family practitioners who might be drawn to solo practice in rural communities are finding that the basic, three-year residency training program frequently does not include enough training and experience to ensure competence in multiple fields of modern medicine." This can cause them to move to a larger area or to specialize. Those who do stay in small or rural practices may find that the professional isolation can be detrimental (Avery, 1990).

Baldwin and Rowley (1990) also found that community expectations are often high in the rural population. They expect the same services and prices as the generation before. This limited view of modern health care is a problem; therefore "any attempt to improve rural health services must include a major element of community development and education, not only to support, but to understand the necessary changes." (Baldwin and Rowley 1990) The study also found that "the health delivery system of a community is inextricably embedded in its historical, social, political, and economical context, and ignoring or overlooking this context is sure to delay, if not seriously impair, efforts at improving or establishing appropriate health services." The authors concluded that the courtship between physician and community might take a while due to constant turnover that leads to disappointment and distrust (Baldwin and Rowley 1990). Rural communities can also be at a disadvantage because a single provider can determine the cost and quality of care while rural providers are at a disadvantage because there are few economies of scale (Bull et al. 2001).

A study conducted by Geller in 1999 found that rural primary care providers have "issues" with psychiatrists, including lack of information primary care practitioners receive from psychiatrists, difficulty in getting patients an appointment, and attitude—which led many primary care practitioners to refer patients to social workers and counselors instead of psychiatrists.

Rural hospitals serve not only as a source for health care but are major employers, supporters of local businesses, and magnets for social agencies and other medical services (Goldsteen et al. 1994, Hicks et al. 2001). Goldsteen et al. suggest that rural hospitals might offer mental health services as a strategy for reducing the emigration of patients (1994). In California, more than 69 percent of its small and rural hospitals are losing money on patient care operations due to low utilization and lack of economies of scale (Avery, 1999). Areas of concern and difficulty for rural hospitals are administrative issues, quality of care, staffing requirements and regulatory issues (Avery, 1999).

Mental Health Providers in Rural Areas

It can take time for a mental health provider to build a practice because prospective clients are concerned about privacy and anonymity (Johnsen et al. 1997). Also, the tendency of the rural culture to resist receiving care from "outsiders" (Mulder et al. 2000) can delay or prevent the build up of a practice. Once the practice does become productive, rural mental health providers, like most rural members, have many roles. Providers work with and within the judicial system, social services, foster care and school districts. These many and demanding roles can be isolating and lonely at times (Dittman 2003). The burden of these many roles and the lack of supervision and consultation can lead to ignorance of best practices and referral resources (Dittman 2003). Mental health providers also can become frustrated with the limited continuum of care (Johnsen et al. 1997) available to their patients outside of their own practice. Goldsteen et al. (1994) points out that mental health requires little technology hence there is no correlation between quality and quantity.

Telemedicine

Telemedicine is defined by Hicks et al. (2001) as "the use of electronic information and communication technologies to provide support and health care where distance separates the participants." Telepsychiatry is one of the most recent applications. It is used for educational, administrative, research and clinical purposes. Telepsychiatry is seen as a partial solution to serving underserved and isolated communities (Brown, 1998 and Ermer, 1999) as it can be used for diagnostic evaluations, medication management, consultation and psychotherapy (Brown, 1998).

Ermer (1999) found that the quality of clinical interaction in child telepsychiatry is comparable to that in face-to-face, while allowing the children to remain in their communities with the support of family and friends. The Office of Rural Health Policy originally funded the RodeoNet telepsychiatry program in 1991. The program, now self-sustaining, enhances communication between providers and ensures better distribution of specialty care providers (Brown 1998). The study found that the program costs were 50 percent less when compared to face-to-face consultations and using telepsychiatry for commitment hearings is five times less expensive than the traditional method. The authors concluded that the feasibility of telepsychiatry could only occur when shared with telemedicine. Brown noted that when looking toward the future, managed care may be more motivated to reimburse for telepsychiatry as a cost-effective way to provide a service that is not very intervening (Brown 1998).

Telepsychiatry can enhance the ability of clinics, hospitals and emergency rooms to provide mental health services, both therapeutic and crisis intervention (Brown 1998 and Hicks et al. 2001). Indirect benefits to the community and provider include reduced traveling costs to distant facilities, reduced absenteeism at work, increased financial health of provider, and increased resources for the community (Hicks et al. 2002).

The limitations of telepsychiatry can include consent, licensing and crossing state borders, cost of capital equipment, maintenance, transmission and operations (Hicks et al. 2001 and Brown, 1998).

Recommendations/Models/Best Practices

Anderson and Estle recommend the development and implementation of rural health networks linking mental health providers and facilities in rural areas to primary care, public health, substance abuse, child welfare, juvenile justice and education (2001). They also recommended creating a common language among

stakeholders and community services, and continuity of care as a prevention method for re-hospitalization (Anderson and Estle, 2001).

Benson (2003) states that in Alaska "examples of promising bottom-up efforts include partnerships between mental health professionals and primary care physicians, linking of specialists to rural communities through telehealth, and the training of the village health aides in Alaska native communities." The researcher also feels that changes in prescriptive authority could have an immediate and dramatic effect on the availability of care. (Benson, 2003)

Bull et al. (2001) found that "one of the most effective approaches used by community mental health centers to build a foundation for serving the elderly people in the catchment was through collaboration with an AAA," (Area Agencies on Aging) and that the most successful programs are "homegrown." Hence we should support development at the lowest level to ensure that the heterogeneity of communities is recognized by all for purposes of local adaptation (Bull et al. 2001). The researchers stressed that the top priority of policymakers and rural communities should be to keep local hospitals open to stabilize infrastructure of local health care (Bull et al. 2001).

The authors listed five factors to resolve problems with and/or improve mental health delivery to the rural elderly (Bull et al. 2001):
- Adequate funding to establish and support innovative programs
- Moving beyond the stigma of mental illness
- Access to better mental health consultation when dealing with abuse and neglect for adult protective services
- Giving priority to the continuous effort to build outreach programs for the isolated elderly
- All facets of health must better integrate with mental health and psychiatric services.

The authors also listed five goals of cultural competence (Bull et al. 2001):
- Identify social, economic, political and religious influences affecting rural communities
- Understand the importance of ethnic and cultural influences in rural communities and the importance of the oral traditions
- Understand the impact of the interaction between social institutions and ethnicity on the delivery of mental health services
- Recognize the impact of providers' own culture, sensitivity and awareness as it affects their ability to deliver mental health care
- Understand alternative treatment sources in the ethnic minority culture.

The Alaska Family Practice Residency was founded in 1997 as a training program for family physicians headed for rural and remote practice sites. The program includes transcultural medicine through discussions and experiences with cross-cultural communication, complementary alternative and indigenous medical practices, exposure to traditional healers, the role of environmental, economical and social factors in health care, professional isolation issues, and wilderness medicine and survival. The residents have become adept at managing patient care from point of emergency stabilization and medical evacuation. The program instills competency in managing care at multiple levels and cultural sensitivity in its residents (Doty and Pastorino, 2000).

Goldsteen believes that an assessment of "the availability of inpatient and outpatient services in relation to mental health needs of rural residents" needs to happen. This will allow for the better creation and implementation of policies. The author also states that once a decision to provide mental health care is made a marketing campaign should occur to attract profitable patients. This is necessary to the financial success of the program—balancing uncompensated care with compensated care to increase the economies of scale (Goldsteen et al. 1994).

The National Rural Health Association published a paper in 1999 that specifically focused on rural mental health. The paper concluded with five recommendations:
- Provide simultaneous treatment for those with co-occurring disorders
- Provide federal funds for states to develop and maintain current data on the distribution of mental health professionals
- Provide federal monies for interdisciplinary training for rural mental health providers with primary care practitioners
- Integrate the de facto mental health system, primary care providers and mental health providers
- Create and support cultural competent programs.

Roland (2003) and Wagenfeld (2000) list four types of collaborations that can be used singly or in combination:
- Diversification: hiring a mental health professional to provide services at the primary care doctor's office
- Linkage: an arrangement with an independent practitioner to provide mental health services at the primary care site
- Referral: mental health services provided by mental health professionals at their practice site
- Enhancement: primary care physicians receive training to recognize, diagnose and treat mental health problems independently.

Sears et al. (2003) states that collaborations could occur among education, health and religious systems. The authors also suggest starting the collaboratives with an established agency for success.

Rost (1999) suggest that interventions need to be developed and tested to improve primary care providers' detection of depression and mental health disorders. Two interventions suggested are to install computerized screening systems to identify patients at risk and to train nursing staff to provide education and intensive follow-up.

The 1999 Surgeon General Report urges improvements to mental health in the United States, not specifically the rural United States. The report discusses seven steps need to be taken:
1. Continue to build the science base
2. Overcome stigma
3. Improve public awareness of effective treatment
4. Ensure the supply of mental health services and providers
5. Ensure delivery of state-of-the-art treatments
6. Tailor treatment to age, gender, race and culture
7. Facilitate entry into treatment.

Slama (2004), focusing on rural areas, states that it is necessary to tailor direct client services through gentle transition into and out of therapy, offering coffee or treats, and addressing how to handle meetings in public. She also feels that it is necessary to encourage and fund educational institutes with rural aspect or rotation, rural mental health research, telemedicine/telehealth, and loan forgiveness programs for those practicing in the rural areas.

Wagenfeld (2000) outlined strategies for developing mental health in Alaska, which can be applied to rural areas:
- Developing primary care networks
- Training primary health personnel in the detection and treatment of mental disorders
- Using population-based approaches aimed at high-risk groups
- Developing special programs to meet local needs and using indigenous personnel
- Decentralizing training that emphasizes local needs.

Wagenfeld also addressed the needs of the rural population in 2003 when stating the importance of understanding the difference in rural and urban values, the perception of rurality and rusticity, and the resiliency that is a result of the farm crisis.

Campbell et al. (2003) argue that the behavioral health needs of the rural population will be harder to meet due to poverty. To address both poverty and behavioral health needs the authors suggest the following recommendations:
- Use and develop educational resources
- Use vocational counseling as a way to increase people's employment/workforce options
- Develop community-based mental health resources
- Tailor prevention and intervention services and activities to individual communities.

Cellucci et al. (2003) suggests two screening methods for behavioral health: Alcohol and Use Disorder Identification Test (AUDIT) and Short Michigan Alcohol Screening Test (SMAST). The authors suggest the Community Reinforcement and Family Training (CRAFT) model for treatment. The authors also recommended the following steps be taken so the behavioral health needs of the rural communities are met:
1. Ensure competent detection and treatment by primary care provider/general practitioner
2. Adopt a public health model
3. Develop a coordinated plan that integrates the services of private services with an adequately funded public system
4. Identify and sustain funding sources
5. Expand the science based knowledge of behavioral health in rural areas
6. Develop effective and efficient treatment programs in rural areas.

Mulder et al. (2003) discuss the needs for a successful community level intervention. Needs assessments, of which there are many types, must fit the community and project needs including financial, temporal and informational. The authors also discuss the need to mobilize community residents/resources and address the issues of motivation and conflict management. Other recommendations from the article include:
- Utilize the assistance of community leaders
- Base interventions on accurate needs and resources
- Use culturally adapted methods
- Ascertain the costs and ensure the cost-to-benefits ratio is acceptable.

Health planning is another model to address the mental and behavioral health needs. Hill et al. (2003) discuss the guiding principles of health planning: 1) community responsiveness 2) cultural competence 3) interdisciplinary efforts and 4) life cycle sensitivity. The authors focus on the importance of securing funding through grant writing. The article concludes with suggestions for mental and behavioral health through health planning:

- Show how quality health care benefits the community as a whole
- Build local leadership to monitor funding opportunities
- Support interagency information sharing
- Improve the system
- Benchmark the project.

Gale and Deprez (2003) discuss how the focus of mental and behavioral health is sometimes put on treatment and diagnosis at the expense of health promotion and disease prevention. This can happen especially in rural areas where resources are limited. Hence the authors recommend using a public health approach. Elements of the public health approach are:

- Diagnosis, treatment, and etiology of disease
- Epidemiological surveillance of the health of the population at large
- Health promotion
- Disease prevention
- Access to services
- Evaluation of services
- Core of the concern is at risk populations.

These elements can be community based and applied at the local level:

- Use community-level prevalence and incidence data
- Develop an understanding of the community's service and workforce needs
- Link primary care and mental health providers with the de facto mental health system.

King et al. (2004) evaluated a training course for emergency department staff that focused on mental and behavioral health emergency visits. The study found that self-ratings of skills and knowledge significantly improved after the course. The authors did acknowledge that the study did not measure actual care. This type of training could be developed by the state and implemented at local hospitals.

Wainer and Chesters (2000) state that rural mental health can be improved by improving education and employment opportunities, increasing the acceptance of diversity and increasing the confidence and control felt by rural people. They also write of the difficulty getting mental health onto the agendas of those working with rural people and places but stress the importance of a health-promoting environment.

The World Health Organization released "Planning and Budgeting to Deliver Services for Mental Health" in 2003. The comprehensive guide lists four detailed steps and could be used by either a community or higher-level agency. The steps are 1) Situation Analysis 2) Needs Assessment 3) Target-setting and 4) Implementation. These steps can be used to develop policies and comprehensive strategies for improving the mental health of populations, use existing resources to achieve the greatest possible benefits, provide effective services to those in need, and assist the reintegration of person with mental disorders into all aspects of community life, thus improving their overall quality of life.

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Appendix D: Literature Review, cont.

SNAPSHOT OF FACTS AND FIGURES ON MENTAL HEALTH
AND PRIMARY CARE COLLABORATION

Facts and figures reproduced here are from review chapters or articles in Maruish, Ed. (2000), Cummings, Cummings, and Johnson, Eds. Sp (1997), Blount, Ed. (1998), Patterson et al. (2002), Klinkman and Oakes (1998), Miranda et al. Eds. (1994); Simon and VonKorff, (1997) and other cited or referenced articles or chapters.

Most mental health care in the United States is done in primary care

- Primary care is where most patients with mental disorders have contact with care, hence has sometimes been called the "de facto mental health care delivery system" for most Americans today, despite the presence of important specialty mental health clinics and clinicians. (Regier et al. 1978, 1993; Shapiro et al.1984; Narrow et al.1993; Burns, in Miranda et al.1994, deGruy, 1997, Surgeon General's report, (1999, 2000).

- Of patients who actively seek care for mental disorders, 50 percent of the care is provided by primary care physicians (Regier et al. 1978, 1993).

- However, only 50 percent of patients with mental disorders actively seek care for their disorders (Regier et al.1993).

- Yet, approximately 70 to 80 percent of patients will make at least one primary care visit annually (Strosahl, in Cummings et al.1997). Primary care will manage, directly or indirectly, 80 percent of patients with mental disorders. Other patients with emotional distress but without a formal mental health diagnosis will also present in primary care.

- 67 percent of psychopharmacologic drugs are prescribed by primary care physicians. Primary care physicians prescribe more psychotropic medications than psychiatrists in all categories (Pincus et al. 1998).

- Depressive disorders, especially in the elderly, may present more often with somatic symptoms than cognitive symptoms (Caine et al.1994; Blazer, 1993). There is frequent co-morbidity with chronic medical illnesses such as strokes, cardiovascular disease, Parkinson's disease, rheumatoid arthritis and diabetes (Blazer, 1993).

- The prevalence of depression with such medical conditions varies from 10 to 50 percent depending on the study (Robinson et al.1984). Differentiating the symptoms of depression versus the symptoms of the medical illness can be a significant challenge.

Primary care is where people take stress-linked physical symptoms as well as medical illnesses

- People usually bring symptoms to their primary care provider without regard to medical or psychological origins. Primary care is the most common pathway for presentations of medical illness, psychiatric disorders and emotional distress and has been called "the somatic symptom superhighway." (Sobel, 1997)

- Approximately 70 percent of office visits to primary care physicians are primarily for psychosocial concerns and do not lead to a diagnosable medical illness (Strosahl, in Cummings et al. Eds.).

- Patients present with a wide range of psychosocial distresses, which are not all diagnosable mental disorders (e.g., "stress," marital discord, job dissatisfaction, financial duress, working two jobs, crime in the neighborhood, family problems, lack of social support). Such life stresses can alter physiology and can lead to significant pathology (Dunman et al.1997) or lead to depression and anxiety or alter the course of major mood disorders (Goodwin & Jamison, 1990).

- Emotional distress beneath the threshold for formal mental health diagnosis is associated with significant disability and high utilization of medical services (Strosahl, 1997; Von Korff et al.1992).

- Patients with emotional distress and mental disorders often present their symptoms as medical symptoms (Hellman et al.1990; Sobel, 1995; Kroenke and Mangelsdorff, 1989).

- Primary care patients may not recognize mental health factors in their medical complaints, nor recognize that their somatic symptoms represent emotional distress and/or depression and anxiety (Barsky, 1995).

- Many primary care patients with psychiatric illnesses or psychological distress do not accept a mental health diagnosis and are managed and treated for their behavioral health disorder by their doctor (Hellman et al. 1990; Kashner et al. 1995).

- When the physician recognizes psychiatric disorders or emotional distress, it may take significant relationship-building over time before a patient is ready to accept psychosocial factors as part of the cause or treatment plan.

Long-term collaborative relationships can be valuable to patients and providers.

- Treatment approaches that build long-term relationships between primary care physicians and behavioral health clinicians likely bring better satisfaction and outcomes than approaches based on referral, stand-alone treatments, or treatments imported from specialty mental health settings (Kates, et al. 2000, Hemmings, 2000)

- The value to providers and patients of a well-developed long-term relationship between a physician and a behavioral health clinician is described in Lucas and Peek (1997) and at Group Health Cooperative of Puget Sound. Over the past decade, Katon, Simon, VonKorff, and their colleagues, have demonstrated the impact that such collaborative/integrative models can have in managing depression in primary care (Katon et al. 1996). Other researchers have found similar positive outcomes with collaborative/structured interventions in primary care (Schulberg et al.1996; Mynors-Wallis et al.1995).

- Experience with medical/behavioral health collaboration and integration of care within medical clinics can lead to creation of flexible and long-term working relationships that are well received by medical colleagues and patients (Fischer et al. 1997).

Behavioral health collaboration may help make good use of primary care resources

- Primary care patients with anxiety and depressive disorders incur more medical costs, even when controlling for medical co-morbidity. Psychologically distressed patients use more health services than non-distressed patients (Von Korff et al. 1992, Simon et al. 1995).

- Better outcomes have been shown for depression treated collaboratively with behavioral health than by primary care providers alone (Katon et al. 1995, 1999).

- Studies have attempted to understand what components of care account for clinical outcomes and costs (Simon and VonKorff, 1997; Katon, 1996; Unutzer et al.1997). A Hawaii Medicaid project demonstrated that focused treatment rather than traditional psychotherapy can effectively manage patients referred from primary care, resulting in significant cost-offset (Cummings in Cummings, Cummings, and Johnson, 1997).

- Financial incentives for integration of mental health and primary care can reduce unnecessary costs and improve care (Goldberg, 1999)

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Appendix E:
Promising Practices

This appendix is an expansion of points made in summary form in the main body of the report. It reflects lessons learned from the many book and article reviews done by work group members and Minnesota Department of Health staff, along with notes from work group discussions on promising practices.

A promising practice is defined here as a useful way of doing things or thinking about things that has appeared and re-appeared as a theme in the literature reviews and discussions among work group members.

Promising practices as described here are to be tailored for application to specific communities and situations. They are not recipes or cookie cutters, nor does the work group claim that these are empirically-confirmed "best practices," even though they appear in many different forms throughout the literature.

These are best thought of as well-known and often-described and tested implementation concepts for integrating mental health and primary care.

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References

1. Discover and orient to community needs

Promising practice: *Do community-based assessment to discover and agree on what pressing needs are actually in the forefront.*

Rally the different stakeholders in the community around a particular starting place or focus for improving rural mental health through better integration with primary care or other healthcare resources.

Examples of top areas of felt need: domestic violence, suicide prevention, crisis intervention or the care of particular populations such as children, elderly, chronic illness, major mental illness.

Discover what key stakeholders in the community believe are the most meaningful focal points for a project to better integrate medical and mental health care. Find out which community pressure points will truly mobilize energy and enthusiasm to meet felt needs.

Different assessment approaches may work better for different communities, depending on what information and consensus already exists, what else needs to be discovered and how that community comes to an opinion on any pressing issue. The lesson is to create programs on the basis of what starting point key stakeholders agree would play a clearly recognized and meaningful role in the community.

Lessons learned from literature and work group discussion: Many articles emphasized the importance of understanding the community and its needs prior to developing specific programs, particularly for rural areas. What does a community already have? What does the community actually need and want, given its priorities? What does collaboration between mental health and primary care need to address in this community? How can this be tailored to cultural realities of the community? The idea is to actually *find out* rather than *assume* that what you are interested in or would like to provide is actually a high priority in the community you are part of. Examples:

- A rural physician in Texas identified his own need to have a mental health practitioner in his practice. By doing a community assessment he discovered that family violence was an issue of great concern in the community. He was able to focus his mental health clinician on issues of greatest felt need in the community and to fund a position in this clinic through a domestic violence grant. The mental health practitioner worked part of the time in the schools and part of the time in the clinic. (Farley in Blount, 1998)

- In another article, communities identified needs for crisis response teams. In some communities crisis response teams were created to respond to community disasters, while in other communities they responded to acute mental health crises in the hospital emergency room. The specific purpose and design of the program or collaboration in each community was shaped by what was actually needed in those communities. (Disaster mental health, 1999)

- Another article dealt with felt needs to manage a very wide range of complex mental health and other chronic health problems in rural communities whose professionals were widely dispersed in different organizations and agencies. These professionals from different organizational homes had not been in the habit of working together and may or may not even have been aware of each others' existence even though they often shared many of the same patients. Inter-agency cooperation with the most complex patients of the community led to arrangements for cross-organizational teams meeting in primary care offices. These proved effective in managing complex mental health,

chemical dependency and other chronic health problems without each agency having to establish a full in-house team, something that would have been impractical. Primary care remained the focal point for rallying community professionals around a common set of difficult clinical situations. (Amundson. 2001)

- Many articles refer to population health goals such as systematic care of depression in a clinic population, just as medical clinicians often have population goals related to diabetes or cardiac care. Concepts and practices for assessing and treating entire panels or populations of patients in a practice were outlined, along with typical challenges of evolving the mindset, measures, and methods to looking at the health of groups of patients rather than only the individuals who happen to come in for care. (Robinson and Strosahl in Maruish, 2000)

2. Collaborate in the design of programs and the care of patients

Collaboration is key—a universal theme in this literature. Virtually all articles and chapters reviewed outline or touch on common elements needed to ensure successful collaboration, and work group discussions reinforced this theme. These theme had several important dimensions that are spelled out separately here, each with a promising practice.

A. Understand and appreciate each profession's practice.

Promising practice: Meet face-to-face with members of the other professions who may be involved in the project. Seek first to understand each other—to see the world of practice through the other person's eyes—and what each profession can bring to the total care of patients in the community.

If you are a mental health professional, get to know local primary care providers, see the demands of their daily practice and the kinds of clinical situations they face every day. Understand differences in professional cultures of mental health and primary care.

The same goes for primary care providers who are interested in building collaborative relationships with mental health professionals—and for social service professionals who may be pulled into the project with the primary care and mental health professionals.

Lessons learned: Many writings emphasize the importance of appreciating the differences in professional culture, daily work habits, roles in care, and the shifts that each profession needs to make in order to work together collaboratively. While this applies to medical and mental health professionals, the greater burden may often fall to mental health professionals because in actual practice, they are most often entering the primary care world. In rural settings, individual practitioners may have a wide range of duties and practice activities that respond to the particular demands of their community. Social service professionals may have a similar challenge in understanding and appreciating the working cultures of other professionals. Here are a few examples of getting to know each other's practice:

- Mental health and medical professionals need to understand the difference between the practice of mental health as a specialty and its practice as integrated into primary care—who I am and what I pay attention to (Patterson, et al. 2002). Or differences between specialty mental health and integrated mental health (Peek and Heinrich in Maruish, 2000). Or the influence of collaboration on the mental health professional's identity and practice (Seaburn et al.1996).

- A mental health therapist made hospital rounds with the primary physician in order to better understand his practice (Farley in Blount, 1998).

- A failed integration attempt resulted when the mental health professionals were unable to adjust to a primary medical clinic setting and were reluctant to be flexible in their own practice styles (Cummings in Cummings, Cummings, and Johnson, 1997).

B. Bring all the right people to the table when designing successful collaborations.

> **Promising practice:** *Establish a "design team" or "implementation team" made up of a cross section of people who will need to make your collaborative program a reality.*
>
> This will probably need to include medical and mental health clinicians, nurses and clinic managers and those with office practice, operational, and financial responsibilities.

Develop a shared view of what you are going to do and how you are going to go about it.

The project has to be designed to work not only for the care of patients, but for the running of the office and the maintenance of financial systems and viability. This will play out somewhat differently in every setting. People who may or may not normally work together need to be brought together in a shared view of how the project will be implemented for success in all these ways.

Lessons learned: Creating collaborative approaches to care is not simply a clinical or systems task that can be imported to a particular setting directly and instantly from the literature. It is also a task of building human community among people who may not know or understand each other well at the outset. Success is much less likely if a finished product is simply delivered to people who were not part of the thought process and journey that led to a particular approach or design in a particular place. Various authors emphasize dialog between the various parties and stakeholders for "co-creation" of the project as best knowledge and practices are brought to bear. This is underlined by the phrase, "You can't achieve a collaborative end with a non-collaborative means."

- A small town, rural primary care practice established an "implementation team" comprised of at least one person from each staff area, e.g., reception, nurse or medical assistant, physician, mental health professional, pharmacist, information system specialist, and a patient advocate or community services liaison. These representatives not only helped design and implement the new integrated system but shared responsibility for educating their colleagues and linking these various parts of the clinic. (Ofstead, Gobran, & Lum in Maruish, 2000)

- Primary care clinics creating improved collaboration with mental health professionals involved physician and administrative leaders, nursing staff, behavioral health staff, and any other formal or informal opinion leaders and "champions" in the clinic in the early stages of planning the project. A representative group from all areas of the clinic later became an "implementation team" to guide implementation and make course corrections along the way. (Peek & Heinrich in Blount, 1998)

C. Appeal to what matters to participants when creating collaborative efforts.

Promising practice: With the implementation team, systematically determine "what most matters to whom" regarding the focus or starting point for doing improved mental health care (or medical care) through collaboration.

Facilitate a meeting(s) or other method that generates "what matters most" or "what's in it for me" within the general purpose of the project—and use that to guide practical steps for the effort.

Make sure all parties understand how the project meets the needs or addresses what is important to the other participants.

Lessons learned: Once people begin to assemble as a design or implementation team, find out what matters most to those participants. Everyone should see what matters most to all the participants or "what's in it for me" for everyone.

Projects that sound good in theory but make life more difficult or create little value for individuals will be hard to start and even more difficult to sustain. Many articles or chapters emphasized the importance of understanding the priorities of local primary care and mental health practices prior to developing specific programs or collaborations. What are the felt needs and trouble spots from the perspective of patients, clinicians and managers of those practices? What are the high priority target goals for collaboration? Examples:

- A mental health professional co-located in a family clinic has easier access to medical intervention for the patient. A primary physician has more resources for the "thick chart" patient. A patient can avoid some of the stigma around mental health care by seeing a therapist partner in the family clinic rather than "going to mental health" in an unfamiliar environment. (Seaburn, et al. 1996)

- A large urban multispecialty medical group identified fragmented care for patients with "mood related physical distress (somatizers)" as a priority for improving clinical care and the lives of primary care clinicians. After agreeing on the goal of helping distressed patients cope with physical symptoms, mental health clinicians began working alongside physicians on site in primary care clinics. They collaboratively assessed and cared for distressed high-utilizing patients and taught a proven patient education course on understanding stress in physical symptoms and what a person can do to manage these symptoms. (Slay and McLeod in Cummings, Cummings, and Johnson, 1997)

- Rural primary care clinics felt a need to "co-provide" care with mental health professionals for patients with significant mental health problems. In one arrangement, the mental health professional set up practice in the same building as the physicians. They developed ways to share information and coordinate care so that medical and mental health portions of care were reinforced by both physicians and therapist. Problems in coordination or caregiving relationships were promptly addressed. In another arrangement a therapist joined a primary care practice, working closely with physicians and nursing staff to maintain communication about patients and for consultation about mental health aspects of hospitalized medical patients. In both cases, the specific arrangements reflected the felt needs of the clinicians and clinics involved. (Seaburn et al.1996, pp.167-172)

- A large primary care system observed that different clinics had different felt needs and target results for improving medical and mental health collaboration. Examples included help for patients with physical symptoms without clear diseases; better use of physician time and improved appointment availability; in-house alternatives to mental health referrals; more successful mental health referrals to clinicians that primary care clinicians actually know; quick access to mental health emergency and

crisis help; help with psychosocially complex and chronic cases; or "curb-side consultation" to help physicians treat mental health conditions in their own practices. The authors developed a "hip pocket consulting process" with questions to help the clinic decide what already matters and design their program to meet those goals. (Peek and Heinrich in Blount, 1998)

- A family physician recounts how he brought a mental health professional to his suburban clinic to address some of the most vexing aspects of his practice, and how this evolved into a dependable partnership that enriched both their professional lives and improved the care of their most challenging patients. (Lucas and Peek in Cummings, Cummings, and Johnson, 1997)

- A program of "shared care" between mental health and primary care providers revealed what important improvements in daily practice life accrued to all parties (Kates, et al. 2001). A qualitative study of an integrated mental health program in a large care system revealed specific benefits to physicians, patients and mental health providers that helped sustain the program and position it for expansion (Fischer, et al. 1997).

- People can be motivated to change based on recognizing common dissatisfactions with separate and parallel systems of medical and mental health care delivery from patient, clinician, care system and employer perspectives (Peek and Heinrich in Maruish, 2000).

D. Build collaborative relationships along multiple dimensions.

Promising practice: *In the design or implementation team, agree on a starting point for each of several dimensions of collaboration:*
- Relationship
- Common purpose
- Paradigm
- Communication
- Location of service
- Business arrangement.

Seek working agreement on each of these dimensions of collaboration. This doesn't have to be highly detailed at the start, but without agreement on the general direction in all these areas, a specific collaborative project is more likely to experience difficulty arising from ambiguity or confusion in these areas.

Lessons learned: Collaboration is not only a spirit, attitude or value. It is also a systematic way of operating with other people along several dimensions that includes but goes beyond the end goal of clinical care of patients. For collaboration to be implemented and to be sustainable over time, all dimensions need to be addressed early on. The points below are adapted from Seaburn, et al. 1996, chapter 3, and Gunn et al. in Cummings, Cummings, and Johnson, 1997.

- **Relationship.** A working relationship among people, especially from diverse professional backgrounds, usually takes time and gradually unfolds through a process of getting to know each other and building trust—mostly through discussing actual clinical cases. Over time, trust may deepen and discussion turn toward what is happening with the clinicians themselves—and provide clues to what is happening with the patient, family and caregiving relationships. Respect for each other and valuing differences in professional perspective and expertise make the collaboration "add up" to more than anyone could provide alone.

- **Common purpose.** Unite around the common goal of effectively treating each patient's concerns and promoting health among all members of the community. This is what binds the collaborators

together in a "shared vision" that gives coherence to the different activities of the individuals collaborating with one another. Short-term goals and "what's in it for me" can be different as long as they are not mutually exclusive and can be blended into a general purpose.

- **Paradigm.** Different kinds of professionals, as well as the patients themselves, have different paradigms or "maps" for health care and their particular roles in it. These don't have to be the same as long as they are not mutually exclusive. In fact, different paradigms can help look at a clinical problem from more than one perspective and discover a fruitful approach. The main task is to understand the different lenses that the collaborators look through and respect that these multiple perspectives are what makes a collaboration effective, if kept from devolving into "us versus them," and instead, combine into particular approaches suited to each difficult clinical situation.
- **Communication.** Clear communication is essential for collaboration, especially early on—prior to a time when people become so attuned to each other that much less needs to be said explicitly. At first, this communication can seem deliberate, stiff or take too much time. This is natural at the beginning and becomes more natural and quicker as people get to know each other and what needs to be communicated. Over time, collaborating teams and individuals become more fluid with frequency and duration of communication, methods of communication, content and language for communication, and confidentiality of communication.
- **Location of service.** Ease of collaboration is related to the proximity of the providers. Collaboration is usually more difficult for clinicians who do not share a location. For those who share space, charts, a reception staff and parking lot, and see patients together when needed, collaboration becomes a natural part of professional life, not a special effort. A shared location does not guarantee close collaboration. It is possible to function in "separate," "together but separate" or "together" modes. Different levels of collaboration may be suited to different settings and goals (Seaburn, et al. 1996).
- **Business arrangement.** A collaborative relationship recognizes a financial relationship as well as a clinical relationship. It is not critical what the business relationship is, but that it be explicit and mutually satisfactory. It can range from "employer/employee" to "parallel businesses" to "colleague" where everyone is employed by the same company. While a financial model is essential, "lead with the clinical foot"—work out a shared clinical vision so that financial issues become "technical challenges" rather than "showstoppers" (Peek and Heinrich in Blount, 1998).

E. Choose the most appropriate level of clinical, operational and business collaboration for your particular goals and setting.

Promising practice A: *Create an explicit expectation for level of clinical collaboration between primary care and mental health professionals that is suited to the clinical purpose of the project*	**Lessons learned:** Several articles and chapters point out that different levels or "closeness" of collaboration suit different goals, settings and aspirations. No single level of collaboration is automatically best for all purposes. Different programs

can choose different levels of collaboration that best fit their purposes.

- Five levels of collaboration and features of goals, geographic and system design are outlined by Doherty, McDaniel and Baird (1996) and Doherty (1995). These include:
  - Level I: Minimal collaboration
  - Level II: Collaboration at a distance

Level III: Basic collaboration on site
Level IV: Close collaboration in a partially integrated system
Level V: Close collaboration in a fully integrated system.

Collaborators should select the level of collaboration they are aiming for to avoid misunderstandings and to set operational methods appropriate to that level of collaboration. Teams may or may not aspire to higher levels of collaboration over time, depending on their clinical, professional and organizational goals.

- A "spectrum of collaboration" (Seaburn, et al.1996) shows that various forms of collaboration are possible no matter what the circumstances. The primary bands on this spectrum are:
  Parallel delivery: Division of labor is clear and does not flow into each other significantly

  Informal consultation: The mental health professional helps the physician deal with a clinical problem, but usually with no direct contact with the patient

  Formal consultation: The mental health professional has direct contact with the patient in a typical contractual relationship as a consulting specialist

  Co-provision of care: Responsibility for patient care is shared and the professionals may see the patient or family together

  Collaborative networking: The provider team is extended to include family and other medical specialists or educators and community resources.

  In this model, collaboration at any point on the spectrum may involve varying degrees of depth just as each color band has a range of hues, richness or intensity.

- Primary health services exist on a "levels of care" continuum that corresponds to the complexity of the problem and the proportion of the patient population that has problems of that complexity (Strosahl in Cummings, Cummings, and Johnson, 1997; Strosahl in Blount, 1998). Patients with more complicated problems tend to receive care that is more integrated "vertically," according to disease-specific protocols and teamwork, whereas care for less complicated problems is integrated on a "horizontal," generalist or "see-all-comers" basis. These modes of integration are suited to different patient needs and are selected ahead of time depending on the clinical problems and severity being addressed.

Promising practice B: *Create an organizational or project design that achieves the level of clinical collaboration between primary care and mental health professionals that is suited to the purpose of the project.*

Lessons learned: Choose the manner of organizational or practice integration or coordination suited to the clinical goals and situation. Make that explicit rather than letting it remain unspecified. No single level of practice integration is the only one that will work. Choice depends on the clinical goals, particular situation, aspirations of the providers, and community goals for collaboration. In the design or implementation group, look at the starting points along dimensions of relationship, communication, location of service and business arrangement. Establish the kind of practice coordination or integration that will best serve those goals in a practical way. Here are several alternative levels or kinds of practice integration:

- **Integration.** Mental health services and professionals are integrated into the primary care clinic where the mental health professional is perceived as part of the clinic team and clinic community. The mental health professional works out of the same hallways and exam rooms as physicians and other primary care providers. Mental health screening, assessment and treatment becomes part of the continuum of care delivered by the clinic. This works especially well for intertwined medical and mental health conditions that do not lend themselves well to referral or separate medical and mental health portions of care. It may work less well for patients who prefer to have their mental health concerns addressed outside their medical setting.

- **Co-location.** The mental health professional is located in the primary care clinic, is quickly accessible, but is seen more as an on-site specialist than a member of the standard primary care medical team. Space and clerical support may be in a separate area of the clinic and may be identified as "mental health." The mental health professional is in routine relationship and communication with primary care providers, with protocols of information-sharing between the mental health and general medical practices very clear to patients. This works very well for "co-provision" of care where coordination and communication is very important but the medical and mental health providers can proceed with their own portions of the care and when patients recognize this difference.

- **Liaison**. A liaison figure such as a nurse works with a primary care clinic and mental health clinic to identify patients in need of care, especially coordinated care, and assists with referral, arrangments and follow-up.

- **Consultation.** A psychiatrist or other mental health professional provides consultation services, often related to diagnosis and treatment of mental health conditions, pharmacological interventions or behavioral/psychosocial aspects to chronic illness care or rehabilitation.

- **Community-based.** The community and its resources becomes the center or organizing level for the care, for example crisis teams in the community or emergency room, home-based care, shared services between community (school, public health, home care) and primary care clinic. Community collaboratives, case management and use of community members for outreach.

- **Telehealth**. Consultation or regular therapy visits through teleconferencing that permits experts from distant sources to consult on a case and collaborate with local providers.

F. Communicate with patients, each other and the community.

| **Promising practice:** *Spell out in advance the communication methods to be used for:*
 • *Clinician-patient communication*
 • *Clinician-clinician communication*
 • *Project-community communication* | Spell this out in the design or implementation team. Some of the detail may be filled in light of experience or may be changed, but an initial set of understandings in this area will help the program get off on the right foot. |

Lessons learned: Many authors emphasize the importance of communication on different levels for long-term success of collaborative models of mental health and primary care:

- **Clinician-patient communication**. Include the patient in the communications, including understandings about information sharing and confidentiality. In one model, communication

guidelines between primary care and therapist are discussed and agreed upon by the patient beforehand (Seaburn et al. 1996). In another, the primary care physician introduces the therapist to the patient and remains for part of the visit. In all cases the patient, physician and mental health professional reach an understanding of what kinds of information are communicated, why and how.

- **Primary care provider-mental health therapist communication**. Professionals need to communicate with each other. This can be a combination of oral or written communication. One therapist described providing immediate feedback to the referring provider following a patient visit. In this case, also stressed the importance of actively involving patient in treatment plan (Seaburn et al. 1996). Telemedicine and teleconferencing was discussed as a means of communication, assessment and patient intervention (Cornish, et al. 2003). Approaches to medical records range from having separate charts, to medical charts in which the primary care physician write notes regarding feedback from the mental health professional, to common charting where both providers write in the chart.

- **Community communication**. The stigma of mental illness is real in rural communities, along with a sense of individualism that says, "I can take care of my own problems." One community mental health outreach model talked of having a booth at a local health fair (Smith and Buckwalter, Mental Healthcare for Rural Seniors). The first year they titled it "Mental Health Screening" and four people stopped. The second year they titled it "Adjusting to the Later Years," and were overrun with business. Modes of communication should suit the community and show real linkage and collaboration between primary care systems and members of the community and its resources. A number of articles spoke to the importance of community education and communication regarding prevention and the concept of mental health, not only mental illness (Malcolm 2000).

3. Train medical and mental health professionals in collaborative practice

Promising practice: Outline a specific learning agenda needed to prepare mental health and primary care providers for the collaborative program being planned.

Training should squarely address the practical needs of providers planning to implement the chosen program. More general training may also be useful, but the implementation or design group should identify the core educational agenda and finds ways to meet those needs.

Lessons learned: Successful partnerships and collaborations require education and training that builds relationships along with practical ways of doing clinical work together within the demands of busy primary care and mental health practice. This is a very common theme in the articles and books.

- Because most professional training does not emphasize collaboration between medical and mental health professionals, skills in this area cannot be taken for granted. It is usually not successful to release medical or mental health clinicians into systems of collaborative practice without preparation. This training involves clinical models, population health, cultural differences, communication and other topics discussed so far in this review of the literature.

- Because integrated models so often involve mental health professionals entering the world of primary care practice, much training is focused on helping mental health professionals adjust and

operate helpfully with the new culture, language, common clinical presentations, and the influence of collaboration on the mental health practitioner's identity and practice. Patterson et al. (2002); Gunn, et al. (1997) in Cummings, Cummings, and Johnson; Seaburn, et al. (1996).

- Primary care providers often need training in assessment, diagnosis and intervention with mental health conditions, including when and how to seek consultation or make effective referrals to mental health specialists that are not perceived by the patient as "being sent away" (Cole et al. in Cummings, Cummings, and Johnson, 1997, Patterson et al. in Blount, 1998). Some of this training is taking place in residency programs.

- Geriatric skills are often needed in rural areas, applied by both primary care and mental health clinicians. The same is true of chemical dependency skills.

- Community education is often needed in specific targeted areas such as suicide, depression, children's mental health, chemical dependency and violence prevention. (Cameron and Mauksch, 2002)

- Culturally informed education for community and professionals is often needed, especially when new immigrant populations develop in rural areas.

4. Expect to move through developmental steps in creating mature collaborative programs

A. Determine whether your effort is more like a pilot, a major project, or a mainstream implementation

Promising practice: Determine with the design group whether the effort being planned is more like a limited experiment or pilot, a major project, or a mainstream implementation across the community. (Davis, 2001)
- A pilot has a few people testing some collaborative ideas, more or less outside usual operating procedures.
- A project is intended to have a significant and visible effect on a major part of the operation
- A mainstream implementation pulls all the basic systems and approaches together across the system or community.

This is important for setting realistic expectations at each point along the path. For example, a pilot project may have less stringent and less formal measures or sources of funding and isn't expected to meet mainstream demands.

As a project matures toward mainstream implementation, clinical, operational and financial expectations increase.

Lessons learned: Successful examples of integrated primary care and mental health practice often develop over time from small scale pilots or demonstrations between just a few clinicians to more widespread and systematic applications. It is important that pilot-level efforts are eventually spread to benefit more people in the community or population rather than remain a more or less isolated pocket of collaborative practice that doesn't reach a significant portion of the population—even if quite effective with the few it does reach. Several authors have discussed stages or developmental steps in creating full-scale applications of integrated practice.

- The creation of large scale integrated practices in an integrated medical group over several years was described as a coherent developmental sequence "from pilot to project to mainstream," with each

phase having different challenges, demands, relationships and champions needed, and different performance expectations in clinical, operational and financial areas. Realistic expectations at each stage are critical along with a process to move the effort from one stage to the next in order to effectively cover the needs of the entire target population rather than just a few patients (Davis, 2001). A brief account of similar developmental stages also appears in Peek and Heinrich (1998) and emphasizes balanced development of clinical, operational and financial methods.

- The development of a fully integrated full-scale practice in a small city and rural health clinic for an uninsured population is described by Cameron and Mauksch (2002) where interagency big dreams start with small successes and a systematic strategy to use small successes to create major change.

- The development of a mainstream program of medical/mental health integration is traced from small starts and early successes to systematic application of key initiatives in the patient, professional and business communities for mainstream application in a large regional clinic and hospital system (Simpson in Blount, 1998).

B. Create practical clinical, operational and financial methods, measures and expectations at each stage

> **Promising practice:** *Set realistic clinical, operational, and financial goals or expectations appropriate to the developmental stage of the effort—a pilot, a larger project, or a mainstream implementation.*

Over time, move the effort toward mainstream implementation in clear stages so that the clinical, operational and financial expectations can be explicitly increased as the maturing effort is able to deliver them.

Expectations that are mismatched to the actual stage of development of a collaborative program can set the effort back and create disappointment.

Lessons learned: Many authors discuss operational and financial issues but are usually much clearer on the clinical aspects. Financial matters are often presented in an abstract or conceptual manner. However, some principles or patterns emerge.

- The stage or sequence models and stories described in the previous section tend to emphasize the balanced development of clinical, operational and financial methods appropriate to each stage. But the financial methods employed tend to vary widely depending on local situations. These range from various fee-for-service arrangements to employee-employer relationships, grant funding, and to partnerships of various kinds. For example, rural interagency partnerships are described by Amundson (2001).

- The reviewed articles and chapters suggest that financing is challenging and depends on local situations and eagerness to collaborate financially as well as clinically. While there are many successful examples, there is no standard financial solution. At the same time, a four-sector model for financing integrated mental health and medical care appears in a U.S. government review of best practices in mental health finance (www.mentalhealth.org/publications/allpubs/SMA01-3481/figure2.asp). However, this conceptual model also requires local tailoring.

- Even though financial solutions appear to be a very local issue, authors mention general principles for creating a single picture that includes clinical, operational and financial elements that work together. This is described in various ways in different articles and several mention a conceptual model called "The three-world view: clinical, operational and financial" (Patterson, et al. 2002; Slay

and McLeod in Cummings, Cummings, and Johnson, 1997; Peek and Heinrich in Blount 1998). These outline the challenges and languages of the clinical world (what care is called for), the operational world (how to execute it well) and the financial world (how to tap resources well). This model is sometimes used to help facilitate dialog and planning in a way that gets people working together on a balanced slate of clinical, operational and financial methods rather than ignoring or conflicting with each other over them.

5. Test for improvements over usual practice based on standards for success: What to look for in applying promising practices, approaches, or models

> **Promising practice:** *Use standards or measures of success to test for improvement over usual practice—a set of criteria that help you judge whether your project is succeeding.*
> Use or adapt the following criteria or measurement areas:
>   A. Quality of completeness
>   B. Effect on population health outcomes
>   C. Linkage to sustainable improvement in overall system of healthcare.

Lessons learned: A basis is needed with which to identify effective implementations of promising practices.

For this purpose, the work group developed a set of simple criteria or list of what to look for while sorting through models, practices and actual examples of rural mental health in primary care. These are features associated with long-term success and improvement over usual care—evidence that "something is working:"

A: Quality or completeness in care process
To make an improvement over usual care, a model, approach or program needs some way of reliably doing the following things. The ability to routinely do these things is thought to be associated with an improvement over usual care:

1. Screening or other method to discover who needs further assessment
    - Is the screening method defined or not?
    - Is it recognizable as sufficient?

2. Level of care assessment or triage to discover what level of intervention of care is needed, and who will need to be involved.

3. Actual availability of the different levels of care that may be needed
    - Access that is timely
    - Availability of different elements of care and different disciplines that provide that care
    - Referral to, or consultation with, mental health professionals. Markers for improvement over usual care in this area include:
        - Primary care co-location with mental health professionals
        - Capacity for consultation and collaboration, not just referring the case
        - Access for referral to crisis management (like other urgent backups for primary care)
        - Access for ongoing care by mental health professionals
        - Availability of education for primary care providers and staff on triage/referral for mental health issues

- Collaboration and communication with schools and other support systems
- Consultative/collaborative services are sustainable: desired, sought and paid for
- A prevention level as well as a treatment level, including preventing co-morbidities.

4. Prescribed care was actually received
   - According to protocols
   - With reasonable patient adherence.

5. A person or the system "looked" to see if the patient actually improved
   - Presence of at least some routine outcomes or evaluation measures and person to notice
   - Especially helpful if there is some indication of improvement of this particular system improvement over usual care, e.g., with a comparison group of some kind.

6. If not improved, reassessment and course correction. Reexamine plan, team function, system support, patient and family understanding of roles in care

B: Effect on population health outcomes

When looking at the care process outlined above, ask what the model, approach, program or care process does for major populations and their important health outcomes, for example:

- Pediatrics: Attention-Deficit/Hyperactivity Disorder, depression, substance abuse
- Adults: Depression, anxiety, substance abuse
- Elderly: Dementia, depression, anxiety, substance abuse.

Many other population health measures exist,* e.g., from "Healthy People 2010" and the "Household Survey on Drug Abuse." The outcomes above were selected as particularly common and important in those populations.

C: Linkage to sustainable improvement in the overall system of health care

The clinical process or health outcomes may also be linked to large-scale system health care system outcomes and goals such as appropriate use of emergency rooms, hospitals and financial resources.

It is worth asking how particular models, approaches, practices or programs address such systemic issues in the larger health care system. Here are two categories of "big picture" improvement:

1. Program addresses larger system problems

- *Reduces social stigma for seeking mental health care*—where culture of "taking care of yourself" or "I don't want to talk about it" is still strong. How the approach helps people seek care, e.g., from their regular doctor in a medical context.

- *Gets around the workforce shortage*—not enough mental health professionals, difficulty recruiting rural physicians, providers not in the roles needed or adequately prepared for mental health care, or not in the collaborative configurations needed in rural areas.

- *Improves chronic illness care*. The health system is designed more for acute than chronic care. Mental health problems are often more like chronic than acute conditions, but the care system

typically does not do as well with chronic conditions of any kind and this affects rural mental health care.

- *Pulls together a fragmented health care system*—a "mind-body split" in clinical care, operational systems and covered benefits. Difficulty integrating the clinical, operational and financial picture for mental health and primary care.

- *Improves primary care provider skill and comfort* with identification, assessment and finding resources for common mental health conditions and patients in primary care practice.

2. Program is designed for long-run effectiveness in the community

- Sustainability: Has the ongoing supports and design for sustainability

- Replicate: Can be reproduced over and over again elsewhere

- Doable: Is simple enough to get off the ground

- Reach: Touches enough people to make a difference to the community

- Acceptability: Appeals to what matters to key people and stakeholder groups

- Capacity to generate new leaders when founders or champions go elsewhere

- Includes critical mass of key elements for success for any rural mental health/primary care population.

*Examples of other population health measures
From the National Household Survey on Drug Abuse
- Percent of population with Serious Mental Illness (SMI) (higher in rural areas)
- Percent of males and females with SMI who are employed
- Percent with SMI who are receiving treatment.

From Healthy People 2010
- Percent of adults and adolescents tobacco dependent
- Percent with alcohol dependence
- Rates of binge drinking
- Number or rate of Driving While Intoxicated (DWIs)
- Percent with other drug dependence
- Percent with drug dependence who receive treatment and follow-up
- Mental illness and chemical dependency treatment in correctional settings
- Percent with depression
- Percent with depression who receive treatment
- Percent with health insurance
- Social participation among adults with mental illness disabilities
- Identification and treatment of people with comorbid mental illness and Hepatitis C
- Rates of firearm related deaths
- Rates of suicides and attempts
- Child fatality reviews
- Rates of maltreatment of children
- Rates of assault by intimate partners

- Percent of people receiving depression treatment that is adequate.

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