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Lori Hopwood

Southern Illinois University Edwardsville

April Schmidt

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Integrating Mental Health Care into Primary Care

Lori A. Hopwood

Executive Summary

Introduction to the Problem

The Centers for Disease Control and Prevention (CDC) has identified that 20% of all visits to a primary care provider include at least one mental health indicator such as depression screening, counseling, a mental health diagnosis, psychotherapy, or prescription of a psychotropic drug (CDC, 2014). The practice has seen an increasing need of mental health services and estimates as many as 30% of all patients seen have a mental health need.

Illinois suffers significant shortages in mental health professionals in 97 of 102 counties (IDPH). Illinois ranks 20th in comparison to other states regarding access to mental health care, citing access to care as a significant problem (IDPH, 2022).

Access to mental health services was identified as the number one community health problem in Montgomery County, Illinois. Need for mental health services was evidenced in the joint Community Health Needs Assessment (CHNA) and Illinois Plan for Local Assessment of Needs (IPLAN) (Montgomery County Health Department, 2015). As a result of this community health need, the practice is aligned with the Healthy People 2030 goal to “increase the ability of primary care and behavioral health professionals to provide a more high-quality care to patients who need it” (USDHHS, 2021). This high priority public health objective is currently in research status meaning it does not have evidence-based interventions to address it. This provides a significant opportunity to pilot and study the impact of the grant funded integrated

behavioral health program. The program receives partial financial support from a practice physician and the county mental health board.

Depression screening using a validated screening tool is a clinical quality measure to screen for patients who do not already have a diagnosis of depression. The current clinical standard defined by Electronic Clinical Quality Improvement (eCQI) is 90%. In November 2021, the practice completed depression screenings at a rate of 42.7% (Patrick Schaeffer, 2021). There was an identified need to increase depression screening to help identify and treat patients for depression.

The purpose of this project was to evaluate a new program model with a health care delivery innovation focus. Research supports integrating behavioral health in primary care as an effective strategy for improving outcomes for people with mental health conditions where services are unavailable or difficult to access due to a variety of service delivery barriers. The aim of this project was to evaluate a new way of integrating mental health services in a rural health, primary care practice in central Illinois.

The mission of the organization is for “physicians and staff strive to deliver humane, caring, top quality medical care conscientiously applied in an ethical, efficient, cost-effective primary care practice to all our patients (Litchfield Family Practice Center, 2022).” The project aligns with the organization’s goals, objectives, mission, vision, and values.

Literature Review

The integrated collaborative care program was implemented to address growing community mental health needs. The program is an innovative evidence-based care model providing a framework on how to integrate mental health into a primary care practice.

Research by Ellis & Alexander (2016) concluded the importance of understanding concepts such as collaboration, integration, and services expansion. Nurses were identified as key players in a tri-dimensional model to integrating all three concepts into a single full-service model to help eliminate barriers to care. Models by Advancing Integrated Mental Health Solutions (AIMS), Substance Abuse and Mental Health Services Administration (SAMHSA) and the Agency for Healthcare Research and Quality Health Care Innovations Exchange provide frameworks and helpful tool kits on how to implement this model effectively (AIMS, 2019; SAMHSA-HRSA, 2013; Zeidler Schreiter, 2014).

The team-based collaborative care model adds two types of services to the usual primary care setting: behavioral health care management and consultation with a psychiatrist (Illinois Department of Human Services Division of Mental Health, 2018). The behavioral health care manager becomes part of the patients' treatment team and helps the primary care provider evaluate the patient's mental health. If the patient received a diagnosis of a mental health disorder and wants treatment, the care manager, primary care provider and patient work together to develop a person-centered treatment plan. This may include medication, or other appropriate options. Later, the care manager reaches out to see if the patient likes the plan, is following the plan, and if the plan is working or if changes are needed. The care manger and the primary care provider regularly review the patients' status and care plan with the psychiatrist to assure the patient is receiving the best treatment options and is improving (National Institute of Mental Health, 2019). The addition of a consulting psychiatrist helps provide practitioners with the expertise of a psychiatrist who can advise on appropriate

treatment regimens for patients that are challenging or difficult to manage (Grazier, Smith, Song, & Smiley, 2014).

Collaborative care models have been shown to improve patient outcomes when compared with the usual health care (University of Washington. Division of Integrated Care & Public Health. Department of Psychiatric & Behavior Sciences, 2014). Despite the value of integrated care models, these models have not been widely adopted in primary care practice.

Project Methods

The integrated behavioral health care model consists of a team of clinicians including a psychiatric consultant, (psychiatrist), behavioral health care manager (registered nurse) and treating clinicians (physician and nurse practitioner) (University of Washington, 2021).

The primary goal of the integrated behavioral health program was designed to increase the ability of primary care providers to provide mental health services with the support and expertise of a consulting psychiatrist and behavioral health specialist. The secondary goal was to improve access to care and improve mental health outcomes by early identification and treatment of those with mental health conditions. The PHQ-9 was utilized in the entire practice as a standard of care to screen patients aged 12 and older for depression.

The practice setting is a certified rural health clinic located in central Illinois, designated a Mental Health Care Professional Shortage Area (HPSA) (Health Resources and Service Administration, 2022). The practice is comprised of seven physicians, twelve nurse practitioners and two physician assistants. The active patient case load for the entire practice is nearly 20,000. On a typical day, it is not unusual for clinician's to collectively see 300 patients (Litchfield Family Practice Center, 2022).

Program participants were males and females, aged 18 years and older, struggling with mental health conditions. Maximum case load for the behavioral health specialist was initially limited to 50 program participants, but later expanded due to additional funding allowing for our behavioral health specialist to move from part-time to full time status. The program currently serves 88 program participants.

Stakeholders are doctors, clinicians and funding sources who piloted this model. The program was financially supported through a community health grant supplement with additional funding from a primary care physician.

Human subjects were limited to those individuals 18 years of age or older. Subject with mental health conditions were recruited without compensation into the program voluntarily with signed consent. This project was approved by the SIUE IRB and was determined to not be human research.

Evaluation

Tools used to collect project data were a quantitative survey: Number of Days to Appointment; depression screening tool: Patient Health Questionnaire-9 (PHQ-9); Electronic Medical Record (EMR): Allscripts Pro; and a qualitative survey: "Reported Side Effects of the Integrated Behavioral Health Program." Program evaluation measures were established as an important part of helping to understand the impact of this model of caring for patients needing mental health care. The purpose of objective measures was to help us understand whether the changes made led to improvement. A balanced set of measures was used to assess quality improvement efforts (Institute for Healthcare Improvement, 2021). Three measures were

established to examine results: outcome measures, process measures, and balancing measures.

Access to care was identified as the primary outcome measure in the project. A survey was conducted at two local health departments within a 30-mile radius and at seven offices within the practice. In this survey, we utilized the “Number of Days to Appointment” survey to collect information on how many days it takes to secure an appointment for a mental health related issue.

The second measure was a process measure. The process measure was established to examine whether patients were performing as planned and if we were on track with our efforts to improve our system of health care delivery. We retrospectively measured the number of patients in our Allscripts electronic medical record (EMR) who had already received depression screening with the Patient Health Questionnaire-9 (PHQ-9) depression screening tool. PHQ-9 scores for the entire practice were 42.7% as of November 17, 2021. Data was run again on March 8, 2022, after IRB approval, and found that patients receiving depression screening by PHQ-9 had dropped to 30.81% for the entire practice. Using that data, we compared the percent of patient screened in the entire practice with the percent currently screened in the integrated mental health program. Initial results showed 65.88% of program participants receiving depression screening. We thought that the results should be closer to 100% for the behavioral health group. The decision was made to investigate the validity of the data further by a hand count of depression screening of program participants, resulting in 86% receiving depression screening. Results suggested that data was skewed as it was not properly documented in the “Health Maintenance” section of the EMR, causing data to not be captured

in the data analysis. This discovery has implications for practice wide education on the proper place to document that screening has occurred. Improper documentation of this screening has prevented the practice from approaching the current benchmark set by the Electronic Clinical Quality Improvement of 90% of patient screened for depression (eCQI Resource Center, 2021).

The third measure is a balancing measure. The balancing measure looked at the integrated behavioral health care program from a different direction. We surveyed the billing and insurance departments, IT person and three team clinicians for qualitative data using the “Reported Side Effects of the Integrated Behavioral Health Program” as to any anticipated problems. This helped us to determine if one part of the system was potentially causing problems in another part of the system. Descriptive survey results elicited the following responses:

1. “My responsibility is billing. I have no problem managing my part of the program. It would be beneficial to have these services paid by our medical payers.”
2. “We do have a large population of Medicaid patients active in our office that are benefiting from the program.”
3. “We have helped numerous people with this program.”
4. “Program is great, definitely a need. It’s the medications that is what is difficult to get approved for the patients that need it. Insurance companies are making it more difficult.”
5. “Depression screening must be documented in “Health Maintenance” in the Allscripts electronic medical record for the assessment to be captured in the data set.”

Outcomes of the evaluation process were heightened awareness of a practice wide problem discovered through a quantitative survey collecting depression screening data. Improper documentation of depression screening was discovered, preventing the practice from approaching the required performance measure of 90% of all patients receiving screening. Additionally, we learned that the quickest way to treatment for those needing mental health services are through our own practice with number of days to appointment being 0-2 days to appointment throughout the practice compared to a week or longer at both county mental health departments.

There were five responses to the descriptive survey eliciting information regarding possible side effects of the program. In this survey, we learned of the insurance department having difficulty getting psychiatric medications approved with various insurance providers. This response led to identification of access to medication pending insurance approval as a barrier to care. We continued to work with insurance companies to get the needed medications approved for our patients. We also learned that we were not able to bill for services provided to Medicaid program participants. Medicaid does not provide reimbursement for this type of service. Lack of reimbursement contributed to need for external funding sources. The program is currently financially supported by a community health grant and a practice physician.

A limitation of the project was sample size. The study encompassed 88 individuals of the 18,545 we currently serve. It would be difficult to generalize this information to other populations due to the small sample size of the behavioral health program. We received five responses to the descriptive survey regarding "Side effects of the Program." We may have learned more with wider dissemination of the survey, eliciting more information on outcomes

of the program. Although, any information obtained regarding outcomes of this project contributes to the body of research.

Impact on Practice

Immediate impact on the clinical site is that patients receive timely mental health treatment at the practice compared to treatment at community county health departments. Patients enrolled in the behavioral health program have access to mental health services and support of a team of medical providers, nurses, and psychiatrist. Research studies have shown this model of service delivery reduces mental health hospitalizations and emergency room visit, providing for better mental health outcomes and patient satisfaction.

The long-term potential impact of the program is ability to get patients to mental health services faster, thus improving patient outcomes. Keeping patients out of the emergency room and hospital decreases the global cost of mental health services. The program helps to keep patients in their community near their home, decreasing transportation barriers and increasing access to a provider that is comfortable with caring for complex mentally ill patients.

Study of the integrated collaborative care model has helped to provide understanding on the effects of the program model in the practice. As an unexpected outcome, we learned the entire practice needs immediate education on location of proper documentation of depression screening in the electronic medical record so the computer system can capture the outcome data. This has important implications for helping to improve the number of depression screenings, in turn helping the practice to meet the quality measure of 90%.

Sustainability of the program is problematic. If the practice does not receive supplemental financial support from community stakeholders, we would not be able to cover the salaries of

the behavioral health specialist and the consultation fees of the psychiatrist. We have identified insurance approval of prescription medication as a barrier to care and continue to work with insurance companies to get the needed medications approved for our patients.

A potential impact of the program may be adoption of the model with other physicians in their individual practices. Study of this model has helped us to understand that we need education on depression screening documentation and ongoing support of stakeholders to sustain the services we are currently providing. Data obtained through the study of this program may help to change perceptions of the program and gain wider acceptance of the model. Results of this research provides a platform on which to build subsequent studies.

Conclusion

This model is an appropriate intervention to address IPLAN and CHNA (local needs assessments) and the Healthy People 2030 goal to “increase the ability of primary care and behavioral health professionals to provide a more high-quality health care to patients who need it.” Perhaps at some point, Medicaid will see the importance of reimbursement for this type of mental health service. This model has the potential to improve quality and reduce cost of the care that is delivered to patients. There is not much research that has been done regarding program implementation of the collaborative care model in a rural setting. Any information obtained from this study contributes to the body of evidence.

Recommendations for further research includes examination of depression screening results to see if patient scores improve over time showing improved outcomes with entry into care while participating in the integrated collaborative program. In the future, a patient satisfaction survey should be administered to gain feedback from patients regarding their

satisfaction with the program and to help bridge gaps in areas needing improvement to better meet needs of behavioral health patients.

Through implementation and evaluation of the new mental health care delivery model, we have developed a better understand of the impact of the practice. Project outcomes demonstrate the program helps to meet patient needs by getting patients into care sooner. The program increases access to care by decreasing barriers to care, such as transportation and cost of specialty services by providing services in the community in which that patient lives. Plans are in place to educate staff on proper depression screening documentation to help the practice better identify and treat patients in need of mental health services and to help meet performance objectives. We learned we need to continue to seek funding sources to provide ongoing financial support for the program if we wish to continue to deliver mental health services using this model of health care delivery.

In summary, a gap in depression screening was an unexpected outcome of the study. It was an important finding because it skewed data. Routine screening for depression helps with early identification and treatment of patients in need of mental health care. Education on frequency of depression screening and proper documentation of screening results are outcomes of this study that result in a practice change. This model was found to increases access to mental health services, decreases barriers to care such as cost and transportation barriers. The project was also an impetus for more education on more frequent and accurate documentation of depression screening.

Author Contact Information

Lori A. Hopwood, MPH, MSN, APRN-FPA, WHNP-BC, FNP-BC

PMHNP-DNP Student

lhopwoo@siue.edu

loriahopwood@hotmail.com