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The Provision of Mental Health Services by Rural Health Clinics

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Maine Rural Health Research Center
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May 2010

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EXECUTIVE SUMMARY

Due to chronic shortages of mental health services, much of the burden of care for mental health issues in rural areas has shifted to the primary care sector (Gale & Lambert, 2006). The National Advisory Committee on Rural Health and Human Services recognized the important role played by the primary care sector in meeting the mental health needs of rural residents in its 2004 report to the Secretary of the Department of Health and Human Services (National Advisory Committee, 2004). With almost 3,800 clinics in operation, Rural Health Clinics (RHCs) are an important rural primary care resource (CMS, 2009). An earlier study of RHCs found that few offered mental health services (0.12% employed a doctoral-level psychologist and 0.07% employed a clinical social worker) (Gale & Coburn, 2003). This study examined changes in the delivery of mental health services by RHCs, operational characteristics of these services, barriers and challenges experienced by RHCs, and policy options to encourage more RHCs to deliver mental health services.

Methodology

Using 2005-2006 Medicare Hospital and Independent RHC Cost Reports, we identified 62 (out of 1,117) independent RHCs and 28 (out of 1,349) provider-based RHC that employed a doctoral-level psychologist or clinical social worker. From this group, we completed in-depth semi-structured interviews with 14 randomly selected RHCs (six independent and 8 provider-based) to explore the reasons for developing mental health services, barriers and challenges to doing so, the operational and clinical characteristics of their mental health services, and challenges to their on-going operation and sustainability. Thirteen clinics were currently providing mental health services and had done so for an average of eight years. One provider-based RHC had terminated services when its sole mental health provider left the practice.

Findings

Approximately 6% of independent and 2% of provider-based RHCs offer mental health services by employing doctoral-level psychologists and/or clinical social workers. The models used to provide mental health services included contracted and/or employed clinicians housed in the same facility as the primary care providers. The most commonly treated conditions were depression, attention deficit hyperactivity/attention deficit disorders, and anxiety. Participants

appeared to be maintaining or increasing access to mental health services as most accept new patients for services, do not limit referrals to existing patients, accept patients from all age groups, and report relatively short waiting times for new patients to access their services. Establishing and maintaining mental health services is challenging. Five respondents (38%) reported that their mental health services were not profitable, four (31%) reported that their services were profitable, three (23%) thought they might be profitable but were not sure, and one (5%) could not answer the question. The most cited common reasons for developing mental health services included community and patient need and a lack of available local services.

A key element in the development of mental health services is the presence of an internal champion who encourages the development of services and/or spearheads efforts to develop and implement them. Internal champions are typically clinicians or senior administrators who identify the need for and undertake the implementation of services, help to overcome internal barriers, and direct resources to the development of services.

Barriers to the Development of Mental Health Services

Study participants identified the following common barriers to the development and on-going operation of mental health services:

- *Recruitment and retention barriers:* RHCs experienced difficulties in recruiting appropriately licensed mental health staff due to chronic shortages of appropriately licensed clinical social workers, psychologists, psychiatrists, or other licensed clinicians in rural areas and policies established by some third party payers restricting reimbursement of services to certain types of providers (e.g., Medicare limits direct reimbursement to clinical social workers and doctoral-level psychologists). Challenges in retaining clinicians are due to the difficulties of practicing in rural communities that include issues of professional isolation, inability to specialize, and difficulties in maintaining professional boundaries.
- *Reimbursement barriers:* RHCs reported challenges to the development of profitable, self-sustaining services due to poor fee-for-service reimbursements rates paid by Medicaid and commercial insurers; cost-shifting to patients by Medicare and commercial

insurers through high deductibles and co-payments; high no-show rates among mental health clients; and high rates of uninsurance among rural residents.

- *Administrative barriers:* Respondents described the administrative demands and costs borne by clinics to deal with multiple third party payers, many of whom establish varying and inconsistent reimbursement and credentialing policies; compliance with managed care contracts and policies to control utilization costs (such as prior authorization requirements and restricted provider panels); and the complexity of state licensure laws. Respondents noted that coping with these administrative demands imposed additional costs on the clinics and increased staff workload.
- *Information and resource barriers:* Respondents described limited availability of RHC-specific resources and technical assistance to support administrators and staff in developing mental health services.

As these barriers are similar to those experienced by other primary care providers, we must ask why RHCs appear to lag behind other providers, specifically Federally Qualified Health Centers, in developing mental health services. We suggest the following reasons for this lag:

- RHCs, as a condition of certification, must be located in rural underserved areas that are plagued by chronic shortages of specialty mental health providers.
- Many RHCs, particularly independent RHCs, operate like small private practices with limited administrative, financial, and physical plant resources.
- The RHC Program lacks the policy leverage (e.g., specific policy direction as well as financial and technical assistance resources) used by the Federally Qualified Health Center (FQHC) program to support the development of mental health services.¹

Given these issues, the growth in RHC mental health services is likely to remain relatively stagnant unless efforts are undertaken to increase interest in developing mental health services among RHC clinicians and administrators and provide resources to support them in doing so.

¹ Federally Qualified Health Centers (FQHCs), for example, are required to provide, directly or by arrangement with another provider, mental health services. The Bureau of Primary Health Care supports FQHCs in fulfilling this requirement by offering Service Expansion Grants as well as technical assistance and educational resources.

Options to Encourage RHCs to Offer Mental Health Services

The number of RHCs providing specialty mental health services remains limited and the growth patterns (or lack thereof) provide little reason to believe that this situation will turn around without greater policy direction and action. Given the access barriers to mental health care in rural communities, the limited provision of mental health services by the nation's 3,800 RHCs may present a missed opportunity to increase access to these needed services. Policymakers should develop approaches to address reimbursement and administrative barriers identified here, while also considering how to train and ultimately recruit mental health providers to rural areas. Practical, comparatively low cost options to support the development of mental services by RHCs in the short-term include the development of RHC-specific mental health educational and technical assistance resources; the identification of existing mental health resources developed by the Bureau of Primary Health Care, the Substance Abuse and Mental Health Services Administration, and other Federal Agencies that could be adapted for use by RHCs; and the development of an RHC mental health toolkit (similar to the ORHP-funded *Starting a Rural Health Clinic: A How-To Manual*) to provide practical resources on mental health billing, coding, and reimbursement; quality management and improvement; provider selection and management; risk management; service development; managed care, prior authorization, and utilization management processes; evidence-based practices; service models; record keeping; and confidentiality.

INTRODUCTION

Access to mental health services remains a long-standing and intractable problem in rural communities, primarily due to the shortages of specialty mental health services and licensed mental health professionals (Gale & Lambert, 2006). As a result of these shortages, primary care providers play a substantial role in the delivery of mental health services in rural areas (Regier, et al., 1978; U.S. Congress, 1990; U.S. Department of Health & Humans Services, 1984). With almost 3,800 clinics across the country, Rural Health Clinics (RHCs) are an important source of primary care services in rural communities (CMS, 2009; Gale and Coburn, 2003). Through the collection and analysis of quantitative and qualitative data, this study examined the extent to which RHCs are providing mental health services, the barriers and challenges encountered by RHCs in developing these services, and opportunities to encourage more RHCs to do so.

Delivery of Mental Health Services by Rural Health Clinics

In an effort to improve access to a range of needed services in rural communities, Congress expanded the range of services and providers that are eligible for Medicare and Medicaid cost-based reimbursement under the Rural Health Clinics Program (Fogel and McQuarrie, 1994). The Omnibus Budget Reconciliation Act (OBRA) of 1987 added reimbursement for psychology services provided by doctoral-level psychologists (ibid). OBRA 1989 added reimbursement for services provided by clinical social workers (ibid). Given the long-standing interest in and support for integration, the documented need for mental health services in rural communities, and the ability of RHCs to provide mental health services, policymakers were interested in the extent to which RHCs are offering mental health services. In an effort to answer this question, Gale and Coburn added questions on the provision of mental health services to a survey of RHCs conducted by the Maine Rural Health Research Center (MRHRC) during 2000-2001. They found that very few RHCs were offering mental health services with only 0.12% employing a doctoral-level psychologist and 0.07% employing a clinical social worker. Recent state-specific surveys of RHCs confirm these findings.

In a 2004 survey of the 37 RHCs in Colorado, none of the 13 respondents employed specialty mental health staff to provide services (Colorado Rural Health Center, 2005). The report noted that a majority of clinics (more than 6) did not offer either mental health or substance abuse

services (an exact figure was not provided). If an RHC did offer mental health or substance abuse services, it was most likely to use visiting staff to provide these services. In its 2002 *Report on the Role of Rural Health Clinics in 2002*, the Office of Community and Rural Health, Washington State Department of Health noted that there were very few mental health professionals practicing at RHCs in Washington State or providing support services. In its 2008 survey of Michigan RHCs, the Michigan Center for Rural Health noted that the majority of RHCs did not offer mental health services. Only four RHCs employed mental health or substance abuse staff. Two clinics employed one full time equivalent (FTE) mental health or substance abuse support specialist each. Another two employed an average 0.35 FTE “other mental health or substance abuse” professionals. The remaining few provided mental health services through a contracted relationship. In a study of RHCs in Oregon in 2007, the Oregon Office of Rural Health found that mental health care was available in 20% of the 50 responding clinics, 12% from regular clinic providers and 8% from visiting providers (Soenen, et al., 2008). Substance abuse services were available in 10% of clinics.

A degree of caution is needed in comparing the results of the MRHRC survey to the more recent state-level surveys as the questions asked in the later surveys were phrased differently. In their study of Rural Health Clinics, Gale and Coburn (2003) identified RHCs as providing mental health services if they employed either a doctoral-level psychologist or a clinical social worker. They also asked the respondents to provide FTE staffing levels for these providers. The more recent state-level surveys asked respondents to indicate if they provided different types of mental health or substance abuse treatment services and whether these services were provided by the clinic staff or by a visiting/contracted clinician. The data provided in the reports made it difficult to determine exactly what services were provided (e.g., RHC primary care providers prescribing anti-depressants or a more extensive set of counseling and therapy services provided by specialty mental health providers). Further, the nature of the MRHRC survey as well as the more recent state surveys did not allow researchers to identify barriers to the development of RHC mental health services or why more RHCs are not offering these services. This study was undertaken to identify the reasons why, despite the interest in the integration of mental health services in primary care settings, comparatively few RHCs are doing so.

THE RURAL HEALTH CLINICS (RHC) PROGRAM

Background

Public Law (PL) 95-210, the Rural Health Clinic Services Act, was passed by Congress in 1977 to increase the availability of primary care services for residents of rural communities. The Act provided qualified RCHS with cost-based Medicare and Medicaid reimbursement for a defined set of core services. Additionally, the act expanded Medicare and Medicaid coverage for services provided by nurse practitioners (NPs), and physician assistants (PAs). Subsequent amendments to the Act added certified nurse midwives (CNMs), doctoral-level psychologists, and clinical social workers to the list of core providers eligible for cost-based reimbursement. PL 95-210 established the following goals for the RHC Program:

1. To improve access to primary care in rural, underserved communities for Medicare and Medicaid beneficiaries, and
2. To promote a collaborative model of health care delivery using physicians, nurse practitioners, physician assistants, certified nurse midwives, psychologists and clinical social workers (Washington & Kushner, 1991; Centers for Medicare and Medicaid Services, 2009).

Although Congress anticipated widespread participation in the RHC Program when it passed PL 95-210, early participation lagged behind those initial expectations (Gale and Coburn, 2003). As of late 1990, only 314 RHCs were in operation across the country (Office of Inspector General, 1996). Beginning in the early 1990s, Congressional amendments to the enabling legislation and economic challenges in the private practice environment made RHC status more attractive to rural providers (Gale & Coburn, 2003). Between late 1990 and October 1995, participation in the RHC Program grew by over 650% (from 314 to 2,350 RHCs) (OIG, 1996). By September 1999, the program had grown to 3,477 clinics (Gale and Coburn, 2003). Since then, program growth has stabilized with 3,761 RHCs providing services in 45 states (Centers for Medicare and Medicaid Services, 2009). In their study of RHCs, Gale and Coburn (2003) noted that RHCs continued to serve rural underserved communities with over 97% located in areas defined as having a shortage of primary care providers at the time of the study.

Certification Requirements

To be certified as an RHC, a facility must meet requirements regarding location, staffing, and provision of services established by PL 95-210 (Office of Rural Health Policy, 2004; CMS, 2009). To be eligible for certification, a clinic must be located in a rural, underserved area. For purposes of the RHC Program, a rural area is one that does not meet the United States Census Bureau's definition of an urbanized area (e.g., a densely settled territory that contains 50,000 or more people).² Based on this program specific definition, a non-urbanized area is one with 49,999 or fewer people.³ For purposes of the RHC Program, an underserved area is one that is currently designated by the Health Resources and Services Administration's Shortage Designation Branch as a Health Professional Shortage Area or Medically Underserved Area or designated by the State's Governor as underserved (CMS, 2009). Under changes to the Program mandated by the Balanced Budget Act of 1997, currently designated means that the area has been designated as a shortage area or had its designation updated within the last three years.⁴ Facilities eligible for certification include for-profit and not-for-profit medical practices and medical clinics. A facility may be housed in a permanent stand-alone building, designated space within a larger facility, or a mobile facility.

In terms of staffing requirements, a facility must employ one or more physicians and one or more mid-level providers (e.g., a Physician Assistant, Nurse Practitioner, or Certified Nurse Midwife (CMS, 2009; National Association of Rural Health Clinics, n.d.)). The mid-level provider(s) must be on-site and available to see patients a minimum of 50% of the time that the clinic is open for

² For Census 2000, the United States Census Bureau defined two types of urban areas, urbanized areas and urban clusters (Federal Register, 2002). Urbanized areas consist of contiguous, densely settled census block groups and census blocks that meet minimum population density requirements, along with adjacent densely settled census blocks that together encompass a population of at least 50,000 people. Urban Clusters consist of contiguous, densely settled census block groups and census blocks that meet minimum population density requirements, along with adjacent densely settled census blocks that together encompass a population of at least 2,500 people, but fewer than 50,000 people. The Census Bureau classifies all population and territories within the boundaries of urban areas as "urban". It classifies all population and territory that are not within any urban area as "rural".

³ The Rural Health Clinic Program's definition of rural as established by P.L. 950210 is not consistent with the more recent definition of rural established for Census 2000. For purposes of the RHC Program, a rural area is one that is not located within the boundaries of an urbanized area.

⁴ The Balanced Budget Act of 1997 (BBA) eliminated the permanent designation of RHCs and requires timely review of shortage-designation areas (Moran & Maxwell, 2005). To date, the Centers for Medicare & Medicaid Services (CMS) have not issued final regulations implementing the BBA's required changes (Ibid, Finerfrock, 2009).

patient care. The physician need not be on-site while mid-level providers are practicing but must be available for consultation and oversight as needed.

An RHC must be capable of delivering a core set of “RHC services” that includes:

- Outpatient primary care services (e.g., diagnostic and therapeutic services commonly furnished in a physician’s office) provided directly by the clinic’s staff;
- At least six laboratory tests including chemical examination of urine, hemoglobin or hematocrit, blood sugar, examination of stool specimens for occult blood; pregnancy test, and primary culturing for transmittal; and
- Emergency medical procedures as a first response to common life-threatening injuries and acute illness and has available the drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums, and toxoids. (42 CFR 491.9, 2004).

In support of these services, each RHC must maintain a written policy and procedures manual that describes the services provided by the clinic, provides guidelines for the medical management of health problems, describes the clinic’s system for recording and maintaining patient information, outlines the clinic’s policies governing the use, removal and release of patient information, and documents the process by which a patient provides consent for the release of his or her medical records (National Association of Rural Health Clinics, n.d.; CMS, 2009). These policies must be developed by a physician, physician assistant, or nurse practitioner as well as a health care practitioner who is not a member of the clinic staff.

THE STATE OF RURAL MENTAL HEALTH

Access to mental health services remains an ongoing problem for residents of rural areas due primarily to the shortage of specialty mental health providers and services. Other barriers to accessing mental health services include long travel distances; lack of transportation, particularly for elderly rural residents; poor or non-existent insurance coverage for mental health care; and high rates of uninsurance among rural residents (Gale and Lambert, 2006; National Advisory Committee on Rural Health and Human Services, 2004).

The practice patterns of mental health providers reflects the distribution of the overall US population with more than 90% of psychiatrists and psychologists and 80% of masters-level social workers practicing in urban areas. This distribution pattern of mental health providers has continued for more than 30 years and has resisted efforts to encourage providers to practice in rural areas. This reluctance to practice in rural areas is a result of the difficulties experienced by providers who practice in rural areas. Rural mental health providers are frequently called upon to treat patients with problems outside of their area of expertise as well as practice without the ability to consult with other professionals (Roberts, et al., 1999; Beeson, 1991). As a result, they are subject to a high level of professional isolation and experience high potential for burn-out (ibid). Rural providers are also more likely to experience boundary issues as they often interact with clients in a variety of non-clinical roles.

The President's New Freedom Commission (2003) described the rural mental health system as "fragmented and inadequate". In addition to the problems described above, the President's New Freedom Commission identified additional mental health disparities affecting rural communities, including greater levels of social stigma associated with seeking mental health services, a lack of a consistent plan to address rural mental health disparities and established models of care addressing the unique issues of rural communities, and an inconsistent definition of "rural" which complicates efforts to target funding for rural areas.

The Case for the Integration of Mental Health into Primary Care Settings

As a result of chronic shortages of specialty mental health providers and services in rural communities, much of the burden of care for mental health issues has shifted to the primary care sector (Gale and Lambert, 2006; Bird, et al., 1998). The National Advisory Committee on Rural Health and Human Services recognized the important role played by the primary care sector in meeting the mental health needs of rural residents in its 2004 report to the Secretary of the Department of Health and Human Services. Regier, Goldberg, and Taube (1978) were among the first to acknowledge the central role of primary care in the delivery of mental health services by identifying primary care as one of the four sectors (e.g., specialty mental health, general medical/primary care, human services, and voluntary support networks) where individuals seek assistance for their mental health needs. This is not to suggest that rural residents view the use of the general medical/primary care for their mental health needs as a "second class" choice.

Rather, the opposite is true. The evidence shows that many rural residents prefer receiving mental health services in a primary care setting given the issues of stigma and perceived lack of confidentiality due to the small town environment (Gale and Lambert, 2006; Bird, et al., 1998).

Although interest in the integration of mental health and primary care services dates back to the 1970s, there has been a renewed interest in and policy support for integration of services, particularly in rural areas (Gale and Lambert, 2006). Seminal reports promoting the concept of integration include the Surgeon General's Report on Mental Health (1999), the President's New Freedom Commission on Mental Health's *Achieving the Promise: Transforming Mental Health Care in America* (2003), the National Advisory Committee on Rural Health and Human Services' Report to the President (2004), the Institute of Medicine's *Quality Through Collaboration: The Future of Rural Health Report* (2005), Mental Health America's *Position Statement 13: Integration of Mental and General Health Care* (2007); and the *Report of a Surgeon General's Working Meeting on The Integration of Mental Health Services and Primary Care* (2001). This widespread support for integration is based on the belief that the integration of services is an effective strategy for maximizing the use of scarce rural health care resources and will improve access to and the quality of mental health services for rural residents as well as reduce the social stigma associated with seeking mental health services (National Advisory Committee on Rural Health and Human Services, 2004).

Potential Barriers to the Development of Mental Health Services by RHCs

In a study of the barriers to the integration of physical and behavioral health services in Maine, Gale and Lambert (2008) conducted an extensive review of the literature along with a state and national-level environmental scan. They identified a range of national and system-level barriers including regulatory, reimbursement, practice and cultural, information technology, and patient barriers to the development of integrated mental health and primary care services. Their work informed the development of the interview protocols for this study. The barriers likely to impact the delivery of mental health services by RHCs are summarized in the following sections.

Workforce Barriers

An ongoing barrier to the development of mental health services in rural areas is the long-term chronic shortage of specialty mental health providers as well as the maldistribution of mental health providers relative to need and geography. As described earlier, the distribution of psychiatrists, psychologists, and social workers is skewed towards practice in urban areas. An inability to recruit and retain appropriately trained mental health providers is likely to be a potential barrier to the development of mental health services by RHCs.

Regulatory Barriers

Regulatory issues related to provider licensure, scope of practice, supervisor requirements, and facility licensure serve as potential barriers to the development of RHC mental health services. State-level licensure laws and scope of practice regulations for mental health clinicians serve as barriers by limiting the types of providers that can practice in specific settings as well as the types of clinical services that different licensed providers can provide. Supervisory requirements, particularly for new professionals, create barriers in settings where appropriately credentialed supervisors may not be available. Facility licensure regulations hinder the development of services by establishing administrative and reporting requirements that are difficult for small organizations to meet, restricting Medicaid reimbursement to programs with specific types of licenses, and limiting flexibility of agencies to work across programs/funding streams to develop and integrate mental health services.

Reimbursement Barriers

In the MRHRC study, RHCs, on average, reported that total expenses exceeded total revenues by approximately \$40,000 (Gale and Coburn, 2003). Similarly, RHCs subject to CMS's cap on per visit reimbursement reported that their adjusted cost-per-visit exceeded the cap in the year prior to the survey (ibid). Given the financial vulnerability of these clinics, reimbursement issues are likely to be significant barriers to the development and ongoing operation of mental health services by RHCs.

In their review of the literature, Gale and Lambert (2008) identified the following reimbursement barriers to the development of integrated mental health services:

- Poor reimbursement rates; particularly for Medicaid (historically among the lowest payers);
- High co-payments and deductibles for Medicare (the highest of all third party payers) and commercial insurers;
- Inconsistent and relatively limited coverage for mental health services across third party payers;
- Complex and inconsistent billing and credentialing policies across third payers and managed care organizations;
- Use of differing diagnostic coding systems and procedure code groups for physical and mental health services;
- Growing use of managed behavioral health organizations by third party payers;
- High rates of uninsurance and underinsurance among rural residents;
- Confusion over what providers and which services may be reimbursed in different settings; and
- Lack of familiarity with mental health diagnostic and procedural coding and billing procedures on the part of primary care staff.

Challenges to the development of mental health services due to low reimbursement rates, limited coverage, high co-payments and deductibles, high rates of uninsurance and underinsurance are exacerbated by the variation in billing and credentialing policies implemented across third party payers. This variation increases the administrative burden and costs for primary care practices. The same is true of the billing process which uses different diagnostic coding systems (the *International Classification of Diseases, 9th Revision, Clinical Modification* for physical health and the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* for mental health services) and procedure code groups (physical health providers use the evaluation and management code series while mental health providers use the psychiatric and health and behavioral health and assessment code series) (Gale & Deprez, 2003; Gale & Lambert, 2008). Selecting the proper code is a complex process due to the varying, and often inconsistent, coding policies implemented by third party payers. Use of the wrong codes may result in lower reimbursement, denial of claims, and exposure to audits and recovery actions.

Practice Barriers

Gale and Lambert identified practice barriers to the development of mental health services including physical plant issues, differing practice styles and productivity patterns, and differing documentation requirements. Not only is there an issue of finding sufficient space within existing primary care facilities, the typical layout of a mental health clinician's practice space is less "clinical" than that of a physical health clinician. The two are usually not interchangeable. Practice patterns and styles also differ as mental health clinicians typically see clients for longer blocks of time and are less inclined to tolerate interruptions and questions while in session. Documentation requirements for mental health services are generally more extensive than primary care services in response to public mental health funding requirements and the nature of the clinical interaction during a mental health encounter. Primary care documentation tends towards brief, immediate, problem-focused records. These are issues that may not be primary barriers to the development of services but, nonetheless require attention to minimize operational conflicts between services and providers within a given practice setting.

Reimbursement of Mental Health Services Provided by RHCs

Mental health services provided by physicians, physician assistants, nurse practitioners, and certified nurse midwives, doctoral-level psychologists, and clinical social workers are covered as part of the RHC benefit and are reimbursed under the cost-based per-visit rate paid to RHCs. All other Medicare mental health reimbursement policies (e.g., 62.5% outpatient payment limitations, life time limits, etc.) apply to services provided by RHCs. Medicaid and commercial insurance reimbursement policies for mental health services provided by RHCs vary by state and carrier.

For outpatient services (e.g., individual, family, and group psychotherapy, therapeutic activities, and patient education services) provided on/or before December 31, 2009, Medicare imposed a 62.5% payment limitation for outpatient services rendered in connection with mental, psychoneurotic, and personality disorders regardless of provider setting. For services received provided by an RHC, Medicare beneficiaries were responsible for at least 37.5% of the all-inclusive rate for applicable mental health services as well as the co-insurance (e.g., co-payment) and any unmet deductible based on the remaining 62.5% of the reasonable charges. Charges for initial diagnostic services (e.g., psychiatric testing and evaluation) were not subject to this

limitation.⁵ Under the 62.5% payment limitation, Medicare shifted a greater burden of the cost of mental health services to the beneficiary which served to discourage utilization of mental health services. Under Medicare's outpatient payment limitation, the co-pay for mental health services subject to the 62.5% payment limitation was essentially 50%. In comparison, the Medicare co-payment for physical health services is 20%.

In recognition of the barrier to the utilization of mental health services by Medicare beneficiaries created by these discriminatory co-payment rates for Medicare outpatient psychiatric services, the *Medicare Improvements for Patients and Providers Act of 2008* established a schedule to phase out Medicare's Outpatient Payment Limitation by 2014 (PL 110-275). Under the provisions of the Act, the barrier to utilization of mental health services by Medicare beneficiaries and the provision of these services by RHCs and other providers should be gradually reduced and eliminated according to the following schedule:

- For expenses incurred for mental health services provided in 2010 or 2011, the outpatient payment limitation shall be reduced to 68.75% of such expenses;
- For expenses incurred for mental health services provided in 2012, the outpatient payment limitation shall be reduced to 75% of such expenses;
- For expenses incurred for mental health services provided in 2013, the outpatient payment limitation shall be reduced to 81.25% of such expenses; and
- For expenses incurred for mental health services provided in 2014 or any subsequent calendar year, the outpatient payment limitation is eliminated.

State Medicaid Agencies (SMAs) are required to reimburse RHCs and Federally Qualified Health Centers (FQHCs) for the behavioral health services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers practicing within the scope of their licenses under applicable state law (Mauch, et al., 2008; CMS, 2003). Prior to the release of October 2003 Program Information Notice (PIN) 2004-05, some RHCs and FQHCs reported difficulty in obtaining Medicaid reimbursement for mental health services

⁵ The initial diagnostic evaluation is typically billed using CPT code 90801, Psychological Diagnostic Interview Examination.

due to conflicts between the reimbursement and coverage policies of some SMAs and Section 1861(aa) of the Social Security Act which defines RHCs/FQHCs and the core services provided by them (HRSA, 2003).

The Centers for Medicare and Medicaid Services' (CMS) policy is that SMAs are required to reimburse FQHCs and RHCs for behavioral health services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers whether or not those services are included in the State Medicaid plan (ibid) and that the requirement to reimburse FQHCs and RHCs for behavioral health services applied to categorically eligible Medicaid beneficiaries (CMS, 2003; HRSA, 2003). It also stated that an SMA is required to reimburse FQHCs and RHCs for behavioral health services furnished to individuals who are eligible as medically needy if the SMA has elected to provide RHC and FQHC services to its medically needy population. The requirement for Medicaid reimbursement for RHC and FQHC applies regardless of whether the services are provided under a fee-for-service or managed care arrangement. HRSA's PIN 2004-05 also clarifies and documents these requirements for FQHCs.

RESEARCH QUESTIONS

This study was undertaken to answer the following research questions:

- How many RHCs currently offer mental health services and how are they distributed nationally?
- Why are more RHCs not offering these services?
- What factors may help to explain why some RHCs offer mental health services and others do not?
- What are the clinical and administrative characteristics of the mental health services offered by RHCs?
- What are the staffing patterns for mental health services?
- What barriers to offering mental health services did RHCs encounter and how were they overcome?
- How are RHCs reimbursed by Medicaid and private insurers/health plans for mental health services?
- What are the "lessons learned" by these facilities that could be used by other RHCs in the development of mental health services?

METHODOLOGY

A significant challenge to conducting research on RHCs is the difficulty in collecting data on their activities and operations. Many RHCs evolved from and still resemble small physician practices with limited administrative staff. In working with RHCs, we have observed a separation between the day-to-day management of the clinic and the higher level cost reporting and financial management activities. In many independent RHCs, accountants and consulting firms are responsible for completing Medicare cost reports and the office staff may not be familiar with them. In provider-based RHCs, the cost reports and financial management of the clinics are generally the responsibility of the hospital accounting/finance staff with the on-site clinic staff responsible for managing activities related to patient scheduling and flow.

This makes it difficult to conduct surveys of RHCs and obtain adequate response rates. In their national survey of RHCs, Gale and Coburn (2003) obtained a response rate of 42% (611 out of an adjusted sample size of 1,449) for their mailed survey of RHCs despite extensive telephone, mail, fax, and e-mail follow-up contacts. The state-level surveys described earlier had similar experiences. Colorado achieved a 35.1% response rate (13 out of 37 RHCs) to its survey. Washington achieved a 42% response rate (43 out of 102 RHCs). Michigan did slightly better with a response rate of 53% (71 out of 133 RHCs). Oregon achieved the best response rate at 90% (46 out of 51 RHCs) with 10 responses that were not complete. The researchers in Oregon entered each participating RHC into a lottery for two awards of \$5,000 each for their time and effort in gathering information.

As cost reports for independent RHCs are not available in an electronic database format, we requested cost reports through a Freedom of Information Act request from the five Fiscal Intermediaries (FIs) that, at the time of our study, handled cost reports for all independent RHCs. We received 1,177 settled costs reports for the time period 2005-2006 in a combination paper records and printable electronic Portable Document Format files. Using these cost reports, we identified 62 independent RHCs that employed either a doctoral level psychologist and/or clinical social worker. These 62 clinics were located in 19 states. We created a limited analytic file detailing the administrative and operational characteristics for these 62 RHCs.

As an alternative to conducting another survey of RHCs, we relied on Medicare Cost Reports rather than a survey to identify RHCs providing specialty mental health services. We used the Medicare Hospital Cost Reports from the Centers for Medicare and Medicaid Services' online Healthcare Cost Report Information System and extracted reconciled costs reports for 833 hospitals with one or more provider-based RHCs. From the 1,349 provider based RHCs represented in this data set, we identified 28 RHCs located in eight states that employed either a doctoral-level psychologist or a clinical social worker. We created an analytic file for these 28 provider-based RHCs detailing their administrative and operational characteristics.

From the population of 62 independent and 28 provider-based RHCs we randomly selected 15 RHCs of each type for in-depth semi-structured qualitative interviews to explore the reasons for developing the service, the barriers and challenges to doing so, operational and clinical characteristics of RHCs offering specialty mental health services, staffing patterns for mental health services, barriers to offering mental health services by RHCs and how they were overcome, reimbursement issues for mental health services provided by RHCs, and lessons learned that can be used by other RHCs to develop mental health services. The interviews were conducted using semi-structured interview protocols. Calls were placed to the administrators of the clinics to determine if the RHC still offered mental health services and to identify the appropriate contact to interview about the clinic's mental health service offerings.

We experienced similar difficulty in conducting the qualitative interviews with RHC administrators as past researchers had in completing telephone and mailed surveys. It was difficult to identify an appropriate contact who could speak knowledgeably about the delivery of mental health services by an individual RHC and to schedule an appointment to interview them. With extensive telephone and e-mail follow up, we were able to complete 14 interviews (47%) with administrators or clinicians from 8 provider-based and six independent RHCs. The results are summarized below.

SUMMARY RESULTS FROM THE COST REPORT ANALYSIS

Using the 2005-2006 Medicare cost report data, we identified basic mental health staffing, cost data, and organizational control characteristics of the independent and provider-based RHCs providing mental health services. These characteristics are summarized in Table 1.

Table 1. Characteristics of RHCs Employing Mental Health Staff

	Independent RHCs		Provider-Based RHCs	
	<i>n</i>	Results / (Range) <i>n</i> = 1,117	<i>n</i>	Results / (Range) <i>n</i> = 1,349
Percentage of RHCs Providing Mental Health Services				
	68	5.8%	28	2.1%
Mental Health Staffing Patterns				
Doctoral Psychologists	28	0.4 (0.01-1.1)	7	0.4 (0.02-0.7)
Clinical Social Workers	48	0.6 (0.02-2.00)	23	0.7 (0.3-2.3)
Total Allowable Costs				
Annual Total Allowable Costs	66	\$360,307 (\$8,050-\$2,619,825)	28	\$2,787,369 (\$419,651-\$13,639,710)
Organizational Control				
Government Hospital District	0	0%	9	32%
Government-State	1	2%	0	0%
Proprietary Corporation	28	41%	2	7%
Proprietary – Other	5	7%	4	14%
Proprietary – Individual	8	12%	0	0%
Proprietary – Partnership	2	3%	0	0%
Voluntary Nonprofit- Corporation	22	32%	0	0%
Voluntary Nonprofit – Church	0	0%	3	11%
Voluntary Nonprofit – Other	1	2%	10	36%
Other	1	2%	0	0%

Source: 2005-2006 Medicare Cost Reports

Slightly less than 6% independent RHCs employed specialty mental health providers. Among the 19 states with independent RHCs providing mental health services, California (17), Illinois (9), and Missouri (16) had the greatest number of these facilities. Twenty eight employed clinical psychologists with an average staffing level of 0.4 full time equivalents (FTEs) (range 0.01-1.1 FTEs). Forty eight employed clinical social workers with an average staffing level of 0.6 FTEs (range 0.2-2.0 FTEs). The total allowable costs for the 68 clinics averaged \$360,300. For independent RHCs, the two most common types of organizational control were proprietary corporations (28) and voluntary nonprofit corporations (22) with these two types accounting for approximately 71% of the independent RHCs providing mental health services.

Slightly more than 2% of the provider-based RHCs employed specialty mental health providers. Of the eight states with provider-based RHCs providing mental health services, California (7); New Hampshire (3), Missouri (16), and Washington (4) had the greatest number. Seven employed clinical psychologists with an average staffing level of 0.4 FTEs (range 0.028-0.7 FTEs). Twenty three employed clinical social workers with an average staffing level of 0.74 FTEs (range 0.28-2.34 FTEs). For these 28 provider-based RHCs, total allowable costs averaged \$2,787,369. The most common types of ownership control for the hospitals associated with these RHCs included other types of voluntary nonprofit organizations (10) and government hospital districts (9) with these two types accounting for 68% of the hospitals with provider-based RHCs offering mental health services.

Results from Qualitative Interviews

Development of specialty mental health services

We completed interviews with staff from 14 RHCs, of which six were independent RHCs and eight were provider-based under hospital ownership. One provider-based clinic had terminated mental health services when the RHC's sole mental health provider left the practice in 2005. Of the remaining 13 facilities, 12 were able to provide data on the length of time that the clinic had offered mental health services. These 12 RHCs had been providing mental health services for an average of 8.2 years each with a range of three years at minimum to twelve years.

Why were services developed? When asked why their clinic had developed mental health services, almost all respondents identified need within the community as the driving force. One respondent noted that the need in the local service area was "huge" and beyond the capacity of the clinic to address on its own. Another noted that 75% of the RHC's patients had mental health problems. Due to local access barriers, only a small percentage of those patients were referred to specialty mental health services within the community.

Another common reason involved shortages of specialty mental health services for the general population and specific populations such as children and adolescents. One respondent noted the local service system was overwhelmed and that the RHC had developed mental health services to address the gap in local capacity. Another noted that the closure of the state hospital left a gap in

service capacity in the area and that the clinic had been approached by the school system to develop services to address the gap.

A third common reason involved needs within the clinic's patient population. One respondent said that the clinic's medical providers were spending too much time on mental health problems which reduced their overall productivity. Another suggested that the clinic's providers were concerned that too many patients were being referred out of the practice for mental health problems. A third noted that many primary care problems were rooted in behavioral health issues. Finally, two respondents described the role that opportunity played in the development of mental health services. In one situation, the clinic's founding physician recruited an available clinician after observing the clinician working with children. The second clinic took advantage of an opportunity to develop services when a mental health clinician leaving a local agency approached the clinic about working for them.

Key factors in the development of mental health services

Based on our interviews, we identified a number of key factors that either supported or hindered the development of mental health services by RHCs. This section discusses those factors and provides examples to illustrate how they impact the development of services.

The role of internal champions in supporting the development of services: One of the key factors supporting the development of mental health services was the presence of a "champion" who encouraged the development of services and/or spearheaded the effort to implement them. Among the clinics participating in our study, internal champions were often physicians or senior administrators who identified the need for mental health services and undertook the development process. These internal champions had the seniority and influence to overcome the barriers that clinics encountered in developing services. While the champion was often an internal staff person, some respondents identified other individuals who were in the position to influence the clinic's leadership and/or provide support to a clinic's efforts by linking the staff to local mental health resources or sharing expertise on mental health issues.

In one independent RHC, the internal champion was the clinic's founding physician and director who developed a plan to recruit a local licensed clinical professional counselor (LCPC) to provide services in the clinic. This physician successfully recruited the LCPC and oversaw the

more than six month process of securing required certifications and credentials to offer services and approvals to bill Medicaid, and commercial insurance companies. Despite the efforts of this key champion, the respondent stated that it would have been helpful to have had access to someone with greater mental health experience to assist in the development process and to overcome the long delays in obtaining certifications, credentials, and billing approval.

In a second independent clinic, representatives from the local school system approached the leadership of the clinic to encourage them to develop mental health services to address gaps in the service system following the closure of the state hospital. The decision to move forward was reinforced by the availability of grant funding from the county to support the provision of services to uninsured individuals and families.

In a third independent clinic, the clinic's founder, a nurse practitioner, had a strong interest in providing mental health services and spearheaded the development of services to address local community needs and the needs of her existing patient population. In developing the service, she sought and received a state specialty mental health clinic license for her clinic; certification for its memory clinic from the state Alzheimer's program; and approval to bill the state alcohol and drug agency for the clinic's drug and alcohol services. As an aside, she noted that these licenses and certifications provide access to better reimbursement but also add greater administrative costs and complexity.

In one provider-based RHC, the respondent explained that the "chief of the clinic" made the decision to develop mental health services. Once the decision to commit resources to the development process was made, developing the service, according to the respondent, was not difficult. The clinic benefited from the help of an outreach community mental health worker (i.e., an external champion) who had a satellite office within the clinic's building. The outreach worker provided a link that enabled the clinic staff to work collaboratively with local community mental health agencies and encouraged them to focus on development of short term therapy and crisis intervention services rather than long term therapy services.

A respondent from another provider-based clinic explained that mental health services had been developed at the urging of its administrator who, for several years, had advocated for the

development of services. This individual oversaw the process of implementing the service. The respondent noted that the clinic received no technical assistance or support to do so.

Factors hindering the development of services

Although these champions were important resources in the development of mental health services and facilitated the development and implementation processes, the clinics still encountered common barriers that needed to be overcome. These barriers include recruitment difficulties, reimbursement and funding challenges, and administrative complexity.

Recruitment difficulties as a barrier to the development of services: A commonly mentioned barrier to the development of mental health services was the difficulty experienced by RHCs in recruiting appropriately licensed mental health staff. Respondents noted that recruiting providers with the credentials to satisfy the requirements of third party payers is difficult in rural communities with few clinical social workers, psychologists, psychiatrists, or other licensed clinicians. Respondents further noted that some insurers have set standards that allow the delivery of services only by specific types of providers further complicating the delivery of services. Even if clinics are successful in recruiting appropriate mental health staff, their challenges are not over as respondents explained that retaining professional staff is difficult given the challenges of practicing in rural communities including professional isolation, inability to specialize, and difficulties in maintaining professional boundaries.

Reimbursement challenges as a barrier to the development of services: Another commonly identified barrier to the development of services was the poor fee for service reimbursement rates paid by Medicaid and commercial insurers for mental health services. This problem is exacerbated by Medicare and commercial insurance policies that shift a higher percentage of the costs of mental health care to patients through high deductibles and co-payment. These cost shifting policies discourage the utilization of services. Related issues included high no-show rates among mental health clients and high rates of uninsurance among rural residents, both of which hinder the ability of RHCs to develop self-sustaining mental health programs.

Administrative complexity as a barrier to the development of services: A final barrier identified by respondents involved the administrative demands and costs borne by clinics due to varying and inconsistent reimbursement and credentialing policies established across third party payers;

growing use of managed care contracts and policies to control utilization costs (e.g., prior authorization programs and restricted provider panels); and complex state licensure laws. Respondents noted that dealing with these administrative demands imposed additional costs on the clinics and increased the staff workload. One respondent stated that her clinic added an additional 0.5 FTE staff person solely to obtain prior authorizations from third party payers before services could be rendered.

Mental Health Service Viability and Non-Financial Benefits

In addition to the barriers to the development of mental health services, we were interested in identifying the barriers to the ongoing viability and operation of these services. Given concerns identified in previous studies about the viability and profitability of mental health services in primary care settings, we sought to explore the extent to which RHC mental health services RHCs were viable and profitable. We also sought to identify any non-financial benefits realized by RHCs operating these services.

Five (38%) respondents stated that their mental health services were not profitable; four (31%) stated that their services were profitable, three (23%) were unsure if they were profitable but thought that they might be, and one (8%) did not know if the services were profitable or not. Among the challenges to profitability and continued viability of mental health services identified by the participants in this study were low reimbursement rates, high administrative complexity, high rates of uninsurance among the patient populations serviced, and ongoing difficulties with recruitment and retention. The non-financial benefits of mental health services included improved primary care provider productivity, better care for existing clients, and the ability to address an important community need.

In the absence of detailed financial and productivity information on the services that were identified as not profitable by respondents, it is difficult to draw specific conclusions as to why they are not profitable or what might be done to increase their profitability. The respondents provided some explanation for the lack of profitability of their services as identified below in the discussions on the barriers to the profitability and viability of RHC mental health services.

Barriers

Barriers to the profitability of services

Among the five clinics with mental health services were identified as not profitable, the most common reasons cited by respondents for their lack of profitability included poor reimbursement rates, high numbers of uninsured patients that are unable to pay for their care, and lack of adequate coverage of mental health benefits by some carriers. One respondent noted that reimbursement rates do not cover all costs of services and that high co-payment and deductibles (Medicare and commercial carriers) are hard to collect. A second stated that ongoing cost-based reimbursement is critical for the continued viability of mental health services in RHCs. Another stated that the arrangement her clinic had with contracted providers required the majority of fees collected to be paid to the providers leaving little money left to cover the administrative and clinic costs of providing the service.

When asked why their clinics provided these services, despite the lack of profitability, most identified high levels of need for mental health services in their communities and patient populations. One respondent stated that the clinic had considered terminating mental health services but did not do so due to community needs. Others suggested similar reasons for developing and maintaining mental health services and noted that the service would not be available in the community if they did not offer it. One respondent stated that clinic leadership did not view mental health services as a profit center but rather a service to patients.

Barriers to continued viability of mental health services

We asked respondents to identify challenges and barriers to the continued viability of mental health services. Some challenges were commonly identified across clinics while others were unique to specific clinics. In general, the barriers to the continued viability of mental health services were very similar to the barriers to developing those services. The following are the challenges to continued viability commonly identified by respondents:

- Low reimbursement rates;
- Recruitment and retention difficulties for specialty mental health clinicians as the loss of a key provider could limit the ability of the clinic to continue services;

- Administrative difficulties related to participating in both fee-for-services and managed care plans including issues related to billing and collection, provider credentialing, cost reporting, and the need to obtain prior authorizations before initiating services;
- High no-show rates among mental health patients which compromise provider productivity;
- Case and payer mixes that are dependent on a limited number of better-paying third party payers; and
- Growing use of managed care plans to manage mental health benefits including Medicare Advantage plans.

As mentioned above, a few of the challenges related to ongoing viability were specific to individual clinics. One respondent was concerned about the retirement of a county-level advocate who has championed the clinic's funding to serve non-Medicaid eligible children and families as it might compromise the continuation of this funding. Another noted that the Medicaid program in her state limited adults to 14 visits per year. Those needing more frequent care were essentially uninsured after reaching their 14 visit cap. One respondent identified a number of barriers to the ongoing viability of services provided by her clinic including the loss of grant funding used to establish the service, poor coverage for substance abuse services and memory clinics provided by her clinic, and the difficulty in serving Alzheimer's patients as Medicare and other payers are reluctant to pay for mental health services for Alzheimer's patients even though services are needed and appropriate.

While the barriers to viability cited above by respondents offer some insight into possible reasons for lack of profitability, the only definitive way to indentify the issues related to lack of profitability of the mental health services of these five clinics would be to conduct a thorough service/practice audit to examine the cost structures of the services; provider productivity (e.g., the number and procedure codes of the services provided by the mental health clinicians during their normal work schedules compared to the amount of time spent in non-billable activities such as meetings, "hallway consults", charting, etc.); payer mix; the codes submitted to third party payers for services; payment and collection experience by payer source including payment rates

and reasons for non-payment; the adequacy of the clinic's billing and administrative practices (including compliance with care management requires such as obtaining necessary prior-approval and re-authorization of services, billing and diagnostic coding accuracy and timeliness of the billing process); and a comparison of medical records and billing records to assess the appropriateness of the codes submitted and the clinician's practice patterns. Such an analysis is beyond the scope of this study.

Non-financial benefits to providing mental health services

Respondents identified a wide range of non-financial benefits of offering mental health services. Chief among them was the belief that patients receive better care due to the co-location of services and providers are better able to track concurrent physical and mental health progress. Some noted that the service was more convenient for patients who no longer had to travel long distances to obtain care. Others noted improved coordination between primary care and mental health providers, reductions in the frequency of primary care office visits for patients with mental health issues (thereby improving access to the primary care services), reduced requests for appointments due to unresolved mental health issues, improvements in primary care provider productivity, and improvements in overall patient health, particularly for patients with co-morbid conditions.

Mental Health Staffing Patterns and Employment Arrangements

Ten clinics reported changes in their staffing patterns since the filing of the cost reports used to identify those employing specialty mental health staff. Through our interviews, we were able to obtain more detailed information on the individual staffing and employment patterns of these 13 clinics than we could through analysis of the costs reports. Eleven clinics employed multiple clinicians to provide a more comprehensive array of services. The staffing patterns of the clinics that participated in the qualitative interviews are summarized in Appendix A.

Five clinics employed *doctoral level psychologists* to provide services with staffing levels that ranged from 0.10 to one FTE psychologist. One clinic employed a child psychologist to provide consultative support to its primary care providers who serve a large number of pediatric patients.

Seven clinics employed *clinical social workers* with staffing levels that ranged from 0.25 to 5 FTEs. Five clinics employed multiple social workers. One clinic contracted with 10 social

workers (estimated at 5.0 FTE positions) and another employed five social workers for a total of four FTE positions.

Eight clinics retained the services of one or more *psychiatrists* to provide services. These psychiatrists were typically employed on a more limited basis than other mental health professionals to provide consultative support to the mental health and primary care providers as well as to treat more complex patients. Five clinics retained the psychiatrists on a one to two day per month basis or as needed basis based on practice demand. Two clinics contracted with an additional psychiatrist (a child psychiatrist in one clinic and a geriatric psychiatrist in another) on a one-day-per-month basis which reflected the needs of their patient populations. The remaining three clinics had staffing levels that ranged from 0.4 to 0.8 FTE.

Three clinics employed *psychiatric nurse practitioners* with staffing levels that ranged from 0.20 (one day per week) to one FTE. Six clinics employed a variety of other types of professional counselors and mental health staff based on the needs of their patients and practices. One employed a 0.20 FTE *pediatrician* and a 0.20 FTE *nurse* to provide disability services. Another employed a 0.20 FTE *licensed clinical professional counselor*. Two clinics employed *licensed marriage and family therapists* (one FTE in one clinic and a 0.20 FTE in the other). The fifth clinic employed one FTE *drug and alcohol counselor*. The sixth clinic employed one FTE *non-licensed social worker* to provide case management services and support the psychologist employed by the clinic. It should be noted that some of these clinicians are not directly reimbursable by the Medicare program but may be reimbursable under Medicare's "incident to" rules that allow for certain services provided under the direct personal supervision of a physician or other Part B-approved "independent practitioner," to be billed as part of the supervising provider's bill (CMS 2009, National Health Policy Forum 2007). They may also be reimbursed by state Medicaid programs or commercial payers.

Employment Arrangements

The study clinics typically engaged mental health clinicians as independent contractors or as employees, often using both methods within the same practice for different types of providers.⁶

⁶ Although we completed interviews with respondents from 14 clinics, one had terminated services in 2005 and did not provide information on employment arrangements, mental health staffing patterns, etc. These sections are based on information provided by the remaining 13 RHCs that continue to provide mental health services.

The methods used to compensate clinicians also varied within and across clinic settings. Independent contractor agreements were used by eight clinics, primarily to compensate the psychiatrists and/or psychologists retained on a part-time basis, although a limited number used them to retain all specialty mental health clinicians practicing in their settings. Independent contractor status limits the obligation of the clinic to provide health insurance, vacation, and other benefits. In terms of compensation of independent contractors, the clinics varied in the extent to which they shared risk with the contractors. Two clinics paid the independent contractors an hourly rate, regardless of whether the clinic was paid for the services rendered. Two others paid the contractor a set fee for each client encounter, regardless of whether the clinic was paid for the services. One also paid the clinician a per-person rate for clients seen in group settings in the local school program. One clinic paid the clinicians a “commission” based on the percentage of fees generated by the clinician. Another paid the psychiatrist a percentage of billings and the social worker a percentage of collections. The last clinic paid the psychiatrist a percentage of revenues with the remaining clinicians paid on an encounter basis.

Seven clinics retained at least some of their mental health clinicians as employees. Three paid a flat salary to the psychiatrist and therapist employed by the clinic. One described the possibility of establishing a productivity-based compensation system for a full-time therapist once the therapist established a consistent patient load. Two clinics paid an hourly wage to their employed clinicians. One paid an hourly rate to the psychologists and nurse practitioner employed by the clinic. In addition, the clinic had established a bonus program for the nurse practitioner based on productivity. Two respondents noted that they offered full benefits to the mental health clinicians including vacation time and health insurance and explained that the provision of benefits made it easier to recruit and retain providers. One clinic also provided housing to a psychologist as part of its compensation package.

Access to and Availability of Mental Health Services Offered by RHCs

In previous work with integrated clinics, some reported that they limited access to mental health services to patients that were currently enrolled with their clinics (Gale & Lambert, 2008). Given the general shortage of mental health services in many communities, these restrictions are implemented to manage the utilization of mental health services to ensure that the clinics can provide access for their existing patients. This did not appear to be an issue for our study RHCs

as 10 of the 13 clinics reported that mental health services were open to all residents of the community, regardless of whether or not they were currently enrolled as a patient of the clinic. Three reported limiting access to existing patients and noted that demand from their current patients was such that they could not accommodate additional clients. Referrals from outside the practice typically came from other primary care providers, mental health agencies, schools, and private and government state social service agencies.

Of the 10 clinics that accept referrals from outside their patient populations, all accepted new referrals at the time of our interviews. One respondent noted that the clinic maintained a waiting list if there are no immediate openings available at the time of the referral. Another noted that the clinic had closed the service for three months due to limited provider capacity but that it had been recently re-opened to new patients. The remaining three clinics currently providing services are not accepting new referrals from outside the practice population as described above. One reported that the provider list is closed at the moment as the providers have no additional capacity. The respondent reported that this happens several times per year for one to two months based on the mental health clinicians' workloads.

In an effort to understand how clinics identified patients in need of mental health services, we asked whether or not they screened all primary care patients for mental health issues. Six respondents reported that their providers screened all patients as part of their ongoing care. Another respondent noted her clinic's providers focused on patients with chronic diseases. Yet another noted that her clinic's providers focused on older adults with memory problems and individuals with depression. Six clinics did not routinely screen all patients and one respondent could not answer the question. The level of assessment described by respondents varied from relatively informal to the use of specific tools and assessment procedures. A few respondents stated that their providers do not conduct formal screenings but rather rely on the primary care providers to identify symptoms or signs of depression and/or other mental health issues. They will do a more in-depth assessment if the patient mentions symptoms of depression or other problems. One respondent noted that the primary care providers in her clinic specifically look for symptoms or behaviors indicative of depression. Another respondent described a process in which the primary care provider completes a referral form describing the patient's symptoms and

issues that lead to the referral. The referral form is evaluated by the clinic's psychiatrist who determines, based on the information provided, whether the patient needs to be seen.

Among those that do more formal screenings, one respondent described the use of a standard psycho-social assessment process by the clinic's primary care providers. Another stated that the primary care providers in her clinic use screening tools recommended by the state and the psychological association but did not know which tools they used. Two respondents stated that providers in their clinics screen for mental health problems using forms and tools built into their electronic medical records. One of the two noted that the primary care providers use an autism screening tool built into their electronic health record consistently but that the use of the other screening tools varied across providers. Another respondent stated that her providers conduct a mini-mental status screening for all patients including the use of a depression questionnaire. Another respondent stated that her primary care providers use tools provided by their mental health clinicians. One respondent said that her clinic screens all patients and was preparing to offer public screenings but could not identify the screening tool(s) used. Another explained that her clinicians use the PHQ-9 to screen patients.⁷ One respondent said that her clinic used a variety of screening tools based on patient needs including the Beck's Depression Scale, a life history questionnaire, the Hamilton Inventory, an attention deficit, hyperactivity disorder screening tool, and a diagnostic memory test for Alzheimer's patients.

Of those that did not screen all patients, we asked if they screened particular types of patients. Three did not as they relied on primary care providers to identify symptoms or indicators of mental illness during routine patient encounters. The remaining three made an effort to screen patients with specific problems and conditions. One focused on patients suspected to be suffering from depression or substance abuse or who had been diagnosed with chronic illness. Another focused on older adults with memory problems or adults with depression. The third screened patients if, in the opinion of providers, the patient suffered from symptoms of mental illness or

⁷ The PHQ-9 is the standardized nine item depression scale component of the Patient Health Questionnaire developed under a grant from Pfizer, Inc. (MacArthur Initiative on Depression and Primary Care, 2009). The two components of the PHQ-9 allow clinicians to assess a patient's symptoms and functional impairment to make a tentative depression diagnosis, and derive a severity score to help select and monitor treatment. The PHQ-9 is based on the diagnostic criteria for major depressive disorder as described in the Diagnostic and Statistical Manual Fourth Edition.

were participating in the clinic's new weight loss program. Participants in the weight loss program are asked to complete a Personality Assessment Inventory. One of the three suggested the need for shorter assessment tools for routine primary care patients.

Initiating Mental Treatment within the RHC

We asked respondents to describe the process by which mental health services were initiated once the need was identified by the primary care providers. We also asked them to describe the length of time required to schedule an initial appointment as well as subsequent follow-up appointments.

In general, respondents described similar processes used to initiate treatment within their clinics. In most clinics, the primary care provider initiated treatment through a written or telephone referral to the mental health clinician or directed the patient to stop at the front desk to schedule an appointment. In one RHC, a psychiatrist who works with the clinic evaluated the referral request form to determine if an appointment is required before it is scheduled. In another, the primary care provider attached a notice to the electronic health records to alert the social worker to contact the patient to schedule an appointment. In all but three clinics, the responsibility for following up with the referral for mental health services were placed on the shoulders of the patient. Patients rarely meet the mental health clinicians prior to the initiation of treatment. The lack of a same-day handoff from the primary care staff to the mental health clinicians may reduce the likelihood that patients will schedule an appointment for mental health treatment.

The exception was an RHC that used an integrated model that emphasized a "warm handoff" from the primary care providers to the mental health staff. If the patient agrees to services, the primary care provider introduced the patient to the psychiatrist or mental health clinician who immediately scheduled a 10-15 minute appointment that takes place before the patient leaves the clinic. The term "warm hand-off" describes a process by which the primary care provider directly introduces the patient to the mental health clinician at the time of the individual's medical visit. The goal is to establish an initial, personal contact between the patient and the mental health clinician. This face-to-face introduction is believed to increase the likelihood that a patient will enter into and engage in treatment by conferring the trust and rapport developed between the patient and primary care provider to the mental health clinician (Integrated

Behavioral Health Project, n.d.). In the remaining two clinics, this warm hand-off only took place when the patient's symptoms were (in the judgment of the primary care provider) severe enough to require more immediate attention. In these situations, the primary care provider walked the patient to the social workers office for a brief consult. An appointment for follow-up care is scheduled by the clinician at the time of the consult. One respondent noted that the follow up appointment is generally scheduled within 48 hours.

The majority of respondents reported that scheduling an appointment to see their mental health providers was straightforward and that an initial patient appointment could be scheduled within seven to ten days depending on level of patient need. For more urgent problems, as determined by the primary care provider in consultation with the mental health clinician, initial patient appointments could be scheduled more quickly. Respondents from two clinics described slightly longer times of one to three weeks before an initial appointment could be scheduled. One respondent noted that the time to see the psychiatrist associated with the clinic was based on demand and could take up to several months. Follow up appointments for existing mental health service patients were not a problem as most respondents stated that follow up appointments could be scheduled with little delay, typically less than one week.

Age Groups Served: Of the 13 study clinics still providing mental health services, 85% treated children 12 years of age and younger. All treated adolescents ranging in age from 13 to 19, adults age 20 to 64, and older adults age 65 and above. Although one respondent stated that her mental health service accepted and treated older adults, she noted that few older adults used the service.

Most Common Mental Health Diagnoses Treated by RHCs

Among the study clinics, the most common mental health diagnoses included depression (13), attention deficit hyperactivity/attention deficit disorders (10), and anxiety disorders (9). Some respondents reported additional diagnoses as they could not distinguish which problems were most common. These additional diagnoses included substance abuse (4), bipolar disorders (4), post traumatic stress (2), obsessive compulsive disorders (1), adjustment disorders (1), and schizophrenia (1).

Access to Services for Patients Needing Greater Levels of Care

Past studies suggest that difficulty in referring complex patients to specialized mental health services may be a barrier to the development of services as primary care providers are concerned that they may be unable to refer complex or unstable patients in a timely fashion. Our interviews suggest this was a problem for some but not all RHCs. Five respondents (38%) stated they had difficulty referring patients to specialty mental health services and identified inpatient, intensive outpatient, and general and child psychiatric services as the most common referral challenges. Although the remaining eight clinics that reported that they did not have difficulty making referrals to more specialized services, they acknowledged that, in some cases, patients experienced long wait times and/or travel distances (up to 1-1/2 hours) to access specialty services.

For clinics with difficulties referring patients to more intensive services, the difficulties varied by the type of service needed and the complexity of the patient's needs. Inpatient psychiatric services were an issue for all five clinics. One respondent said that gaining admission to an inpatient psychiatric unit sometimes required a court order and that the process of arranging an admission was difficult and diagnosis dependent. Another respondent described the following issues that complicated the referral of patients: a general lack of psychiatrists; long travel distances to the nearest major medical center; transportation difficulties; and a lack of services available to patients without payment sources. Another respondent noted difficulties in referring patients to the county mental health system as that system focused primarily on complicated patients including "chronic schizophrenics and unstable bi-polar patients". One stated that the nearest inpatient services were located over an hour away.

Respondents also described problems referring patients to the following services:

- Outpatient (beyond those provided by the clinicians at the RHC) and intensive outpatient mental health services due to long waiting lists (a four to eight week wait in one case) or long travel distances of an hour or more;
- Residential treatment services (identified by three respondents);
- General psychiatric services (with wait times of between one to four months);

- Child psychiatric services (with long travel distance and waiting lists of several months or more); and
- Detoxification, inpatient and outpatient due to travel distance or long wait times.

Two clinics described difficulties referring to services based on the patient's health insurance coverage. One respondent said that it was hard to find providers that will accept commercial insurance patients as, at least in her state, community mental health agencies favor Medicaid clients as the state Medicaid agency has established payment rates for licensed mental health facilities that exceed the rates paid by commercial insurers. She described the community health agency in a nearby town as having a "huge" waiting list for commercially insured patients due to the Medicaid payment policies in her state. The second respondent noted that the local hospital provided mental health services but stated that it primarily treated Medicare beneficiaries. As a result, it is difficult for patients with other payments sources to access care.

When faced with patients that could not access more intensive services in a timely fashion, one respondent stated that she referred patients in crisis to the local emergency room. Another explained that clinic staff, when faced with difficulties referring patients or long waiting time for more intensive services, responded by seeing those patients more intensively until the needed services could be initiated.

Reimbursement Issues

Past studies of identified low reimbursement rates, administrative difficulties related to enrolling providers with third party payers, and billing and coding difficulties as barriers to the development of mental health services (Gale & Lambert, 2008). We explored this issue in our interviews with respondents from the participating RHCs.

Medicare Reimbursement Issues

Of the study clinics, six reported Medicare reimbursement issues. Two respondents noted problems with collecting the high co-payments associated with the Medicare program. As noted by one respondent, the current co-payment for mental health services under Medicare, given the 62.5% outpatient payment limitation discussed earlier, is 50% of the approved charges. One respondent explained that Medicare would not pay for the type of therapist that his clinic

employed (Medicare will only reimburse for the services of doctoral-level psychologists or licensed clinical social workers). We observed that some respondents held confusing and, in some cases, erroneous opinions regarding Medicare reimbursement practices. For example, one respondent [incorrectly] stated that Medicare seemed to pay either \$7.00 or \$17.00 per mental health encounter and that the amount paid seemed to be unrelated to the codes submitted. Another offered the [unsubstantiated] opinion that Medicare reimbursement was lower than other payers that reimbursed her clinic for mental health services.

Medicaid Reimbursement Issues

Although nine clinics described problems with reimbursement under their states' Medicaid program, caution should be used in drawing conclusions from individual state-level experiences. Although there are general issues with Medicaid reimbursement reported by many of the nine clinics including low reimbursement rates and administrative difficulties dealing with the state Medicaid programs, variations in Medicaid regulations, payment methodologies, and coverage policies across the states can create barriers to the development of services in some states that may not exist in others. When viewed across all nine states, some of the identified barriers to the development of mental health services may, on first review, appear to be inconsistent. This is not necessarily the case. Individual state-level barriers to the development of services must be viewed and understood within the context of individual state Medicaid programs.

One common barrier is the administrative difficulties reported by respondents in dealing with their states' Medicaid Programs. One respondent described the coding process as difficult and noted that the first mental health encounter had to be billed as an evaluation. She also noted that the reimbursement process was difficult and almost always required multiple corrections and re-submissions. Another respondent focused on issues with the Medicaid managed care plan in her state. She explained that the process to credential a provider was difficult and can take three to six weeks for approval. In addition, she noted that most services required prior authorization before they can be provided.

Inadequate Medicaid reimbursement for mental health care was another commonly identified barrier. As an example of the variation in Medicaid reimbursement policies across states, one respondent described Medicaid reimbursement in her own state as "adequate" and the Medicaid

reimbursement in an adjoining state, where a large part of her clinic's patient population lives, as inadequate. Another respondent explained that her state's Medicaid program did not pay well for office visits. Yet another noted that her state's Medicaid program limited adults to 14 encounters per year for all health needs which is inadequate for mental health patients that may need to be seen more frequently. One last respondent stated that Medicaid in her state paid less well than other payers and required an extraordinary amount of paper work including very detailed treatment plans. She estimated the additional paper work burden for her state's Medicaid program to be five times greater than other payers.

Commercial Payer Reimbursement Issues

Eight respondents identified reimbursement problems with commercial payers. Two described commercial reimbursement rates as low. One noted that patients were required to make their own referrals by contacting their insurer to obtain prior authorization before an appointment could be scheduled. Another noted that high deductibles associated with commercial insurance plans were difficult to collect from low income patients. Two respondents reported difficulties with getting their providers through the commercial insurers' credentialing processes. The last respondent explained that some commercial insurers did not cover mental health services unless delivered by a provider enrolled in the insurer's network panel. None of the clinics belonged to any commercial insurers' network panels.

Involvement with Managed Behavioral Health Plans

We explored the extent to which RHCs participated in managed care programs implemented by third party payers to manage mental health benefits. Two clinics reported that Medicare Advantage plans operated in their areas, seven reported that their states' Medicaid programs used managed care organizations to manage mental health services, and two reported the use of managed care programs by commercial payers. All clinics participated in the managed care programs operating in their areas.

The respondents identified difficulties working with managed care programs including low reimbursement rates and an increased administrative burden due to paperwork and the prior authorization process. One respondent described working with the Medicaid managed care vendor as a "very burdensome" process. Another explained that the county board responsible for

approving services is understaffed and, as a result, experienced difficulty making the initial contact to obtain approval to initiate services. One respondent described a situation in which the managed care vendor would pay for the diagnosis of attention deficit/hyperactivity disorder but would not pay for any follow up treatment.

One respondent noted that reimbursement rates for commercial managed care plans were too low. Another described the prior authorization process as a challenge as any course of treatment involving more than three visits must be approved in advance. The insurer contracted the prior authorization process out to a managed care organization which increased the administrative burden. One respondent has enrolled the clinic's providers in the local Medicare Advantage plan but has yet to see any clients covered by that program.

Private/Self-Pay Issues

Given the high rates of uninsurance, underinsurance, and seasonal coverage experienced by rural residents, RHCs experience higher numbers of patients paying for services out-of-pocket. While not all private/self-pay patients are low income, the burden of paying for mental health care out-of-pocket can be substantial, particularly for those whose conditions require regular appointments. Eight clinics described issues with obtaining payment from private and self-pay patients. One respondent noted that self-pay patients had "high rates of non-payment". Two described the problems faced by this population in paying for mental health services even with sliding fee scales. Another explained that mental health clients were not eligible for the clinic's sliding fee scale due to requirements established by the clinic's contracting mental health providers. Two respondents explained that their clinics offered sliding fee scales to all qualifying private/self-pay patients and stated that they had little difficulty in obtaining payment from these patients. Another respondent noted that her clinic has committed to seeing existing patients that lose their medical coverage.

Charity and Discounted Care Policies

All 13 clinics have a formal or informal policy governing the provision of charity and/or discounted care to their patients. Eleven (85%) included mental health services under their charity and discounted care policies. Of the two that did not, one explained that the decision to exclude mental health services was based on the contractual relationship with their mental health

providers. The second clinic provided up to a 50% discount on the services of the nurse practitioner but does not discount the services of the therapist.

Three respondents described the use of informal policies to qualify patients for charity care with reviews conducted by the administrative or clinical staff. The remaining eight clinics used sliding fee scales to determine eligibility. Five clinics based their sliding fee scale on Federal Poverty (FPL) Guidelines. One required applicants to apply for Medicaid coverage before charity care is made available. If denied, patients are eligible for a sliding fee scale with free services for those with incomes under 200% of FPL based on family size. For those that do not qualify for free care, discounts ranging from 25% to 100% are available based on income and family size. Any balance due from the patient must be paid at the time of service. Another clinic provided free (e.g., charity) care to individuals earning less than 200% of FPL with discounts available to those earning between 200 to 300% of FPL. Another clinic based its sliding fee scale on the state's Breast and Cervical Cancer Program income guidelines. One clinic's sliding fee scale required proof of income and extensive personal disclosure during the application process. In the words of the respondent, the process "tends to discourage individuals from applying".

Quality Management

Respondents were asked to describe the process used to manage the quality of mental health services and to supervise individuals involved in the delivery of those services. Past studies have identified difficulties in obtaining appropriate supervision for mental health clinicians as a barrier to the development of services (Gale & Lambert, 2008). Respondents identified three primary approaches to quality management as described below.

Use of a psychiatrist to provide supervision and quality oversight

Three clinics used psychiatrists to provide quality management for mental health services and/or supervise the clinical staff. In one clinic, responsibility was shared between the staff psychiatrist and the medical director who jointly managed quality and supervised the licensed clinical social worker (LCSW). Both individuals met weekly with the LCSW to discuss cases. In the second, the clinic contracted with a community mental health agency psychiatrist to supervise its licensed clinical social worker. Overall quality improvement and management activities were directed by a primary care provider who served as the head of clinical services. In the third, a

psychiatrist supervised the nurse practitioner and counselor. The Chief Executive Officer of the Clinic oversaw quality management activities.

Use of a Non-psychiatric physician to provide supervision and quality oversight

Three clinics used primary care physicians to supervise the mental health clinicians and provide quality oversight. In one clinic, the primary care physician and the part-time (0.20 FTE) licensed clinical professional counselor (LCPC) worked closely together on shared cases with progress for each patient client tracked by the physician and LCPC. If the patient does not make progress, the providers review the case and agree to refer the case to another provider. In another, the clinic's physician supervised the mental health clinician although she (the mental health clinician) was technically exempted from such supervision based on her licensure. The clinic also conducted monthly quality improvement meetings for case review and trouble shooting. The third clinic did not have a formal quality improvement program. The two physician founders of the clinic supervised the mental health staff and conducted periodic meetings with the staff to discuss quality matters and other issues.

Use of a non-physician staff to provide supervision and quality oversight

In the remaining clinics, a variety of quality and supervisory management programs were employed, typically involving clinic staff and/or outside contractors. In one Joint Commission accredited clinic, the mental health services coordinator supervised the mental health contractors. The mental health coordinator was supervised by the medical director for administrative services only. In another clinic, the owner, a masters-level clinical nurse specialist, collaborated with the part-time medical director (18 hours per week) and two staff nurse practitioners to supervise the clinic's two LCSW contractors. In a third clinic, the Vice President, one of the clinic's primary care providers, was responsible for providing supervision and overseeing quality improvement activities. Once a year, an outside psychiatrist conducted an overview of the service and completed an independent chart review. The quality improvement committee met once a month to review records. A fourth clinic employed quality assurance staff and contracted with an LCSW who is not part of the staff, to conduct a peer review of records on a quarterly basis. The clinic director oversaw the process and reviewed the results of the reviews.

As mentioned earlier in this report, one clinic operated as a licensed mental health agency in addition to operating as an RHC. The state mental health agency licensing regulations established specific quality management and assurance activities that must be undertaken by all licensed mental health agencies. The clinic's quality management activities for mental health services adhered to these regulations and included the development and maintenance of an internal policy manual clearly describing all clinical policies and procedures and the establishment of an internal quality management process involving the agency's mental health staff. As a licensed mental health agency, it was periodically inspected and surveyed by the state's licensing agency.

Administrative and Clinical Characteristics of RHC Mental Health Services

Our final questions focused on the clinical and administrative characteristics of the mental health services offered by the study clinics. We examined the physical location of mental health services (e.g., within the same building as primary care services or in a separate location); the handling of medical records (e.g., separate or consolidated primary care and mental health records kept electronically or in paper format); and the coordination of mental health and primary care services through the development of integrated clinical teams, participation in formal provider and clinical meetings, and use of shared scheduling and administrative systems. The results of our interviews are summarized in Appendix B. Although not part of our initial research questions, we used this information to explore the extent to which mental health were integrated clinically and administratively into the overall operations of the clinics as recommended by the Institute of Medicine in its report on *Improving the Quality of Health Care for Mental and Substance-Use Conditions* (2006).

Physical location of services

Co-location of services is presumed to improve the delivery of services by allowing easier communication and interaction between the clinical staff from both disciplines (Gulmans, et al., 2007; Craven & Bland, 2006; Doherty, McDaniel, & Baird, 1996; Minnesota Department of Human Services, 2006; Shim, 2009; Institute of Medicine, 2006). In 10 clinics (77%), mental health services were co-located in the same facility as primary care services. Three (23%) were located in the separate building on the clinical campus. One of these three was soon to be moving to a new building that would house both services.

Medical records

The use of a consolidated medical record in which clinicians have access to all services provided to a patient is presumed to enhance the coordination and quality of care by allowing appropriate clinical team members access to the patient's full medical history at the time of the encounter (Alfano, 2004; Alfano, 2005; Doherty, McDaniel, & Baird, 1996; Minnesota Department of Human Services, 2006; Shim, 2009; Institute of Medicine, 2006). Eight clinics (62%) maintained medical records in which primary care and mental health information were recorded in two separate records. Seven of these eight clinics maintained their medical records in paper format and one used separate electronic health records for primary care and mental health services. Five clinics maintained integrated records containing progress notes and data for primary care and mental health services. Three maintained their records in paper format while two used an electronic format.

Coordination of services

Coordination of services is presumed to enhance quality of care by developing collaborative treatment teams, allowing clinicians to develop good working relationships; enhancing overall formal and informal communication; and sharing scheduling and administrative support systems (Institute of Medicine, 2006; Craven & Bland, 2006; Doherty, McDaniel, & Baird, 2006; Alfano, 2005; Gulmans, et al., 2007). All but two respondents described good working relationships between their primary care and mental health providers with collaborative work styles and good communication. One respondent described additional efforts to coordinate services through development of collaborative treatment protocols for patients with chronic medical conditions. Another described development of niche programs including a pain clinic, ADHD/ADD clinic, and a weight management program. Four clinics (31%) held regular monthly collaborative meetings of providers and staff to discuss clinical and administrative issues and conduct peer or joint case reviews. One (8%) held occasional but not regular case reviews. Three clinics (23%) did not hold regular meetings of the clinical staff and five (38%) did not respond to the question. Eight (62%) operated under a shared scheduling system. Seven clinics (54%) shared administrative systems and support while one did not.⁸ Two noted that the services did not share

⁸ Five respondents did not describe either their scheduling or administrative support systems

intake forms. One did not share demographic information due to concerns about confidentiality. In both cases, patients are required to complete separate intake and history forms.

Clinical and administrative integration of mental health and primary care services in RHCs

Based on our analysis of the clinical and administrative characteristics of mental health services offered by RHCs (e.g., physical location of services, types of medical records, coordination of services, scheduling and administrative support systems, coordination of services, and formal meetings/interactions between clinicians), it is clear that the majority of the study clinics have achieved a level of integration that can be best described as “basic collaboration on-site” in that they are co-located (or located in adjoining space on the same campus), share some scheduling and administrative support services, and, participate in formal and/or informal clinical team meetings, peer review activities, and joint case reviews. Some are arrayed on the lower end of this category while others show greater evidence of integration. These findings suggest that opportunities exist for all study clinics to improve their level of integration.

DISCUSSION

Despite amendments to the Rural Health Clinic Program that added the services of doctoral level psychologists and clinical social workers to the list of core services eligible for cost-based reimbursement under Medicare and cost-based prospective payment under Medicaid, the number of RHCs offering specialty mental health services has not grown substantially in recent years. This suggests that the barriers to the development of these services by RHCs are more than financial and, as a result, may be more difficult to address.

In exploring the barriers to the development of mental health services, we found that the respondents identified many, if not all, of the barriers described earlier in this paper. The commonly identified barriers identified by the respondents in this study included:

- Chronic shortages of specialty mental health professionals and provider distribution patterns that favor urban areas creating recruitment and retention difficulties;
- A complex and inconsistent regulatory, licensing, and reimbursement environment that adds to the administrative burden of clinic administrators, clinicians, and staff;

- Poor reimbursement rates;
- Reimbursement policies that shift greater financial responsibility for the costs (e.g., co-pays and deductibles) of services to patients and limit the types of providers that can be reimbursed for the delivery of services;
- Dealing with multiple third party payers that each have their own credentialing and reimbursement policies;
- Extensive use of managed behavioral health care strategies to control utilization such as prior authorization processes and limitations on provider panels; and
- Limited resources to assist administrators and staff in developing services and improving the level of integration within their clinics.

These barriers to the development of mental health services identified by study respondents are consistent with those identified by other types of primary care practices. Given the benefits of Medicare and Medicaid cost-based reimbursement for mental health services provided by RHCs, we must ask why more RHCs have not elected to provide these critical services. Based on our past work on the development of integrated mental health services as well as our previous studies of RHCs, we offer three potential reasons for the relatively limited development of mental health services by RHCs.

The first involves the nature of the program. To be certified as an RHC, a clinic must be located in a rural underserved area. As previously discussed, rural communities are plagued by chronic shortages of specialty mental health providers. Difficulties in recruiting appropriately trained and credentialed mental health clinicians are a major challenge. A number of respondents described relatively fortuitous opportunities to hire or contract with available mental health clinicians that had more to do with the clinician's availability and/or interest in practicing in a primary care setting than it did purposeful recruiting. This difficulty in recruiting and retaining clinicians can create situations in which the continuation of the service may be compromised by the loss of a key clinician. This was the case for the one clinic in the study that had terminated its service as they were unable to replace their previous clinicians.

Another reason involves the limited staffing, funding, and space resources available to RHCs to assist them in developing mental health services and improving integration. Many RHCs, particularly independent RHCs, operate much like small private practices with limited office and administrative staff, tight budgets, and limited office space. Although RHCs receive cost-based reimbursement under Medicare for mental health services, Medicare's 62.5% psychiatric outpatient payment limitation pays the clinic much less and shifts the balance to the patient for payment. As we learned from the interviews, collecting co-pays and deductibles from Medicare beneficiaries without supplemental insurance and commercially insured patients can be very difficult. At the same time, sharing available office space with a mental health clinician may conflict with the space and support needs of the primary care providers and reduce their productivity.

The third reason is the lack of policy leverage for the development of mental health services within the RHC program. RHC administrators noted the lack of funding, technical assistance, and consulting support specific to RHCs to assist them in developing mental health services. In addition, there are no specific policy initiatives or funding to support the development of these services by RHCs as there are for Federally Qualified Health Centers. The Bureau of Primary Health Care (BPHC) supports the expansion of FQHC services through Service Expansion Grants that provide funding to add new or expand existing mental health/substance abuse, oral health, pharmacy, and enabling services for special populations at existing health centers. In addition, FQHCs received grant funding to support the provision of services to low income individuals those who cannot afford to pay for them. BPHC also offers technical assistance and educational resources to FQHCs interested in establishing mental health services. This lack of policy support for the delivery of mental health services by RHCs suggests that the growth of these services may remain relatively stagnant unless some way is found to increase the interest in developing mental health services among RHC clinicians and administrators and provide resources (e.g., funding, technical assistance, educational resources, and evidence-based tools) to support them in doing so.

A key element and necessary resource in the development of mental health services is the presence of a local internal champion who identifies the need for and undertakes the implementation of services. Within the study clinics, local champions were typically clinicians or

senior administrators. The importance of the local champion cannot be overemphasized given the relative shortage of resources on the development of mental health services in RHCs. The local champion serves as a motivator and problem-solver during the development of services and can help to overcome internal barriers. Ideally, the internal champion will be in a position to direct necessary resources to support efforts to develop these services.

The study clinics used different models and approaches to the development of mental health services. Some used relatively simple models in which contracted mental health clinicians were supplied with office space to provide services. In some clinics, the clinicians themselves or an outside agency provided needed billing, administrative, and supervisory support services. Others clinics exhibited greater levels of integration by hiring clinicians directly, providing billing and support services, encouraging greater coordination between the mental health and primary care teams, and implementing electronic medical records. Still others used more advanced models in which the RHC sought and obtained a separate mental health license to provide more specialized services, serve more acutely ill populations, or obtain better reimbursement.

The clinics exhibited similar levels of diversity and sophistication across the domains of operation covered by our interviews such as staffing and employment arrangements, access to and availability of services, reimbursement processes, quality management, and administrative and clinical integration. It is clear that developing and offering mental health services is not an easy undertaking. Of the thirteen study clinics, only four stated conclusively that their services were profitable. Another three thought their services might be profitable but were not sure and five stated that they were not profitable. This diversity in operations and understanding of program requirements along with the number of RHCs that reported that their services were not profitable suggest that RHCs need additional operational, financial, clinical and consulting support to develop consistent, viable services.

OPTIONS TO ENCOURAGE RHCS TO IMPLEMENT MENTAL HEALTH SERVICES

The number of RHCs providing specialty mental health services remains very limited and the growth patterns (or lack thereof) provide little reason to believe that this situation will turn around without greater policy direction and action. Given the barriers to access to mental health

care in rural communities, the limited provision of mental health services by the nation's 3,800 RHCs may present a missed opportunity to increase access to these needed services.

Policymakers should develop approaches to address the reimbursement and administrative barriers identified here, while also considering how to train and ultimately recruit mental health providers to rural areas. Practical, comparatively low cost options to support the development of mental services by RHCs in the short-term include the development of RHC-specific mental health educational and technical assistance resources; the identification of existing mental health resources developed by the Bureau of Primary Health Care, the Substance Abuse and Mental Health Services Administration, and other Federal Agencies that could be adapted for use by RHCs; and the development of an RHC mental health toolkit (similar to the ORHP-funded *Starting a Rural Health Clinic: A How-To Manual*) to provide practical resources on mental health billing, coding, and reimbursement; quality management and improvement; provider selection and management; risk management; service development; managed care, prior authorization, and utilization management processes; evidence-based practices; service models; record keeping; and confidentiality.

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APPENDICES

Appendix A. Staffing Patterns for RHCs Participating in Qualitative Interviews

RHC	Psychologist	Nurse Practitioner	Psychiatrist	Clinical Social Worker	Other Mental Health Provider
A (Independent)					0.20 FTE LCPC
B (Independent)			0.4 FTE 2 days/week	5.0 FTE (10 contracted providers)	0.20 FTE Pediatric and 0.20 nurse 1 day/week
C (Provider-Based)		0.6 FTE (3 days/week)	1 day/month		1 FTE Licensed Family Therapist
D (Provider-Based)			1 adult and 1 child each retained for 16 hours per month	1 FTE, 2 0.5 FTEs, and 1 0.25 FTE	
E (Provider-Based)	Child 2 days/month		1 General and 1 Geriatric each retained 1 day/month	1 FTE	
F (Provider-Based)		0.20 FTE 1 day/week	1 General 1 day/month		0.20 FTE Family Marriage Counselor 1 day/week
G (Provider-Based)	0.26			0.64 FTE	
H (Independent)	1 FTE		1 Part-Time General as needed		1 FTE Clinical Alcohol and Drug Counselor
I (Independent)				2 0.50 FTEs	
J (Independent)	1 FTE				1 FTE Non- Licensed Social Worker for Case Management
K (Provider-Based)		1 FTE	0.5 FTE		
L (Independent)				2 FTEs	
M (Provider-Based)	2 0.5 FTEs		0.8 FTE	4 FTEs (5 LCSWs)	

Source: Qualitative Interviews with 13 RHCs

Appendix B. Clinical and Administrative Characteristics of the Mental Health Services of RHCs Participating in Qualitative Interviews

RHC	Physical Location	Medical Records	Coordination of Services			
			Clinical Integration	Clinical Meetings	Scheduling of Services	Administrative Support
A	Co-located	Separate paper records, stored in separate locations	Small clinical staff-tight relationship	Not described	Not described	Not described
B	Different buildings, same campus	Separate paper records	“Not very close” “Both services work on the same page but are distinct and separate”	No collaborative meetings	Shared scheduling system and staff	Intake/ demographic not shared
C	Co-located	Consolidated paper reports	Same clinical leadership over both services. Communicate directly in person, by phone, or e-mail	Monthly collaborative meetings	Not described	Not described
D	Co-located, clinical pods with mental health, primary care, and nursing assigned to each section	Consolidated, electronic records	Developing collaborative treatment protocols for patients with chronic medical conditions. Communicate by phone, e-mail, or flags on EMR	Mental health clinician works with primary care providers monthly and does “rounds” with primary care staff	Shared scheduling system	Shared administrative support
E	Co-located	Consolidated, electronic records	Close working relationship between staff	Regular meetings and joint care reviews	Same scheduling staff	Shared records, paperwork, and staff
F	Co-located	Consolidated paper records	Very good communication in person, by phone and e-mail	Occasional but not regular case reviews	Shared scheduling system	Shared administrative support
G	Co-located	Separate paper records	Frequent communication in hallways between providers	Frequent meetings over lunch, no regular staff meetings	Shared scheduling/ practice management system	Shared practice management system
H	Co-located	Separate paper records	Some separation among staff, “not all	Not described	Not described	Not described

RHC	Physical Location	Medical Records	Coordination of Services			
			Clinical Integration	Clinical Meetings	Scheduling of Services	Administrative Support
			clinicians interact with one another”			
I	Co-located	Separate paper records	Regular contact for patient consultation	Not described	Shared scheduling system	Shared administrative support
J	Co-located	Consolidated, paper records	Not described	Not described	Note described	Not described
K	Different buildings, same campus	Separate paper records	Collaborative work styles, separate clinical support personnel	Monthly peer review meetings	Shared scheduling system	Shared administrative support
L	Co-located	Separate electronic records	Collaboration occurs on a patient-to-patient basis	No formal meetings or case reviews	Shared scheduling system	Shared administrative support, Separate intake forms
M	Different buildings, same campus, Both services scheduled to move to same new building	Separate paper records	Good cooperation, developing niche programs to integrate services (pain clinic, ADHD/ADD clinic, weight management program)	Not described	Not described	Not described

Source: Qualitative Interviews with 13 RHCs

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