

Mental Health and Primary Care in Rural Minnesota

In 2005, the Rural Health Advisory Committee formed a rural mental health work group to study the delivery of mental health care in rural primary care settings. The resulting report, *Mental Health and Primary Care in Rural Minnesota*, identified the issues surrounding mental health care delivery and highlighted successful models of integrated primary care and mental health services in rural Minnesota. Some of the key findings from the report included:

- Shortages of rural mental health providers result in long waits for appointments and long travel to obtain specialty care.
- The cost of mental health care and the complexity of the payment system are barriers for patients seeking care.
- A stigma about mental/behavioral health is a barrier to care, especially in rural areas.
- Rural primary care practitioners would like more education on managing mental/behavioral health.

From these findings, efforts for improving mental health care delivery through the rural primary care system depend on a number of factors including:

- Availability of a trained professional workforce in primary and mental health care
- Adequate funding so health systems are able to provide needed mental health services
- Effective state and federal policies that support mental health care.

The report proposes a series of recommendations addressing three broad areas:

- The need for a competent and qualified workforce
- Up-to-date education for primary providers and policy
- Funding streams that support the complexity of care in rural communities

The report's recommendations are listed on the following pages, along with known progress related to each recommendation. The full report is available on the Office of Rural Health website at: <http://health.state.mn.us/divs/orhpc/pubs/mentalhealth.pdf>.

A) Health Professional Education Recommendations in this section are targeted at academic health programs that train medical students, nurses, mental health professionals and other health professionals who care for patients with mental/behavioral health concerns. These recommendations also apply to health professional organizations and associations responsible for continuing education of their constituents.	
Recommendation	Progress
A-1. Enhance and promote mental/behavioral health education and training for all health profession students training in primary practice.	
A-2. Enhance mental/behavioral health training for those in family medicine residencies. It is critical that family medicine physicians, in particular those planning to practice in rural areas, have an understanding of the interaction between physical and mental health and disease, and are adequately prepared to diagnose, treat and/or refer patients with mental or behavioral conditions. The UMN and Mayo Medical Schools should seek out practicing rural and family medicine physicians who successfully collaborate with mental health practitioners (either on-site or via telehealth) and develop education and residency programs that highlight the experience of these teams.	
A-3. Promote and develop rural site experiences for primary care and mental health practitioners. Emphasize collaborative practice within the primary care setting. As a starting point, curriculum developers should tap into lessons learned through the experience of the UMN Rural Health School, which was recently absorbed into the Minnesota Area Health Education Center (AHEC) program. Curriculum/site developers should explore potential on-site training experiences with the successful collaborative teams identified in recommendation A-2.	<ul style="list-style-type: none"> ○ 2008 Rural Health Conference breakout session: New Models of Care: Interprofessional Practice and Education Teams (PDF: 160KB/25pgs)

Recommendation	Progress
<p>A-4. Develop and support rural site experiences for those in psychiatric residency programs. Curriculum/site developers should think creatively about potential on-site residency opportunities, including community mental health centers, state Regional Treatment Centers, correctional facilities, larger regional hospitals and clinics in rural areas of the state (e.g., Marshall, Bemidji, Willmar, Mankato), as well as sites served by successful teams identified in recommendation A-1.</p>	<ul style="list-style-type: none"> ○ 2008 Rural Health Conference breakout session: Design, Implementation and Progress of a Post-Doctoral Residency in Rural Psychology (Detroit Lakes)
<p>A-5. Develop and support mental health related continuing education for rural primary care providers through accessible means such as distance learning, regional conferences and traveling programs. Traveling programs should consider modeling their approach after the Comprehensive Advanced Life Support (CALs) course. CALs is structured to maximize the intensity and volume of material presented, while minimizing the amount of time providers need to take away from their practice or facility. Continuing education opportunities should be developed collaboratively with the Minnesota Department of Human Services. Existing trainings for mental health professionals could be expanded and adapted to include primary care providers.</p>	<ul style="list-style-type: none"> ○ 2008 Rural Health Conference breakout session: CALs: Emergency Team Training for Rural Health Care Providers (PDF: 1MB/63pgs)
<p>A-6. Include mental/behavioral health content in conferences and other continuing education opportunities for primary care physicians, nurses, nurse practitioners, physicians' assistants and nursing assistants, as well as nontraditional audiences such as pharmacists, dentists, school nurses and counselors and law enforcement personnel.</p>	<ul style="list-style-type: none"> ○ 2007 Rural Health conference breakout session: Mobile Mental Health Support for Rural Older Adults

B) Health Systems

Health systems includes a variety of entities including health care provider systems and networks, hospitals, clinics and payer systems.

Recommendation	Progress
<p>B-1. Promote and support demonstration projects and models of collaborative care between mental health providers and primary care providers. Successful examples include co-location of services, integration of services within the primary care clinic system, and the “shared care” model. Work group members’ experience and the relevant literature point to collaborative models of care as one of the most effective and efficient means of integrating mental health and primary care services to better meet the needs of patients.</p>	<ul style="list-style-type: none">○ The Center for Rural Mental Health Studies (CRMHS) at the University of Minnesota Medical School Duluth is integrating mental health into primary care settings for underserved rural populations. CRMHS partners with the Family Medicine clinics in Bigfork, Cook, Ely, Littlefork, Mora and Paynesville, Minnesota communities to provide telemental health consultative services: www.med.umn.edu/duluth/about/CRMHS/home.html○ St. Elizabeth’s Medical Center brought a together multidisciplinary team to undergo onsite, computer-based, specialized training as a group in recognizing and caring for patients and residents with dementia and Alzheimer’s disease. St. Elizabeth’s sponsors community Alzheimer’s prevention programs, shares Alzheimer’s and dementia information with local primary care clinics and community, and sponsors a local caregiver expert team available to when hospital staff need additional knowledge, resources and assistance.
<p>B-2. Develop a common set of mental health benefits. Support the work being done through the Minnesota Mental Health Action Group (MMHAG) to develop a basic set of mental health benefits common to all health plans. With the development of this common benefit set, people who change insurance could be assured of continuity of coverage levels for mental and behavioral health services, and providers would benefit from administrative consistency across plans. Even with a common benefit set, it is important to bear in mind that rural Minnesotans are more likely to be uninsured or under-insured than their urban counterparts. Therefore, efforts to promote coverage/service options for rural Minnesotans who lack or have inadequate mental health coverage should continue.</p>	<ul style="list-style-type: none">○ 2005 MMHAG Road Map for Mental Health System Reform in Minnesota: www.citizensleague.org/mentalhealth/index.html Based on MMHAG recommendations, the Governor proposed a Mental Health Initiative in 2007, calling for \$44.8 million in new investments over the coming biennium and \$38 million per year thereafter. The proposed investments were to finance the addition of a comprehensive mental health benefit to the state’s publicly funded health care programs (GA, MNCare, PMAP) and fund preferred integrated networks (PINs) demonstrating integration of mental and physical health services for adults and children within prepaid health plans and coordination of health care with social services. www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_056871

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<p>B-3. Advocate for funding streams that promote collaborative and integrated mental health and primary care models. Funding should support reimbursement for consultations between the primary care provider and the mental health provider, as well as care management, care coordination and other collaborative models such as co-location. The work group identified several existing coding and funding mechanisms that create barriers to collaborative care. These mechanisms should be catalogued & brought to the attention of funders & policymakers.</p>	
<p>B-4. Promote and expand telehealth collaborations to strengthen delivery of mental health services in remote and underserved areas. Many rural health care providers have begun to use telehealth technology. In some cases, telemental health applications could be developed using existing equipment. Equipment does not need to be costly; simple telephone technology can often be used effectively. Although reimbursement is often assumed to be a barrier to providing telemental health services, Medicare does cover teleconsultations by psychiatrists, clinical nurse specialists, clinical social workers and clinical psychologists for beneficiaries living in rural health professional shortage areas. State efforts to expand this coverage to the Medical Assistance program should be supported.</p>	<ul style="list-style-type: none"> ○ 2006 Rural Health Conference breakout session: Telemental Health for Minnesotans - Harvey Caldwell, (PowerPoint 86MB) New Connections: Minnesota Association of Community Mental Health Programs, Inc <i>and</i> Telehomecare: Pursuing, Planning and Prospering - Joyce Doughty, (PowerPoint 64KB) Good Samaritan Home Health Care
<p>B-5. Improve delivery of mental health crisis services at small rural hospital emergency rooms through quality improvement projects that address mental health bed capacity, appropriate patient transfer and continuing education for emergency room personnel. Provider networks, Stratis Health, the Minnesota Hospital Association, and other health care organizations and associations should incorporate this goal into their quality improvement plans. The Minnesota Department of Health’s Office of Rural Health and Primary Care should add this to its list of federally fundable objectives under the Rural Hospital Flexibility Program.</p>	<ul style="list-style-type: none"> ○ Flex Program Grant FFY 2007 to Arrowhead EMS: “Rural Behavioral Health Inter-Facility Transfer Education Project” - The goal of this project to assist rural EMS providers, including facility staff, in developing a starting point for use of standardized behavioral health guidelines related to planning and fulfilling inter-facility transfers involving patients presenting at rural hospitals an acute behavioral crisis. ○ Flex Program Grant 2008-09 to Arrowhead EMS: “Behavioral Crisis Mgmt. for EMS Leadership” - Training targeted to EMS leadership to develop local agency response protocols and provide guidance in assessment and care practices for first responders and inter-facility rural care providers when faced with behavioral crisis patients requiring treatment and transportation.

Recommendation	Progress
<p>B-6. Create an understandable guide to the current payment system for mental health care for rural primary care and rural mental health providers. The current system reflects a complex combination of payment methodologies and has become very difficult to understand and use. As a result, rural providers and administrative staff may not know how to obtain reimbursement for specific mental health services; this can lead to restrictions on patients' access to care. Also, since billing and coding patterns do not always accurately reflect diagnoses and treatment delivered, payment patterns do not accurately reflect actual incidence of certain conditions. Therefore the occurrence of these conditions in the community as a whole is understated. The payment system guide should include concrete examples of how to access, interpret and blend payment mechanisms and sources to most accurately reflect patient diagnosis and treatment, while simplifying and clarifying billing and coding procedures for providers. The Minnesota Department of Human Services, in cooperation with other payers and representatives of the provider community, should be charged with developing this guide, using information from the Minnesota Mental Health Action Group.</p>	

C) State and Federal Policies and Programs

This set of recommendations is meant for policymakers including the legislature, state agencies and the federal government.

Recommendation	Progress
<p>C-1. Expand state-funded health professional loan forgiveness programs to include psychologists, social workers and other mental health professionals who agree to work in rural areas. Currently, the Minnesota Department of Health’s Office of Rural Health and Primary Care administers state-funded loan forgiveness for physicians, nurses, mid-level providers and dentists. To address the shortage in rural areas, this program should be expanded to include psychologists, social workers and other mental health professionals. Funding for the overall program should be increased so as not to draw needed funds away from professions already included in the program.</p>	<ul style="list-style-type: none"> ○ Rural Physician Loan Forgiveness Program: offered to primary care medical residents (including Psychiatry residents) who plan to practice for at least 30 hours per week, for at least 45 weeks per year, for a minimum of three years in a designated rural area. ○ Urban Physician Loan Forgiveness Program: offered to primary care medical residents (including Psychiatry residents) who plan to practice for at least 30 hours per week, for at least 45 weeks per year, for a minimum of three years in an underserved urban community ○ Federal National Health Service Corps (NHSC) Loan Forgiveness Program: includes Clinical Psychologists, Clinical Social Workers, Psychiatrists, Mental Health Counselors, Psychiatric Nurse Specialists, Marriage & Family Therapists ○ Minnesota State Loan Repayment Program (SLRP): includes Clinical Psychologists, Clinical Social Workers, Psychiatrists, Mental Health Counselors, Psychiatric Nurse Specialists, Marriage & Family Therapists
<p>C-2. Support efforts to expand public program coverage of telehealth consultations by mental health professionals. Medicare currently covers teleconsultations by psychiatrists, clinical nurse specialists, clinical social workers and clinical psychologists for beneficiaries living in rural health professional shortages areas. State level efforts to expand this coverage to the Medical Assistance program and other public health care programs should be supported.</p>	<ul style="list-style-type: none"> ○ Effective October 1, 2006, MHCP covers delivery of mental health services through telemedicine. Telemedicine delivers mental health services using two-way interactive video which can: <ul style="list-style-type: none"> ○ Extend limited resources ○ Expand the geographical area over which a mental health provider can offer direct service ○ Save time and energy without compromising quality ○ Allows providers and the recipient greater flexibility and increased access when delivering/receiving services ○ Allows recipients to receive needed services without having to travel long distances ○ Services provided via telemedicine have the same service thresholds and authorization requirements as services delivered face-to-face. MHCP does not reimburse for connection charges, or origination, set-up or site fees.

Recommendation	Progress
<p>C-3. Eliminate the funding rule for the Medical Education and Research Costs (MERC) program that requires small sites to have at least a 0.5 FTE health professional student in any given discipline to receive training reimbursement. Work group members reported—and Minnesota Department of Health data confirmed—that this rule, which was instituted during the 2003 legislative session, has resulted in substantially reduced training reimbursements to many small rural hospitals, clinics, pharmacies and other training sites. While MERC reimbursement does not support mental health training sites per se, it does support primary care training sites, which are needed to promote and develop collaborative, interdisciplinary practice models.</p>	<ul style="list-style-type: none"> ○ In 2004 and 2005, clinical training sites that hosted fewer than 0.5 FTE trainees from an eligible clinical training program were eliminated from the distribution, as were any advanced practice nursing programs sponsored by organizations not part of the Minnesota State Colleges and Universities (MnSCU) system, the University of Minnesota Academic Health Center, the Mayo Clinic, or the Private College Council. ○ Legislation in 2007 requires the Commissioner to review the impact of the revised distribution on sponsoring institutions and clinical training sites with low numbers of eligible trainees and report the findings to the Legislature by January 15, 2009.
<p>C-4. Eliminate the copayments on psychopharmaceuticals for Medicaid and MinnesotaCare instituted in the 2003 legislative session. Creating financial barriers to care can be risky, particularly in the area of mental and behavioral health. If patients are unable to afford their medications, or if they cut back on doses as a result of financial pressures, their conditions may deteriorate, causing worsening symptoms and even a need for emergency and/or inpatient care.</p>	<ul style="list-style-type: none"> ○ As of Oct. 2007, All parents and single adults and households without children with incomes not exceeding 75 percent of FPG, who are not pregnant, pay \$3 copay per prescription ○ As of Oct. 2007, Single adults and households without children, with incomes greater than 75 percent but not exceeding 175 percent of FPG, pay \$3 copay per prescription which is subject to a \$20/month maximum
<p>C-5. Support the Minnesota Mental Health Action Group's (MMHAG) efforts to develop best practice and benefit models to address rural mental health needs in the primary care setting.</p>	
<p>C-6. Provide Medical Assistance reimbursement for care management and coordination of appropriate mental health patients at the primary clinic level. Some rural patients with complex mental health and physical health needs could be helped at the primary clinic level with care management services that could include regular follow-up by nurses or social workers for medication monitoring and counseling. Most primary care clinics do not have the resources to provide this type of service without a reimbursement.</p>	<p>In 2008, the Minnesota Legislature passed health care reform legislation that expanded medical homes to serve not only children with special health care needs, but adults with chronic and complex health conditions, calling this expanded concept "health care homes". The legislation includes payment to primary care providers for partnering with patients and families to provide coordination of care. The term "health care home" can be considered synonymous with "medical home".</p>

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<p>C-7. Establish an access-to-care standard for the Medical Assistance and other public health care programs that recognizes both distance to services and waiting time. Currently, geographic distance to care is defined in statute as an access indicator. Given the long waiting time sometimes required to see a mental health practitioner, these should also be factored into the access standard.</p>	
<p>C-8. Promote development and use of electronic health records in mental/chemical/behavioral health. Ensure that the rural mental health community is represented in state level discussions on developing and implementing electronic health records. Electronic health records are especially needed in the areas of mental, behavioral and chemical health because of the fragmentation of the treatment system.</p>	<ul style="list-style-type: none"> ○ Several significant mandates were enacted in the 2007 and 2008 legislative sessions that impact all health care providers in Minnesota: <ul style="list-style-type: none"> ○ A mandate that all health care providers and hospitals have an interoperable electronic health record (EHR) system by 2015. ○ A requirement to develop a statewide implementation plan to meet the 2015 interoperable EHR mandate. ○ The requirement to establish uniform health data standards by 2009. ○ A requirement that all health care providers and payers establish and use an e-prescribing system by January 1, 2011.
<p>C-9. Support the development of crisis response teams through collaboration among the Minnesota Department of Human Services, counties and health plans. This might include rural regional urgent mental health care clinics, crosstrained crisis response teams or mental health telemedicine networks.</p>	<ul style="list-style-type: none"> ○ In 2006, DHS State Operated Services (SOS) began providing inpatient psychiatric care for adults in dispersed 16-bed psychiatric hospitals in Greater Minnesota rather than in larger, institutional facilities on regional treatment center campuses. Development of these Community Behavioral Health Hospitals is part of a redesign of community mental health services in Minnesota. Community Behavioral Health Hospitals are short-term, acute psychiatric hospitals with about 35 staff, including mental health professionals specializing in psychiatry, nursing, psychology and social work. Referrals for admissions are processed 24 hours a day through a centralized pre-admission center where medical necessity and medical stability is assessed to insure an appropriate placement at an appropriate level of care. ○ Update on adult mental health crisis response services: www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_136571.pdf

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<p>C-10. Promote mental health emergency quality improvement projects in Critical Access Hospitals through funding from the Medicare Rural Hospital Flexibility grants. The Office of Rural Health and Primary Care administers the federally funded Medicare Rural Hospital Flexibility (Flex) Program in Minnesota. In publicizing and distributing Flex mini-grants, the ORHPC should encourage development of quality improvement projects focused on Critical Access Hospitals’ mental health emergency response capabilities.</p>	<ul style="list-style-type: none"> ○ FFY 2008: Flex Grant to Northfield Hospital to respond to heroin/opiate abuse in northern Rice County ○ FFY 2007: Flex Grant to St. Gabriel's, Little Falls for \$22K to improve early identification of mental health needs of elementary school students. ○ FFY 2007: Flex Partnership Grant to Arrowhead EMS for \$15K to continue EMS inter-facility transfer training. ○ FFY 2006: Flex Partnership Grant to Arrowhead EMS for \$15K to develop training and provide training statewide for EMS agencies on inter-facility transfers for behavioral health emergencies. ○ FFY 2006: Flex Grant to Avera Marshall for \$25K to enhance behavioral health services in SW MN through an architectural study for an in-patient unit.
<p>C-11. Improve and bring Medicare coverage for mental illness to parity with physical illness coverage. The current Medicare Part B coinsurance rate for mental health services is 50 percent as opposed to 20 percent for physical health services. This high coinsurance rate creates a barrier to care for Medicare beneficiaries.</p>	<p><i>The Mental Health Parity Act</i> – The House and Senate overrode the President's veto of H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008, providing the two-thirds vote necessary by votes of 383-41 and 70-26, respectively. The bill reverses the 10.6 percent reduction in Medicare reimbursements for physicians that took effect on July 1. It also provides Medicare mental health equity, by phasing in, over six years, a reduction in the 50 percent mental health copayment requirement to the 20 percent required for all other outpatient services.</p>
<p>C-12. Create a coordinated data collection and analysis system for mental health incidence, prevalence and treatment data in Minnesota. This database should be developed in coordination with the Minnesota Departments of Health, Human Services, and Corrections, health plans, Minnesota Mental Health Action Group and other mental health stakeholder groups representing consumers and providers.</p>	