



North State Rural Primary Care - Mental Health Summit:

# ***Collaborating for Care***

## **FINAL REPORT**

*This Summit is made possible through the support of The California Endowment*

# **The North State Rural Primary Care and Mental Health Summit: Collaborating for Care**

## **Report 2002**

We wish to express our appreciation to the more than 125 primary care staff, county mental health staff, statewide policy representatives and consumer advocates who gave their time and creative energies to develop strategies to meet the mental health needs of California's rural north state. Through generous funding from the California Endowment, The North State Rural Primary Care and Mental Health Summit was held April 26, 2002 in Chico, California. The groups met to discuss priority issues and to develop collaborative solutions. This report reflects the collective thinking of the summit participants.

It is our hope that this report will not gather dust on a shelf—rather, that it becomes a stimulus for action in your local communities, as well as in regional and statewide policy venues, to make changes large and small, that will improve availability and access to mental health services in the North State.

Speranza Avram, MPA, Northern Sierra Rural Health Network

Sandra Naylor Goodwin, MSW, PhD, California Institute for Mental Health

Patricia Ryan, MPA, California Mental Health Directors Association

# **THE NORTH STATE RURAL PRIMARY CARE AND MENTAL HEALTH SUMMIT: COLLABORATING FOR CARE**

## **BACKGROUND**

Rural communities in Northern California face challenges similar to rural communities throughout the United States: distances are vast; population centers are small; and resources are limited, including health resources. In particular, health specialty services can be very difficult to access.

Recognizing the need to improve access to mental health services, The Northern Sierra Rural Health Network (NSRHN), the California Mental Health Directors Association (CMHDA) and the California Institute for Mental Health (CIMH) worked together to both identify issues and develop solutions for improving access and availability of mental health services in rural Northern California. It is our shared vision to fill gaps in services in rural and frontier areas by identifying and prioritizing collaborative solutions without compromising existing services.

Through surveys and focus groups, the following question was presented to individuals and representatives from mental health and primary care organizations throughout Northern California during the fall of 2001:

“The mental health system in California is challenged in many ways. What unique challenges do rural communities face in providing a comprehensive level of mental health services to their residents?”

Responses to this question were received from individuals and focus groups representing primary care providers, county mental health systems, and consumers. The responses were synthesized and categorized into “like groups” of answers. The twelve most common or most frequently mentioned problems were then listed and brought to a work group of interested mental health and primary care providers who volunteered to help distill them into the top three most pressing issues for rural northern California. The work group examined and discussed the top twelve issues at length and selected the following three issues as being the most important:

- Lack of mental health providers of all kinds in rural Northern California
- Lack of resources to support mental health services, including reimbursement issues for all parts of the mental health system
- Lack of coordination along the full spectrum of mental health services, including stigma of receiving services in small communities and the different models of care between primary care and county-based systems

More detail about these three issues, as well as a list of all the issues identified by the focus groups, is included as Appendix A of this report.

Through funding received from The California Endowment, NSRHN, CIMH and CMHDA co-sponsored The North State Rural Primary Care and Mental Health Summit: Collaborating for Care on April 26, 2002. Over 125 primary care, county mental health staff, statewide policy

representatives and consumer advocates met in Chico to review the issues identified and develop strategies to address them. This report summarizes the findings of the Summit for use by conference attendees and others interested in supporting mental health services in rural Northern California.

## **OVERVIEW OF RURAL MENTAL HEALTH SUMMIT**

The Summit participants opened with a presentation by Keynote Speaker Assemblywoman Helen Thomson, Chair of the State Assembly Health Committee, who reminded the audience of the importance of caring for the most vulnerable members of our communities. The complexities associated with reimbursement for mental health services are challenging, yet through collaboration and persistence, small but lasting changes can be made.

NSRHN Executive Director, Speranza Avram, provided an overview of relevant data that supported many of the findings identified through the Summit research process. A copy of this presentation is included as Appendix B of this report.

Dr. Neal Adams, Medical Director for Adult Services, California Department of Mental Health discussed the development of the mental health system and how it interfaces with the health care delivery system. A copy of his presentation is included as Appendix C of this report.

Mental Health Claims Data and Statistics as presented by Sandra Naylor Goodwin, Ph.D., Executive Director of CIMH, is included as Appendix D.

A panel of mental health professionals from a variety of disciplines used a case based scenario to discuss how the different agencies would provide services to a fictional family with a variety of presenting problems. This discussion helped clarify roles and responsibilities across the range of services represented.

The major activity of the Summit was discussion in small regional work groups to identify:

- Strategies to address each of the three top issues
- Existing assets and resources that can be used to implement the strategies
- Overarching policy issues that need to be addressed at regional, state, and national levels
- Create a local area action plan

Each work group brought their work products back to the full Summit. Dr. Goodwin summarized major themes.

A summary of the work group findings is presented below and details of each of the work group discussions is included as Appendix E of this report.

## SUMMARY OF WORK GROUP FINDINGS

Four main themes emerged from the Work Groups:

- The value of regionalization to share resources, overcome access barriers, and address system change
- The need for better communication, collaboration and cross-training along the full range of existing mental health services (state, county, primary care and community-based)
- Increased use of telepsychiatry to expand access to services
- The importance of advocacy for increased funding for services and to address policy issues, including reimbursement barriers, relating to a variety of provider issues

Work Group participants identified the following **ASSETS/RESOURCES** in rural northern California that can be used to impact rural mental health:

- A range of community-based, safety net and county services typified by limited personnel, “wearing more than one hat,” and limited resources to commit to large service areas often with less than 7 people per square mile
- Advocacy, lobbying and coalition building
- Networking/Networks/Consortiums
- Telemedicine/connectivity
- Commitment to collaboration

Common **POLICY ISSUES** mentioned by the Work Groups included:

- Allowing reimbursement for telepsychiatry services initiated by primary care providers
- Overcoming barriers created by confidentiality (HIPAA)
- Reimbursement rates inadequate to provide services/ Restrictive regulations that affect reimbursement/mandates
- Lack of genuine mental health parity
- Simplifying billing codes
- Maintaining and expanding mental health provider shortage designations
- Implementation/enforcement of Knox-Keene
- Allowing Licensed Marriage Family Therapists (LMFT) to be reimbursed by Medicare and Medi-cal when providing services in hospitals and primary care practices.

The **STRATEGIES** identified by the Work Groups to address each of the issues include:

### **Lack of Providers:**

The issue of lack of providers in rural northern California is profound. Focus group and mail-in respondents state a particular lack of bilingual providers, few to no specialty providers such as child or geriatric psychiatrists, provider licensing issues such as inability to use certain providers for Medicare and Medi-Cal in certain venues, problematic recruitment and retention from Masters level to Psychiatrists and providers who are geographically available,

but may not provide services to those most in need (e.g. don't take Medi-Cal, Healthy families, Medicare, etc., may not serve Developmentally Disabled, or treat certain diagnosis, such as dementia) as some of most troublesome aspects of this issue.

**Strategies include:**

- Access recent retirees for part time positions, draw upon large pool of skilled retirees – pay them to mentor students
- Increased use of Telepsychiatry and Telemedicine, use technology for supervision component of licensing, telepsychiatry, training, direct service provision and more
- Develop partnerships to “grow your own” personnel in rural communities, provide career ladder trainings
- Financial incentives (stipend bonus) to come to the area and local university stipends for training and non-economic incentives
- Paid internships
- Advertise in recreational magazines for professionals who might enjoy rural life
- Improved behavioral health training or availability of specialty consultation for primary care providers
- Collaborations and partnerships for Training and Telemedicine Services with Foundations, Community Based Organizations and County Behavioral health Departments, Primary Care, Department of Mental Health, Public Education, lobbyists, elected officials, media, Faith-based providers, and Coordination with Medical Centers/Universities
- Residency Rotations
- County-wide and/or regional (shared) recruitment
- Grants and loan forgiveness programs
- Better use of volunteers and peer counselors

**Lack of Resources:**

The issue of lack of resources in rural Northern California includes inequities in the funding base for county behavioral health programs and the fact that the cost of providing the full range of services for a very few people is often greater than the reimbursement for those services. Insurance parity issues are prevalent, and when this is coupled with the serious and persistent nature of mental illness, creates an environment of serious unmet need. Issues for clinics include the need for behavioral health specialty consultation, inability to obtain reimbursement for the full range of behavioral health providers, difficulties with reimbursement for telepsychiatry visits and being unable to bill for more than one service in a single day. In addition, rural communities are vulnerable to the market economy because resources and quantity are so scarce and demand is so high.

**Strategies include:**

- Regionalize behavioral health care
- Grants or special legislation to fill holes and pilot projects to effect change

- Increase the number and availability of crisis beds – children/adults (increased funding for liability, etc), and treatment facilities for children
- Website for centralized information
- Increase human services and adequate housing for Children and adults in crisis
- Collaborations and partnerships for Training, Telemedicine Services, and Residency Rotations with Foundations, Community Based Organizations and County Behavioral health Departments, Primary Care, Department of Mental Health, Public Education, lobbyists, elected officials, media, Faith-based providers, and Coordination w/Medical Centers/Universities

**Lack of Coordination:**

Coordination is impacted by “small town” confidentiality issues and consumer denial of need, due to stigma. Conflicts between different service models, the lack of interdisciplinary training and funding for time spent in cooperative/coordinated efforts are also problematic. Coordination problems are encountered due to the inadequate emergency services access, follow-up, transportation, bed space, efficacy of emergency interventions, cost to county system of in-patient care, closures of psychiatric hospitals, and burdens on hospital emergency rooms. This issue also includes barriers to coordination and collaboration between primary care and specialty mental health systems created by differences in language (medical vs. mental health terminology) and separate service components and delivery systems. Focus group respondents state there is a general lack of understanding of the full range of services from one provider to the next.

**Strategies include:**

- Improved behavioral health training for primary care providers/integration of mental health and primary care services
- Geriatric training for multidisciplinary services
- Improve educational and cross training standards – opportunities
- Anti-Stigma – satellite clinics located in the community and/or locating services in primary care clinics where consumers could be seeking services for a variety of reasons
- Develop multi-agency release form to allow easy collaboration on high risk patients
- Work with local pharmacies to track medical usage/compliance
- Local multi-agency, multi-disciplinary task forces, which include schools and law enforcement
- Collaboratives for early intervention
- Public-private partnerships
- Use technology to make collaboration, shared trainings and conference meetings/calls most cost effective/time efficient

## **NEXT STEPS**

As a result of the Summit, a number of county mental health and primary care providers have committed to continue to work together to address specific strategies relevant to their community and county-wide situation. Additionally, NSRHN, CMHDA and/or CIMH have committed to:

- Distribute this report to Summit participants, as well as policy makers and funders who have an interest in rural mental health.
- Invite the annual conference held by the National Association for Rural Mental Health to Northern California
- Pursue the development and distribution of a HIPAA compliant inter-agency release form to support case-based collaboration
- Support technical assistance and training for increased use of telepsychiatry in the region
- Continued collaboration and advocacy to protect and expand existing resources for rural northern California

## **LIST OF ATTACHMENTS:**

**Appendix A – Mental Health Issues Impacting Rural Northern California**

**Appendix B – A Review of Relevant Data – Presentation by Speranza Avram, M.P.A**

**Appendix C – “Bridging the Gap” – Presentation by Neal Adams, MD**

**Appendix D – Mental Health Claims Data and Statistics – Presentation by Sandra Naylor Goodwin, PhD**

**Appendix E – Details of Work Group Reports**