

**Rural Integrative Care Planning in
Sullivan County, New Hampshire**

RURAL INTEGRATIVE BEST PRACTICES

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THE CASE FOR RURAL INTEGRATIVE CARE

Integrated primary care represents a structural realization of the biopsychosocial model that is emphasized so broadly in medicine and mental health care. The term Integrated Primary Care describes a clinical practice that integrates behavioral and medical health services within a primary healthcare setting. Blended into a single setting, integrated primary care more fully addresses the spectrum of problems that result in patients seeking help in primary care. Because a great proportion of patients in primary care present with either physical conditions that are influenced by stress, difficulties maintaining a healthy lifestyle, or purely behavioral/mental health issues, it is clinically effective and economically efficient to integrate mental health providers into primary care (Bauer, Batson, Hayden, & Counts, 2005; Callahan et al., 2005; Gerdes, Yuen, Wood, & Frey, 2001; Hartley, Turner, LeVine, Schank, & Leichter, 2006).

Rural areas, confronted with economic, geographic, and cultural (e.g., social stigma) barriers, face unique and significant challenges to providing adequate mental health care (Fox, Blank, Rovnyak, & Barnett, 2001; Hoyt, Conger, & Valde, 1997, Sawyer, Gale, & Lambert, 2006). For instance, more isolated rural areas were found to be significantly less likely to have a community health center (CHC) or a community mental health center (CMHC) (Merwin, Snyder, & Katz, 2006). In one review of rural communities, 6.5-9.4% of ER visits per week involved a mental health issue. However, in 42.9% of these communities, there was no mental health service provider locally available (Hartley, Ziller, Loux, Gale, Lambert, & Yousefian, 2005). As a result, many rural residents rely on primary care to treat their mental health issues (Hartley, Turner, LeVine, Schank, & Leichter, 2006).

The prevalence of psychiatric disorders in rural and metropolitan areas is roughly equivalent, as are entry-into-care rates for those with such disorders. However, residents of rural areas with less severe disorders fail to stay engaged in care and thus receive poorer quality of care than metropolitan residents. Rural health service systems tend to also lack specialty mental health providers. Overall, this leads to residents in rural areas having less access to mental health providers than their more urban counterparts (Johnson, Brems, Warner, & Roberts, 2006; Rost, Fortney, Fischer, & Smith, 2002; Petterson, 2003).

Behavioral health interventions hold promise for improving the diagnosis and treatment of mental disorders in the primary care setting, with strong evidence of effectiveness in improving patients' physical and mental health status (Callahan et al., 2005; Lin et al., 2006). Some of the documented benefits of integrated care include better management of specific diseases (e.g., diabetes, congestive heart failure, asthma); decreased utilization of emergency services, medical office visits, and hospitalizations; and increased patient buy-in and compliance with prescribed treatment regimens. In addition, increasing access to short-term psychotherapy for primary care patients with psychological conditions such as depression may result in more prolonged, health-related benefits than does increasing access to medication alone (Amundson, 2001; Bauer, 2001; Callahan et al., 2005; Katon et al., 2003; Wells et al., 2005). Research also indicates that integrated primary care diminishes the negative effects of depression upon work, family, and social life (Schoenbaum et al., 2002; Hedrick et al., 2003). In addition, research has found that meeting with a psychologist prior to the initiation of pharmacotherapy can lead to more effective patient care than treatment as usual in primary care (Pollin & DeLeon, 1996). Finally, primary care physicians (PCP's) and nurse practitioners reported higher levels of job satisfaction and work productivity when their practices implemented integrative care (Bauer, Batson, Hayden, & Counts, 2005).

The goal of incorporating an integrated primary care model into an existing primary care practice is achievable. Researchers have found that models proven efficacious in controlled research environments, such as Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E), Improving Mood-Promoting Access to Collaborative Treatment (IMPACT), Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) and Re-engineering Systems for Primary Care Treatment of Depression (RESPECT-D), can successfully be implemented into a real world setting and achieve similar results (Gallo et al., 2004; Gryma, Haverkamp, Little, & Unutzer, 2006; Hegel et al., 2005; Lin et al., 2006; Price, 2006). Further, despite high initial implementation expenditures, existing evidence suggests that the long-term benefits significantly outweigh the start-up investment, and that costs actually decrease over time (Gilbody, Bower, & Whitty, 2006). For instance, primary care prevention programs for depression have been found to reduce the risk of developing a depressive disorder from 18% to 12%, and such interventions have demonstrated a 70% chance of being more cost-effective than treatment as usual (Smit, Willemse, Koopmanschap, Onrust, & Beekman, 2006). When inpatient and indirect costs are taken into account, the cost-effectiveness of this integrative care increases (Simon, Katon, VonKorff, & Unutzer, 2001; Dickinson, Rost, Nutting, Elliot, Keeley, & Pincus, 2005; Amundson, 2001).

RURAL INTEGRATIVE CARE: BEST PRACTICES

We reviewed approximately 125 articles relevant to integrative care in a rural environment. This literature ranged from provider and patient opinion surveys to randomized controlled trials of various integrative care models. In addition to utilizing traditional research databases, core articles were dissected to identify additional studies to obtain and integrate into our sampling. Our review focused on distilling the common themes with empirical support pertinent to either the development or implementation of integrative care in rural areas. It soon became clear that there was a consistent set of rural integrative care “*core components*” with considerable empirical support and widespread acceptance, and another, less consistently supported or accepted set of “*additional options and upgrades*.” It was also clear that one set of findings pertained to the *development* of integrative care models in rural areas, whereas another set of findings had to do with the *clinical models*. We have organized the following section accordingly, with separate sections for “*core ingredients*” and “*additional options*” and by separating, when relevant, practices according to whether they pertain to *developing* integrative care models or the *clinical models* themselves.

Rural Integrative Care Development Best Practices: Core Components

Assess the culture and readiness of the primary care environment. Central to working in rural environments is the importance of assessing the “culture” within rural primary care clinics targeted for integrated primary care. This can be accomplished through surveys or focus groups with both primary care practitioners and consumers. Ideally, the culture should be accepting of the need for mental health services and ready, willing, and able to implement integrative care (i.e., Brand & Hayes, 2002; Chene et al., 2005; Sawyer, Gale, & Lambert, 2006).

Establish strong communication among key stakeholder groups. Good partnering skills, strong organizational and management involvement, adequate knowledge of the community’s needs, and effective public relations are keys to successful collaboration between primary care organizations and providers, mental health organizations and providers, and the communities

they serve (Brand & Hayes, 2002; Harowski, Turner, LeVine, Schank, & Leichter, 2006; Korsen, Scott, Dietrich, & Oxman, 2003).

Cultivate a culture that values treating mental and behavioral health conditions.

Within the clinic culture, a value must be cultivated and maintained about the benefit of treating mental illness, including how it translates more satisfying, effective, and efficient primary care. Part of developing a culture of valuing integrated primary care includes focusing on incentives, both financial and non-financial. This can be accomplished by training primary care providers in the multifaceted benefits of integrated primary care and cultivating organizational leaders and other champions who are enthusiastic about integrative care and who will support the hard work and financial support needed to make it a reality. Leadership that values the treatment of mental illness propagates the transmission of training to the next generation of primary care physicians. Also central to effective integrated primary care is the cultivation of institutional support, which can be accomplished through surveying and involving enthusiastic individual supporters, especially those with decision-making authority, into planning efforts (Bauer, 2001; Brand & Hayes, 2002; Pincus, Pechura, Elinson, & Pettit, 2001).

Get to know the specific needs and attitudes of the primary care patients. In addition to incorporating the perspectives of the participating institutions and PCP's, a thorough assessment of consumer opinions to inform model development is essential. Collecting this data will elicit invaluable information about patient needs, and attitudes towards mental illness as well as delineate possible alterations to program focus that respond to the unique demographics of the patient population to be served (Brand & Hayes, 2002).

Rural Integrated Care Clinical Models: Core Components

Locate the mental health professional within primary care setting. It is best to house the medical and mental health services within the same organization. In this scenario, PCP's report fewer barriers to obtaining mental health care for their patients. This "carve-in" onsite placement of the MHP may help to reduce stigma sometimes associated with the seeking of mental health care. If co-location is not possible, it is helpful if the MHP's and PCP's work within the same system and are located within 30 minutes of one another (Gerdes, Yuen, Wood, & Frey, 2001; Hedrick et al., 2003; Oxman, Dietrich, & Schulberg, 2005; Pollin & DeLeon, 1996).

Create structures, policies, and training opportunities that enhance communication build shared values between mental and physical health providers. An integrated model's approach is most effective when it incorporates a multifaceted focus on provider training and access to tools, case management techniques, and improved communication between mental health and medical providers (Korsen, Scott, Dietrich, & Oxman, 2003). Essential to integrated primary care is the development of fluid modes of communication between professionals. Enhanced communication between mental health and primary care professionals is best supported through co-located model (e.g., Gerdes, Yuen, Wood, & Frey, 2001). Additionally, electronic medical records (EMR's) that facilitate collaboration between disciplines will enhance communication, reduce errors and lead to better quality care (Rollman, 2003).

Recognize and delineate the multifaceted role of the mental health professional. The onsite MHP role, suggested for psychologists, is one of a "care manager." This role consists of assessment, patient psychoeducation, treatment coordination with PCP's, monitoring of progress, and brief psychotherapy. Care managers should have a professional background and expertise in

psychological and/or psychiatric care (Rollman, 2003; Oxman, Dietrich, & Schulberg, 2003; Brand & Hayes, 2002; Bower, Gilbody, Richards, Fletcher, & Sutton, 2006).

Develop a systematic method for identifying the primary care patients most in need of mental and behavioral services. Integrated care efforts are most successful and cost-efficient when targeted at those patients who have proven treatment refractory in primary care “as usual,” present with the most intense mental health concerns, and/or utilize medical services at the highest rates. This can be accomplished by asking PCP’s to nominate patients from their caseloads, reviewing medical and/or insurance records, or by using a mental health screening measure (e.g., Bauer, 2001). Keep in mind, however, that cost-effectiveness analyses show that screening is only justified under highly restricted conditions, and improvement rates average only 48% when using universal screening (Coyne, Thompson, Klinkman, & Nease, 2002). Despite these mixed findings, the use of a screening instrument can potentially increase collaboration between primary care and mental health providers. On the basis of psychometric quality, ease of administration, and the demands of the primary care clinic setting, the Patient Health Questionnaire (PHQ-9) and the Center for Epidemiological Studies–Depression Scale (CES-D) have been suggested for initial screenings (Areal & Ayalon, 2005). The Primary Care Evaluation of Mental Disorder (PRIME-MD) has also been useful in identifying depression. Regardless of instrument selected, it has been shown to be important to screen for comorbidity, as studies of collaborative care models have shown concurrent diagnoses to interfere with directed treatment of another diagnosis (Dickinson et al., 2005).

Destigmatize the role of the mental health provider in integrative care. The use of terms such as “behaviorist” and “behavioral care” rather than “psychologist” or “mental health care” can help bypass the stigma related to primary care consumer use of mental health services. Other examples include referring to treatment as stress management training, coaching, and/or skills training. This practice will also contribute to the overall clinic’s cultural acceptance of the MHP as an integrated component of primary care. Patient education can also be helpful in this regard (Lang, Norman, Casmar, 2006).

Utilize evidence-based practices, such as chronic disease management protocols, when delivering integrated care in rural settings. Research has shown the utility of using chronic disease management protocols for the most commonly encountered mental disorders in primary care settings, such as depression and anxiety. This approach has proven to be demonstrably superior to treatment as usual in terms of treatment adherence, outcomes, and patient satisfaction (e.g., Badamgarav et al., 2003). Bibliotherapy could be utilized as an adjunct intervention for patients who require less contact time and fewer resources (Reeves & Stace, 2005). All interventions should focus on treatments that utilize evidence-based practice for the particular disorder at hand (Rollman, 2003).

Rural Integrative Care Development: Options and Upgrades

Network with elected officials and advocate for integrative care with key stakeholders to address financial barriers. Many challenges to integrated care involve financial barriers. Development of relationships with legislators to help change existing reimbursement practices will be essential to the progression and proliferation of integrated primary care. Financial reimbursement enhancements can be pursued with third-party payers (Oxman, Dietrich, & Schulberg, 2005; Pincus, Pechura, Elinson, & Pettit, 2001). In addition, state offices of rural health should act as liaisons for primary care and mental health systems in order to create

collaborative networks that expand access to care and improve service delivery in rural areas (Pincus, 2003).

Rural Integrative Care Clinical Models: Options and Upgrades

Provide specialized training to facilitate more effective mental health care for a wider spectrum of primary care patients. Enhancements to the basic level of integrated primary care might include specialized training for PCP's in diagnosing additional conditions commonly presenting to the clinic. Training could come from outside sources or tap the resources of academic institutions. Providing both MHP's and PCP's increased connectivity to an academic institution can offer additional pipelines for consultation and assessment (Kroenke, Taylor-Vaisey, Dietrich, & Oxman, 2000; Slack, Cummings, Borrego, Fuller, & Cook, 2002).

Implement telepsychiatry to improve the diagnosis and provision of psychotropic medication in rural primary care. Telehealth can be utilized as an asset in expanding consultation, long-distance treatment, and education about psychotropic medication issues in primary care settings. Telepsychiatry can be implemented successfully in primary care clinics and may function to reduce barriers to care such as geographic distance and social stigma. In addition, the effectiveness of telepsychiatry is well established. In an area with limited resources, telepsychiatry can often make good use of existing structures without excess cost or disruption to existing primary care settings. Obstacles to telepsychiatry include the high cost of equipment, though cost analysis should be considered relative to the diversion of unnecessary hospitalizations, reduced travel, and more efficient use of limited specialty expertise across networks (Fortney et al., 2005; Graham, 1996; Meresman et al., 2003; Mohr, Hart, Marmar, 2006; Pearson et al., 2003, Urness, Wass, Gordon, Tian, & Bulger, 2006).

The Internet, where available, can be used to accentuate treatment adherence and care management. Methods to utilize the popularity of the internet to promote treatment adherence and patient self-management techniques received some support in the literature. Possible examples include providing patient access to stress management techniques or self-directed homework assignments on a clinic run website (Rollman, 2003).