Models of Mental Health Integration for Rural Health Clinics

John Gale, MS

National Rural Health Association
2020 Virtual Rural Health Clinic Conference
September 23, 2020

UNIVERSITY OF SOUTHERN MAINE
Muskie School of Public Service

Maine
Rural Health
Research Center

Acknowledgements

Support for this work was provided by the Federal Office of Rural Health Policy within the Health Services and Resources Administration.

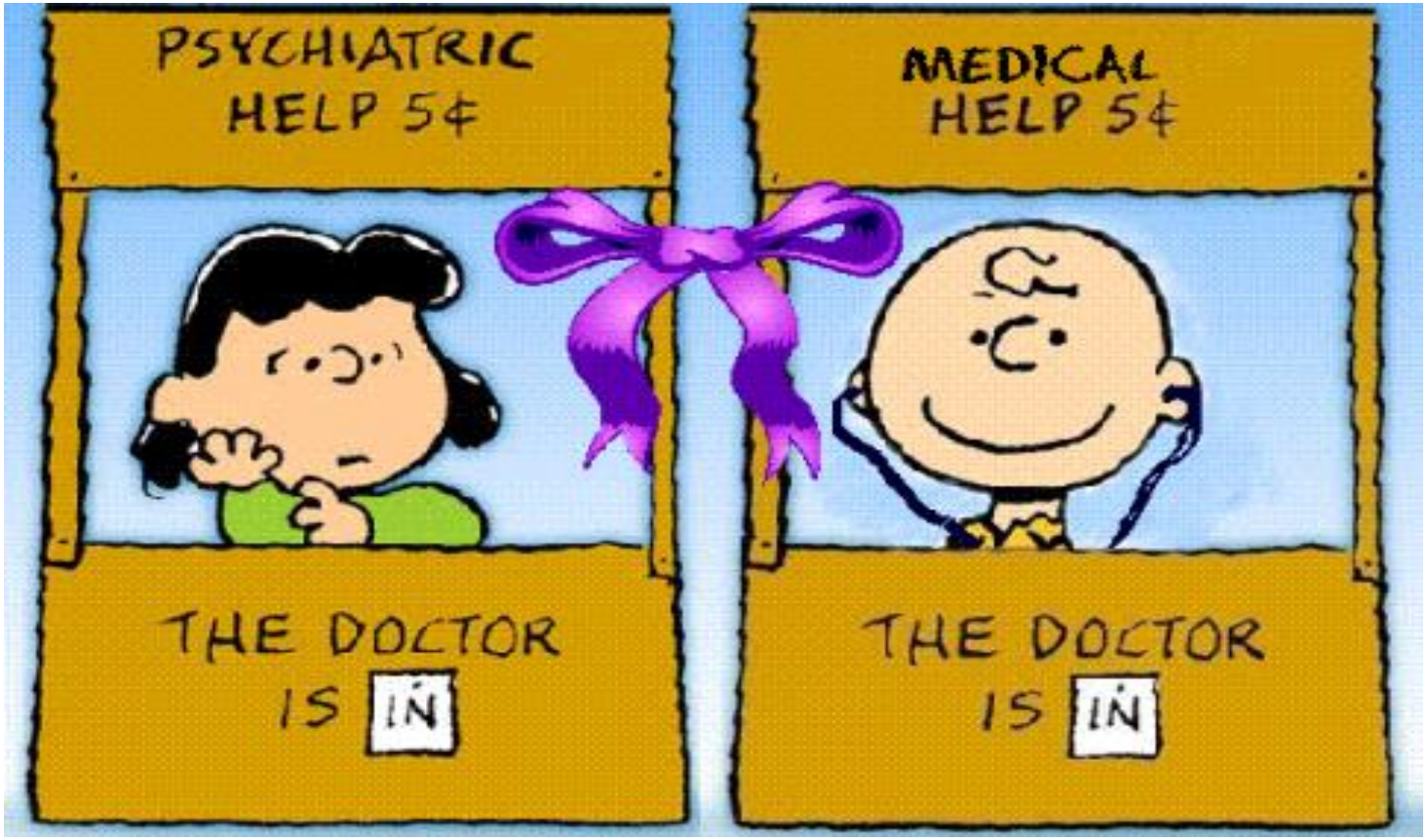
Co-Authors:

- Zachariah Croll, MPH
- Nathan First, LCSW, MSW, MA
- Sara Kahn-Troster, MPH

Learning Objectives

- Overview of the dimensions of integration
  - Five-tier framework Four quadrant model
- Understanding administrative and coding issues
- Clinical models of integration
- Benefits of providing mental health (MH) services through Rural Health Clinics (RHCs)
- Understand key decision points
- Discuss Medicare and Medicaid rules
- Examine models of MH services implemented by RHCs
- Where to begin?

Who Remembers Charlie Brown and Lucy?



Context

- Rural residents face:
  - Longstanding access barriers to MH services
  - Rely more heavily on primary care providers (PCPs) and acute care hospitals to meet their MH needs than do urban residents
- RHCs receive Medicare cost-based reimbursement for MH services provided by doctoral-level clinical psychologists (CPs) and licensed clinical social workers (LCSWs)
- RHCs may be reimbursed by Medicaid for additional masters-trained MH clinicians such as licensed professional counselors (LPCs)

Integration Issues

- Great deal of interest in integration as a "buzzword"
  - Little conceptual clarity
- No consensus on what is meant by "integration"
  - Unclear how much progress we are making
  - Support is high, commitment is relatively weak
  - Little progress in overcoming barriers to sustainability
  - New requests for integration funding are similar to past requests
- Focus needed on functional integration to meet patient needs
- No one model or approach is right for all settings
- Little appetite for new spending by payers

Defining Integration

- Continuum from collaborative models (without co-location) to fully integrated co-located models
- Collaboration without co-location (horizontal)
  - Focus is on integrating services across practices and providers
  - Barriers: communication, sharing of patient information, lack of integrated IT systems, care coordination, availability of referral sites
- Co-location within practices (vertical)
  - MH in primary care practices or primary care services in behavioral health settings
  - Barriers: reimbursement, staffing/workforce, billing and coding, space, practice culture, viability, charting/record keeping by payers

Functional Aspects of Integrated Care

- Clinical integration
  - Shared medical records
  - Shared decision making
  - Common treatment plans and models
  - Regular communication
  - Use of critical pathways or practice guidelines
- Internal referral process
  - Structural integration
  - Co-location (e.g. shared space)
  - Fully integrated (single organizational structure with employed staff)
  - Single medical record
  - Shared billing and scheduling systems
  - Shared risk

Evidence Supporting Integration

- Evidence for integration, particularly for depression, is encouraging but far from conclusive
  - Integrated care achieved positive outcomes (improvements in symptom severity, treatment response, and remission response) (AHRQ 2008)
  - Improvements in outcomes did not increase as levels of provider integration or integrated process of care increased (AHRQ 2008)
  - Clinicians and consumers are satisfied with integrated care (AHRQ 2008)
  - Neither the use of evidence-based practices nor measures of trust or collaboration among CICH network agencies were significantly associated with client service use or client outcomes during clients' first year of entering the program (HUD/HHS/VA Collaborative Initiative to Help End Chronic Homelessness)

What Does the Evidence Tell US?

- Need for integration across physical/behavioral health settings
- No single model is right for all providers and settings
- Integration at the provider level is a work in progress
  - Assess current readiness for integration and implement an appropriate model of integration. With experience, move further along the continuum as appropriate
- We need an integration framework that:
  - Recognizes integrated services regardless of position on the continuum
  - Makes sense for funders, payers, purchasers, providers, and consumers
  - Facilitates sustainability through adequate reimbursement for all components of integrated care

What Does Integration Mean?

- Bringing together of inputs, delivery, management, and organization of services as a means of improving access, quality, user satisfaction, and efficiency (Grone & Garcia-Barbero, 2001)
- Others emphasize different aspects
  - Integration allows for greater efficiency and effectiveness, less duplication and waste, more flexible service provision, and better co-ordination and continuity (Brown & McCool, 1992)
  - Integration has the ability to encourage more holistic and personalized approaches to multidimensional health needs (WHO Study Group, 1996)
  - A pragmatic, rather than ideological or idealistic approach to health care integration is needed

Provider and Practice-Level Barriers

- Differing practice styles
- Differing practice cultures and languages
- Selecting integration model based on practice context
- Difficulty in matching provider skills with patient needs
- Management and supervision of behavioral health staff
- Tension between direct patient care services (reimbursable) and integrative (non-reimbursable) services
- Differing coding and billing systems
- Heavy reliance on physician services
- Provider resistance

Regulatory, Licensure, and Reimbursement Barriers

- Regulatory, licensure, and scope of practice
  - Primarily licensure and scope of practice at the state level
  - Governs types of services that can provided and the extent to which clinicians can practice independently in different settings
  - Difficulty in arranging for clinical supervision
- Reimbursement and financing
  - Low reimbursement rates, variations in payment methods
  - High deductibles and co-pays
  - Coverage of provider types and services vary by payer type
  - Administrative and access restrictions imposed by MBHOs
  - Medicaid funding issues
  - State-level mental health and substance abuse budget issues

Patient-Level Barriers

- Stigma
- Limitations on third party coverage for BH care
- Impact of high deductibles and co-payments on utilization of services
- Limitations on access to behavioral health services
- Patient preferences regarding settings in which they receive behavioral health care

Models of Integrated Care

- Target population
  - Models may focus on the general population of primary care patients or specific populations (e.g., persons with chronic disease, high users of primary care services, persons with depression)
- Types of Services
  - Brief intake followed by short series of visits
  - Traditional BH services
  - Patient education in self-management skills
  - Referral to community resources
  - Referral in acute and emergency care MH situations
  - Behavioral management of chronic/physical health conditions

Levels of Collaboration

- Level 1 – Minimal collaboration
  - Separate systems and facilities
  - Minimal communication
  - Inadequate for complicated problems
- Level 2 – Basic collaboration from a distance
  - Separate systems and facilities
  - Periodic communication, no awareness of “cultures”
  - Adequate for moderate needs
  - Inadequate for significant problems or when medical or MH treatment is not satisfactory

- * Developed by Doherty, McDaniel, and Baird

Levels of Collaboration (cont'd)

- Level 3 – Basic collaboration on site
  - Shared facility but separate systems
  - Regular communication
  - Appreciation of roles but with a power imbalance
  - Adequate for moderate need, some treatment coordination
  - Inadequate for significant problems/ongoing need for treatment coordination
- Level 4 – Close collaboration in partially integrated system
  - Shared site and some shared systems
  - Regular communication with coordinated treatment plans
  - Some tensions systemically and with role influence
  - Adequate for significant problems or complicated management
  - Inadequate for complex cases; multiple providers, or conflicting agendas

Levels of Collaboration (cont'd)

- Level 5 – Fully integrated system
  - Shared site and systems
  - Regular face to face communication
  - Shared treatment plans and models
  - In-depth understanding of roles and culture
  - Regular team meetings
  - Balanced power
  - Adequate for difficult, complex, and challenging situations
  - Inadequate when resources are insufficient or when there are breakdowns within the larger service network

Preparatory Training

- PCPs
  - Type of patient to refer;
  - What to say to patients when referring;
  - How to integrate behavioral feedback into a medical care plan;
  - How to co-manage patients with a behavioral health team member;
  - How to integrate behavioral health into the primary care team; and
  - Population management strategies for patients with mental disorders

Preparatory Training (cont'd)

- BH consultants:
  - Understand/adapt to primary care mission, roles, and culture
  - Adjust to the primary care work pace
  - Provide curbside and written consults
  - Chart for medical records
  - Develop and evaluate population specific treatment programs
  - Co-managing patients

Proposed Guiding Principles

- Integrated care initiatives should be:
  - Patient centered (e.g., address the needs of the patient; is responsive to patient preferences, needs, and values; and ensures that patient values guide all clinical decisions)
  - Expand access to care, decrease burden of illness, optimize care
  - Delivered in settings preferred by patients
  - Evidence based
  - Driven by clinical and care issues and functions not practice and administrative issues
  - Focused not only on integrating care within practices/facilities but also across practices and care settings
  - Focused on both physical health and behavioral health settings

Primary Care vs. Specialty Mental Health Care

Primary Care MH Care	Specialty MH Care
Population-based	Client-based
Often informal client inflow	Formal acceptance process
Tx usually limited -1-3 visits	Often long term Tx
One component of health care	Focus on mental health care
Patient with mild or episodic needs	Often restricted to serious problems
Informal counseling	More formal, private interchange
Typically 15-30 minutes	Often 50 minutes
Lower intensity Tx	High intensity
Counselor part of health team	Counselor not aligned with team
Referrals from medical team	Traditional referral patterns
Care returned to medical provider	Therapist remains point of contact

The Four Quadrant Clinical Integration Model

Behavioral Health Risk/Status (Low → High)

Physical Health Risk/Status (Low → High)

Quadrant II
BH ↑ PH ↓

- BH Case Manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

Quadrant IV
BH ↑ PH ↑

- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ ER
- BH and medical/surgical IP
- Other community supports

Stable SMI would be served in either setting. Plan for and deliver services based upon the needs of the individual, consumer choice and the specifics of the community and collaboration.

Quadrant I
BH ↓ PH ↓

- PCP (with standard screening tools and BH practice guidelines)
- PCP-based BH*

Quadrant III
BH ↓ PH ↑

- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH (or in specific specialties)*
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports

*PCP-based BH provider might work for the PCP organization, a specialty BH provider, or as an individual practitioner, is competent in both MH and SA assessment and treatment

Perceptions of Collaborative vs. Integrated Care

Dimension	Collaborative Care	Integrated Care
Mission	Provide MH care, keep PCPs in the loop	Provide a primary care service focused on MH issues
Location	In separate location or co-located in MH wing	In medical practice area
Primary provider	Therapist	Health care provider
Service modality	Therapist session, conjoint visits with PCP more likely	Consultation session, conjoint visits with PCP less likely
Team identification	"One of them"	"One of us"
Professional title	Therapist/behavioral health specialist	Mental health consultant
Referral Statement	"See a specialist I work with"	"See one of our primary care team who helps out with these issues"
Philosophy of care	MH is a specialty service done outside of context of routine care	BH is part of the process of primary care
Patient's perception	As separate service who is in close collaboration with the PCP	Looks and feels like a routine aspect of health care

Coding Choices for Mental Health

E/M Codes

Inpatient
Outpatient
Consults
Nursing Homes
Residential Treatment

Psychiatry Family of Codes

Psychotherapies
- Patient and/or family
- Family
- Group

Other Psychotherapies
- Crisis
- Psychoanalysis

Electroconvulsive therapy
Transitional management services

Code choice is driven by services provided and licensure/scope of practice. Evaluation and management (E/M) codes are used by physicians, nurse practitioners, and physician assistants.

Health Behavior Assessment Services Assessment, or Re-assessment

- 96156 Health behavior assessment or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making) Health Behavior Intervention Services Individual Intervention
- 96158 Health behavior intervention, individual, face-to-face; initial 30 minutes
- 96159 Each additional 15 minutes (List separately in addition to code for primary procedure) Group Intervention
- 96164 Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
- 96165 Each additional 15 minutes (List separately in addition to code for primary procedure) Family Intervention WITH patient present
- 96167 Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
- 96168 Each additional 15 minutes (List separately in addition to code for primary procedure) Family Intervention WITHOUT patient present
- 96170 Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
- 96171 Each additional 15 minutes (List separately in addition to code for primary procedure)

Example of Offering M/BH Services

- Sacopee Valley Health Center (Maine)
  - FQHC in operation since 1976 with a long-term commitment to providing mental health services
  - Traditional mental health counseling services
  - Substance abuse counseling
  - Integrated primary care (behavioral health and assessment) services (since 2005) targeting the behavioral health needs of patients with chronic health problems such as diabetes, hypertension, obesity, fibromyalgia, etc.
  - Behavioral Health Consultant works with patient and medical provider to design strategies to help them reach goals for a healthier lifestyle
  - Service billed using diagnosis for physical health condition

CAH-Based RHCs Providing Mental Health Services

Measure	With CPs/LCSWs (n = 126)[a]	Without CPs/LCSWs (n = 1,264)[a]	All CAH-based RHCs (n=1,390)[a]
Percent of RHCs by Type of Mental Health Providers			
Clinical Psychologists and Licensed Clinical Social Workers	8.7%	-	0.8%
Clinical Psychologists only	19.0%	-	1.7%
Licensed Clinical Social Workers only	72.2%	-	6.5%
Percent of RHCs by Ownership Status			
Non-profit/governmental	97.6%	94.1%	94.4%
For-profit	2.4%	5.9%	5.6%
Percent of RHCs by Region* **			
Northeast	12.7%	3.4%	4.2%
South	5.6%	28.7%	26.6%
Midwest	51.6%	49.1%	49.4%
West	30.2%	18.8%	19.8%
Percent of RHCs by County Rurality* **			
Urban (Metro areas)	11.1%	16.7%	16.2%
Large Rural (≥20,000 residents)	7.9%	9.3%	9.1%
Medium Rural (2,500-19,999 residents)	67.5%	45.7%	47.6%
Small/Isolated Rural (≤2,500 residents)	13.5%	28.4%	27.1%
Percent of RHCs by Mental Health HPSA **			
Whole county	77.0%	87.0%	86.1%
Partial county	21.4%	11.6%	12.5%
Not HPSA	1.6%	1.4%	1.4%

Source: Medicare Cost Report Data, 2016

Differences between RHCs with and without CP/LCSW services significant at p≤.01** and p≤.001***

[a]Columns may not total due to rounding

CAH-Based RHCs MH Staffing Patterns

Measure	With CPs/LCSWs (n = 126)[a]	Without CPs/LCSWs (n = 1,264)[a]
Average Number of FTE Staff[b]		
Physicians***	2.7	1.1
Physician Assistants and/or Nurse Practitioners***	2.4	1.4
Visiting Nurses	0.02	0.03
Clinical Psychologists and/or Licensed Clinical Social Workers***	0.6	-
Total Staff***	5.8	2.5
Average Number of Visits by FTE Staff		
Physicians***	10,728	4,292
Physician Services Under Agreement	406	232
Physician Assistants and/or Nurse Practitioners***	7,298	3,965
Visiting Nurses	18	8
Clinical Psychologists and/or Clinical Social Workers***	949	-
Total Visits***	18,994	8,265

Source: Medicare Cost Report Data, 2016

Differences significant at p≤.001***

[a]Columns may not total due to rounding

[b]The number of FTE physicians under agreement is not reported on the Medicare Cost Report

Functional Elements of MH Integration

Clinical Integration	Decision Points
Roles for clinicians and staff	Are roles clearly defined? Is there a team-based culture? How will MH clinicians be integrated within clinical team? Supervised? How will quality be monitored and managed?
Medical records	Shared vs. separate? Who has access?
Shared decision making	Clear decision-making process? How are team and patient input obtained? How are differences negotiated/ resolved?
Common treatment plans	How are treatment plans developed? Who has oversight responsibility? Process to review/revise treatment plans?
Regular communication	How often? How is it facilitated? Formal or informal?
Use of critical pathways or practice guidelines	How are pathways/guidelines developed? Who is involved? Review process? How are staff trained on pathways/guidelines?
Internal referral process	Patients routinely screened for MH issues? Internal referral process? Are referrals monitored to ensure appointments are made? Is there feedback to referring clinician?

Functional Elements of MH Integration (cont'd)

Clinical Integration	Decision Points
Structural Integration	Characteristics and Decisions Points
Service location	Separate patient treatment space vs. shared?
Workspace	Shared clinician workspace/offices vs. separate? In what ways does it allow for interaction?
Engagement of MH staff	Employed by the practice? Contracted staff? Sub-contracted from another agency?
Billing and scheduling	Shared billing and scheduling systems vs. separate?
Clinical and financial risk	Who bears the risk for the provision of services – the practice, the provider, or both?
Source: Gale, JA, Lambert PhD, D. Maine Barriers to Integration Study: Environmental Scan. 2008	

CAH-Based RHC MH Models

- Abbeville Area Medical Center, Abbeville, SC: An independent CAH with two RHCs providing MH services. Employs two LISWs, a board certified psychiatrist, and an administrative assistant. Staff provide traditional counseling and medication management services.
- Adventist Health Clear Lake, Lake County, CA: A faith-based system with eight RHCs. Employs three psychiatrists, five LCSWs, and a PNP. Several case managers address social determinants of health.
- Aspirus Ironwood Hospital, Ironwood, MI: Employs two CPs, a psychiatrist, and a PNP, with patient demand that exceeds staff availability. Providers offer counseling, psychotherapy, and psychiatric medication management.

CAH-Based RHC MH Models (cont'd)

- Bingham Memorial Hospital, Blackfoot, ID: Employs a psychiatrist, four CPs, and a number of licensed counselors. Services include medication management, counseling, and MH screenings.
- Lakewood Health System, Staples, MN: Employs five LCSWs, four CPs, a psychiatric nurse practitioner, and a licensed practical nurse, along with a team of case managers and other support staff.
- Livingston HealthCare, Livingston, MT: Employs a psychiatrist, a psychiatrically-trained PA, two LCSWs, and a nurse care coordinator. Psychiatrist and PA provide medication management/consultation, LCSWs offer short-term individual psychotherapy and counseling; and nurse care coordinator offers case management.

CAH-Based RHC MH Models (cont'd)

- Ozarks Community Hospital, Gravette, AR: Operates 12 RHCs and two clinics in Missouri, Arkansas, and Oklahoma. Most of its RHCs house at least one LCSW. Five psychologists divide their time between the RHCs.
- Pagosa Springs Medical Center, Pagosa Springs, CO: An 11-bed CAH with an on-campus RHC. Employs two LCSWs, an LPC, and a CP. For urgent needs, its clinicians complete emergency evaluations via telepsychiatry with an external provider.
- Regional Medical Center, Manchester, IA: Operates an RHC on the hospital campus and four satellite clinics. It employs three LMHCs, a licensed independent clinical social worker (LICSW), and a psychiatric nurse practitioner.

CAH-Based RHC MH Models (cont'd)

- Weeks Medical Center, Lancaster, NH: Operates four RHCs and employs three LADACs, two LICSWs, two PNPs and a number of support recovery workers and master's level mental health counselors.
- Western Wisconsin Health, Baldwin, WI: An independent CAH that operates two RHC and employs one psychiatrist, two PNPs, one CP, and six LCSWs and licensed counselors to provide short-term outpatient counseling, MH screenings, and medication management.

Conclusions

- MH services provided by CAH-based RHCs can be financially sustainable, particularly when considering their impact on system performance rather than as a standalone "profit center."
- Although study participants reported that MH services were sustainable, only 9 percent of all CAH-based RHCs provide them.
- RHC providers are satisfied with MH services provided in their clinics and believe they help to overcome stigma and other barriers that discourage patients from accessing needed services.
- It is important that CAH-based RHCs understand third-party MH payment policies and regulations prior to developing these services.

The Rural Health Research Gateway provides access to all publications and projects from seven research centers funded by the Federal Office of Rural Health Policy

Visit our website for more information: http://www.ruralhealthresearch.org/

Sign up for email or RSS alerts at: http://www.ruralhealthresearch.org/alerts

Contact Information

John A, Gale, MS
Senior Research Associate
Maine Rural Health Research Center
Muskie School of Public Service
University of Southern Maine
PO Box 9300
Portland, ME 04104-9300

John.gale@maine.edu
207.228.8246

Maine
Rural Health
Research Center