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# The Reach of the MeHAF Integrated Care Initiative

2009 - 2012

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## Introduction

The Maine Health Access Foundation (MeHAF) launched the Integration Initiative in 2007 to improve integration of primary care and behavioral/mental health care services as a means of promoting patient and family-centered care. Between 2007 and 2009, MeHAF funded three rounds of grants, including one- and two-year planning grants and three-year clinical implementation, data, and systems transformation grants. Forty-two grants were awarded and involved over 100 practices and over 150 partnering organizations. Of these, 23 were clinical implementation grants, awarded in 66 care sites.

In January 2009, John Snow, Inc. (JSI) was contracted by MeHAF to conduct a cross-site evaluation of the clinical implementation (CI) grants. The RE-AIM framework was selected to guide the formative evaluation (see [www.re-aim.org](http://www.re-aim.org)) because it is a structured approach to identify critical elements related to successful program implementation in a variety of settings, as well as to identify implications for spread to other settings. RE-AIM is an acronym for the five evaluation domains: Reach, Effectiveness, Adoption, Implementation, and Maintenance. This framework was chosen for this formative evaluation.

Over the past five years, JSI has produced many evaluation documents, focusing on different dimensions of the RE-AIM framework. Two cumulative reports (in 2009 and 2011) touched on all dimensions of the framework, but with particular emphasis on the adoption and implementation of care integration in participating Maine organizations. Four case studies were produced, systematically describing some unique aspects within the Initiative: a wellness and peer navigation program for persons with severe and persistent mental illness, mental/behavioral health integration in nursing home settings, patient engagement, and case and care management in the integrated care context. In 2013-2014, JSI also focused on analyzing the quantitative data from the initiative. In July 2013 a report describing the effectiveness of the program from the perspective of patient level clinical outcomes was produced.

This report will describe the "reach" of the Integration Initiative. The formal definition of reach in the context of the RE-AIM framework is "the absolute number, proportion, and representativeness of individuals who are willing to participate in a given initiative." ( See [http://www.re-aim.hnfe.vt.edu/about\\_re-aim/what\\_is\\_re-aim/index.html](http://www.re-aim.hnfe.vt.edu/about_re-aim/what_is_re-aim/index.html) ) Uptake of integration services is one way to evaluate the Initiative, since relatively high levels of uptake indicate a well-functioning program that meets the needs of patients/clients. It also provides a sense of the extent of the Initiative's impact among Maine residents. For the MeHAF Integration Initiative, we will examine the number of patients/clients who accessed the integrated services offered at the grant funded clinical implementation sites. The four sets of questions addressed in this report are:

- What was the number of people who accessed integrated care and what were their demographic characteristics?
- What proportion of clinical sites' practice panels accessed integrated care? What proportion of the county and state population receives care at clinical implementation sites?
- How representative are participating Federally Qualified Health Center (FQHC) practices of all FQHC practices in Maine?
- For what reasons were people referred for integrated mental health/behavioral health services?

The “reach” of the initiative as described here is based on data collected during 2009-2012 grant period. Many of the grantees have since expanded integrated services beyond the initial clinical sites, while some closed down integrated sites, and some no longer offer the same services that they did during the grant period. Integrated care has spread extensively in Maine. As a result of a systems transformation grant, all sites participating in Maine’s all-payer (including Medicare) Patient Centered Medical Home pilot are required to integrate behavioral health and primary care. This included the 25 sites in the first round of the pilot and the 50 who joined in Round 2 of the pilot in 2013. Additionally, the Maine Department of Health and Human Services MaineCare office required integrated care as a core principle in its ACA Section 2703 Health Homes and Behavioral Health Homes. By 2014, 45% of all primary care practices were engaged in some level of integrated care, often with state policy supports. By 2015, close to 50% of practices were integrating care. These more recent changes in the spread of integrated care are not captured in this report.

## Methods

All clinical implementation grantees were required to systematically and consistently collect counts of patients/clients who came in contact with the Initiative. JSI developed a Microsoft Access database to collect these "client data elements" (hence the name CDE database), and worked with each grantee to define each data element and develop a process to collect the data from each of their clinical sites. Grantees entered the data quarterly into their Access database and uploaded their database to JSI's secure web portal. For the first year of data submission, JSI performed detailed data quality checks, gave each organization a quality rating for its data, and worked to resolve inconsistencies. After two to four quarters, nearly all organizations were able to consistently and accurately provide most CDE data elements.

The set of data elements was intentionally small in order to: 1) minimize reporting burden; 2) maximize the comparability of data elements across diverse organizations. The key data elements were: the number of people who were screened for symptoms, number of symptomatic people who were assessed by an integrated care provider, and the number who made and kept a second face-to-face visit within 90 days after the initial visit. The focus of the reach analysis is on those who had ***an initial assessment visit with an integrated services provider*** as the measure of access. Demographics – age, gender, insurance status, and race/ethnicity – were collected on the people who were assessed for integrated services. Descriptions of the top five referral reasons for additional integrated services (post-initial assessment) were also ascertained, which we examine as a proxy as to why people initially accessed integrated services.

There are limitations to the CDE data. Our key reach measure, initial assessment, is a marker of having one face-to-face encounter, a good indicator of access. However, it does not provide any information about longer term engagement in care. Many organizations struggled with reporting the number of persons screened for mental health/behavioral health (MH/BH) issues. Many practices continued to rely on informal screening rather than systematic use of screening tools, making it difficult to identify and count all occurrences of screening. Also, many patients’ health-related behavioral needs were addressed

in a single encounter with a behavioral specialist and were not always tracked. For this reason we do not report on the reach of the screening effort.

To avoid dealing with various procedure and diagnostic coding conventions and billing systems, organizations were asked to simply provide the (informal) names of the "top 5" reasons for referral each quarter, typically abstracted from the integrated (often behavioral health) provider's notes; however, they did not report counts of the number of patient/clients by referral reason. Thus, we can describe in a general way the reasons why people accessed integrated care, but cannot report out the prevalence of specific conditions.

To put the results about access in context, we used supplemental data from several sources. Maine population counts by county were taken from the 2010 U. S. Census,<sup>1</sup> and prevalence of mental health symptoms and diagnoses were taken from the 2010 Maine Behavioral Risk Factor Surveillance System (BRFSS).<sup>2</sup> JSI collected information about the panel sizes of participating sites by using a survey that was reviewed with grantees either during their annual site visit or conference call. For federally qualified health centers (FQHCs), demographics of panel sizes were taken from the Uniform Data System (UDS) 2010 dataset.<sup>3</sup> Information on the insurance status of Maine residents comes from the Current Population Survey, Annual Social and Economic Supplement, analyzed by the Kaiser Family Foundation<sup>4</sup>.

All but one grantee provided CDE data for all or at least some of their care sites. ***We focus on the 22 grantees and their associated 62 clinical care sites that provided useable CDE data.*** Only 45 care sites provided panel size information. Thus, for some analyses, some sites may drop out due to missing data, resulting in an undercount of the actual count of clients/patients reached.

## Results

- **What was the number of people who accessed integrated care, and what were their demographic characteristics?**

During the period from ***January 2009 through December 2012, over 11,124 Maine residents accessed the new services provided by the Integration Initiative.*** The majority had at least one face-to-face visit with a behavioral health provider (n=9,237; 83%), or their primary care provider had a consultation with a psychiatrist (n=1,329; 12%). Others received dental care (n=318; 3%), typically after an emergency room visit for a dental issue, and several were persons with a serious mental illness who accessed primary care (n=240; 2%).

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<sup>1</sup> Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2012. Source: U.S. Census Bureau, Population Division. <http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>

<sup>2</sup> Maine Behavioral Risk Surveillance Survey Interactive Web Query. 2010 Survey results. Maine Department of Health and Human Services accessed at <https://data.mainepublichealth.gov/brfss/>.

<sup>3</sup> From the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Primary Health Care Uniform Data Set. Program Grantee Health Center Profiles 2012 (2011 Data). Accessed from the Health Resources and Services Administration. <http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&state=ME#glist>

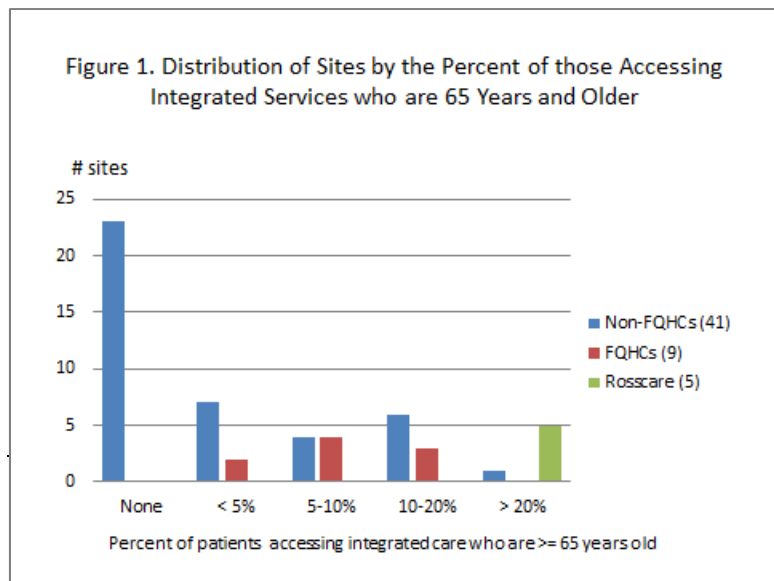
<sup>4</sup> <http://kff.org/other/state-indicator/total-population/?state=ME>. Accessed January 30, 2014.

Demographics of participants are presented in Table 1. The majority of participants were female (n=6,904; 62%), though substantial numbers of males also accessed integrated care (n=4,124; 37%). The majority were adults in the age range from 19 to 64 years (n=7,542; 68%), and the vast majority were white non-Hispanics (n=8,858; 80%). Nearly 20% were missing data on race/ethnicity. Those who accessed care were more likely female and adults age 19 to 64, than the population of Maine as a whole. [in chart, put Demographics of Maine Population on the top line and USCensus—2010 under it]

**Table 1: Demographics of the Initiative Compared to the State**

	MeHAF Integration Initiative CDE Data: # Initially Assessed by Demographic Category		United States Census - 2010: Demographics of Maine Population	
	Total # People	11,124	Total # People	1,328,361
<b>Gender</b>	# people	% of total	# people	% of total
Females	6904	62%	650,056	49%
Males	4124	37%	678,305	51%
Unreported	96	1%	0	0%
<b>Age Range</b>	# people	% of total	# people	% of total
0 to 18 years	2493	22%	274,533	21%
19 to 64 years	7542	68%	842,748	63%
65 years and over	969	9%	211,080	16%
Unreported	120	1%		
<b>Ethnicity</b>	# people	% of total	# people	% of total
Hispanic/Latino	230	2%	16,935	1%
Other Ethnicities	8449	76%	1,311,426	99%
Unreported	2445	22%	0	0%
<b>Race</b>	# people	% of total	# people	% of total
Asian/Hawaiian/PI	88	1%	13,913	1%
Black/African-Amer.	101	1%	15,707	1%
Amer.Indian/AK Native	165	1%	8,568	1%
White	8858	80%	1,264,971	95%
Multi-racial	56	1%	20,941	2%
Unreported	1856	17%	4,261	0%

While the overall rate of access among older adults was 9%, it was not uniformly distributed among all sites. One organization, Rosscare, provided integrated behavioral health services in 4 nursing homes and



West Side Court, a unit at EMMC for patients with special needs, such as dementia and Alzheimer's Disease. At these 5 sites, between 65% and 80% of patients were over 65 years old. Among the other 41 non-FQHC practices, over half had no older adults participating. Enrollment was generally better at FQHCs; at 6 of the 9 FQHCs, between 10-20% of

participants were over 65 years old. Compared to elsewhere in the United States, FQHCs in Maine serve a higher proportion of adults over age 65 (15% compared to 6.8% in 2010). Because Maine FQHCs play a significant role in serving the over 65 population, it is notable that they included this population in their referrals for integrated services.

Pediatric participation also varied depending on the organization type. At FQHC locations 20% of integrated behavioral health patients were under the age of 18 compared to 15% in non-FQHC sites. The age distribution by organizational type indicates that FQHC locations distributed services across a broader age mix of patient populations than did non-FQHC sites.

As shown in Table 2, 21% of participants were uninsured, 51% enrolled in Medicare or Medicaid, and 23% had private health insurance. In comparison, only 10% of Maine residents and 16% of FQHC patients were uninsured. Fourteen of the 62 clinical sites were FQHCs (22%), and accounted for nearly half of the participants (n=5,483; or 49%). Uninsured people clearly were referred to integrated behavioral health at higher rates than people with other types of insurance.

**Table 2: Insurance Coverage of IBH Patients Compared to State**

Insurance Coverage	IBH enrolled patients (2010)	MAINE: US Census (KFF) 2012	FQHC Total Population Insurance Distribution
Uninsured	21%	10%	16%
Medicaid	29%	23%	31%
Medicare	22%	13%	19%
Private	23%	52%	35%
	5% - unreported	2% - other public (VA, military)	

There are no comparable public access data sets that provide information about utilization of MH/BH services for demographic groups. However, there are population-based estimates of mental health diagnosis and symptoms. The Maine 2010 BRFSS data system provides this information for the adult population (Table 3). By about a 2-to-1 margin, women were statistically significantly more likely to report they were told by a doctor that they had depression or anxiety, or were currently receiving MH treatment. However, the prevalence of current (past two weeks) depressive symptoms was equal between genders. About 9% of both men and women expressed anhedonia [is this a term most readers would know?] or depressed mood or both; most of these respondents had moderate to severe symptoms.

Table 3 also shows that Maine BRFSS data indicate similar prevalence history of doctor-diagnosed depression (21.1%), anxiety (17.3%), diagnosis and treatment (15.7%) across the age groups of 18-34 years, 35-49 years, and 50-64 years, and statistically significantly lower rates were found among those aged 65 and older. This age group also has significantly lower current symptoms than younger adults (6% vs. 10%). It is important to remember that BRFSS is a survey of the non-institutionalized population, and so excludes persons living in nursing homes.

**Table 3. Maine 2010 BRFSS Results for Mental Health Questions by Gender and Age**

	Has a doctor or other HP ever told you that you had depression?		Has a doctor or other HP ever told you that you have anxiety disorder?		Current PHQ2 Positive		Are you now taking medicine or receiving treatment from a doctor or HP for MH condition or emotional problem?	
Gender	Prevalence	95% CI	Prevalence	95% CI	Prevalence	95% CI	Prevalence	95% CI
Female	26.9%	(25.2 - 28.6)	21.7%	(20.1 - 23.2)	9.1%	(7.5 - 10.7)	20.2%	(18.7 - 21.7)
Male	14.7%	(13.2 - 16.3)	12.6%	(11.0 - 14.1)	9.2%	(6.7 - 11.7)	10.9%	(9.5 - 12.3)
<b>TOTAL</b>	21.1%	(19.9 - 22.3)	17.3%	(16.2 - 18.4)	9.2%	(7.7 - 10.6)	15.7%	(14.7 - 16.8)
Age Group	Prevalence	95% CI	Prevalence	95% CI	Prevalence	95% CI	Prevalence	95% CI
18-34 years	21.1%	(17.7 - 24.6)	20.1%	(16.8 - 23.5)	9.9%	(6.4 - 13.3)	14.3%	(11.3 - 17.3)
35-49 years	22.7%	(20.5 - 24.9)	18.8%	(16.7 - 20.8)	9.7%	(5.9 - 13.6)	17.9%	(15.9 - 19.9)
50-64 years	25.1%	(23.3 - 27.0)	18.7%	(17.1 - 20.4)	10.2%	(8.5 - 11.8)	18.2%	(16.6 - 19.8)
65+ years	13.3%	(11.9 - 14.7)	10.1%	(8.8 - 11.4)	6.2%	(4.6 - 7.7)	11.2%	(9.9 - 12.6)
<b>TOTAL</b>	21.1%	(19.9 - 22.3)	17.3%	(16.2 - 18.4)	9.2%	(7.7 - 10.6)	15.7%	(14.7 - 16.8)

CI = 95% Confidence Interval; the range of values that has a 95% probability of including the true, but unknown, value

The implication of these findings (data from Figure 1 and Table 3) is that there may be under-identification of depression and anxiety in men and older adults. We cannot determine from the data whether the clinical implementation grantees identified the "correct" number of men and older adults, but future programs should give consideration to gender and age differences in accessing services. Importantly, most of the participating sites had broad criteria for accessing integrated services (not just depression and anxiety), which increases the potential to address the needs of sub-groups, such as men and older adults.

Detailed prevalence data for behavioral health needs and treatment among children are not available in the BRFSS Survey; however, some information is available in the National Survey of Children's Health (NSCH)<sup>5</sup>. Among children age four months to five years in Maine, 5.7% of children are at high risk for developmental, behavioral or social delays. In terms of treatment, the 2011/2012 NSCH found that 9.7% of Maine children age 2-17 were taking medication for emotions/concentration/behavior (including ADD/ADHD). Among the population served through integrated services 22% (2,493) were pediatric, age 0-18 years. Most of these children were at sites that also served adults (1,580 children). There were 18 sites with integrated projects providing specialized services to children or families. These sites variously provided psychiatric consultation to pediatricians, autism screening, parenting advice for problem behaviors, and/or mental health services in school-based health centers (913 children).

<sup>5</sup> Data Resource Center for Child and Adolescent Health, National Survey of Children's Health 2011/2012. From the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Accessed at <http://www.childhealthdata.org/browse/survey?q=2487&r=21>

- **What proportion of clinical sites' practice panels accessed integrated care? What proportion of the county and state population received care at clinical implementation sites?**

**For sites that supplied their average annual practice size, we were able to estimate the proportion of their practice that accessed integrated care.** There were 45 such sites, representing 73% of those included in this analysis (45/62). **Overall, the penetration rate was 6.1%** (9,809 of 160,699 total patients) with 25 sites having rates between 1-5%, 10 sites having rates between 6-10%, and 10 sites having a rate >10% (Table 4).

These 45 clinical sites were located in various counties throughout the state. While each of the clinical sites may serve patients beyond their local area, the population count for the county in which each site is located is a reasonable estimate of its target population. Our cross-site evaluation found that most participating sites were making integrated care available to all of their patients/clients if they needed it. Thus, another way to estimate the reach of the initiative is to examine the proportion of the population that is served by the clinical sites. **Overall, about 12% of the population of Maine received services at the 45 (of 62) integrated sites that provided panel size information and had the potential for accessing integrated services** (Table 5). In some counties, the penetration rate was even higher: Aroostook (30%), Kennebec (24%), Knox (76%), Oxford (47%). Some counties had relatively few and/or small sites (Franklin, Washington, York), and some had no sites at all (Piscataquis, Somerset). These data are based on sites involved in integrated care during the grant period. Many grantees expanded to other sites, but those numbers are not reflected here.

**Table 4. Estimated Proportion of Participating Practices' Patients Who Accessed Integrated Care, by Grantee Organization and Grant Award Year**

Grantee Organization	Site	County	# Patients Assessed	Practice Size (# Patients)	Estimated Participation Rate
Acadia Hospital-2007	Downeast Occupational Health Center	Hancock	63	n/a	n/a
Acadia Hospital-2007	Blue Hill Family Medicine	Hancock	14	n/a	n/a
<b>Acadia 2007 Total</b>			<b>77</b>		
Acadia Hospital-2008	Acadia Hospital	Penobscot	318	3,500	9.1%
Amistad, Inc.	Amistad	Cumberland	55	800	6.9%
Aroostook Mental Health Services/Impl.	Pines Health Services	Aroostook	497	15,050	3.3%
Aroostook Mental Health Services/Impl.	Fish River Rural Health Center	Aroostook	137	3,257	4.2%
Aroostook Mental Health Services/Impl.	Houlton Regional Hospital	Aroostook	17	973	1.7%
<b>AMHS Total</b>			<b>651</b>	<b>19,280</b>	<b>3.4%</b>
Community Counseling Center	Deering High School	Cumberland	58	1,326	4.4%
Community Counseling Center	Portland High School	Cumberland	72	1,107	6.5%
<b>CCC Total</b>			<b>130</b>	<b>2,433</b>	<b>5.3%</b>



Grantee Organization	Site	County	# Patients Assessed	Practice Size (# Patients)	Estimated Participation Rate
Community Dental	Community Dental - Rumford	Oxford	240	13,700	1.8%
DFD Russell Medical Center Combined	Leeds, Monmouth, Turner Health Centers	Androscoggin/Kennebec	1,090	7,582	14.4%
Downeast Health Services, Inc.	Family First & PATT-Indian Township	Washington	47	334	14.1%
Downeast Health Services, Inc.	Milbridge Medical Center	Washington	44	314	14.0%
Downeast Health Services, Inc.	Pleasant Point	Washington	25	482	5.2%
<b>Downeast Total</b>			<b>116</b>	<b>1,130</b>	<b>10.3%</b>
EMMC	Center for Family Medicine	Penobscot	115	5,977	1.9%
Evergreen/Franklin Behavioral Services	Franklin Pediatrics/Developmental Pediatrics	Franklin	32	486	6.6%
Health Reach Community Health Centers	Belgrade, Lovejoy, Western Maine, Sheepscot, Madison, Mt. Abram Combined	Kennebec	1,276	29,071	4.4%
Maine-Dartmouth Family Medicine Residency (expected to enroll from among 200 BOLM participants)	FMI	Kennebec	275	n/a	n/a
Mercy Hospital	Fore River Family Practice	Cumberland	183	4,865	3.8%
Pen Bay Health Care	All (10) sites combined	Knox	843	30,000	2.8%
Penobscot Community Health Center	Capehart Community Clinic	Penobscot	180	2,000	9.0%
Rosscare Nursing Home, Inc.	Rosscare Colonial Home	Penobscot	29	142	20.4%
Rosscare Nursing Home, Inc.	EMMC WSC	Penobscot	17	n/a	n/a
Rosscare Nursing Home, Inc.	Rosscare Dexter Home	Penobscot	15	125	12.0%
Rosscare Nursing Home, Inc.	Rosscare Ross Manor	Penobscot	72	774	9.3%
Rosscare Nursing Home, Inc.	Rosscare Stillwater Home	Penobscot	31	285	10.9%
<b>Rosscare Total (excluding EMMC WSC)*</b>			<b>147</b>	<b>1,326</b>	<b>11.1%</b>
Sacopee Valley Health Center	Sacopee Valley Health Center	Oxford	2,176	4,000	54.4%
Spring Harbor Hospital-2007 Combined	Phase III Aggregate (7 sites)	Cumberland	610	n/a	n/a
Spring Harbor Hospital-2008	Martins Point Brunswick	Cumberland	174	3,761	4.6%
Spring Harbor Hospital-2008	Bowdoin Medical	Cumberland	140	7,500	1.9%
Spring Harbor Hospital-2008	Parkview Pediatrics	Cumberland	34	3,906	0.9%
Spring Harbor Hospital-2008	MidCoast Pediatrics	Penobscot	56	3,718	1.5%
Spring Harbor Hospital-2008	Westbrook Pediatrics	Cumberland	88	n/a	n/a
Spring Harbor Hospital-2008	Lincoln Medical Boothbay, Intermed Yarmouth	Lincoln	13	n/a	n/a
Spring Harbor Hospital-2008	Western Maine Pediatrics	Oxford	88	n/a	n/a

Grantee Organization	Site	County	# Patients Assessed	Practice Size (# Patients)	Estimated Participation Rate
<b>Spring Harbor Total (Martins Point, Bowdoin, Parkview, MidCoast Only)*</b>			<b>404</b>	<b>18,885</b>	<b>2.1%</b>
Tri-County Mental Health Services	River Valley Internal Medicine	Oxford	185	n/a	n/a
Tri-County Mental Health Services	Swift River Family Medicine	Oxford	625	6,645	9.4%
Tri-County Mental Health Services	Ellsmore-Dixfield Family Medicine	Oxford	178	2,651	6.7%
Tri-County Mental Health Services	Bridgton Integrated Primary Care	Cumberland	923	2,588	35.7%
<b>Tri-County Total (excluding River Valley IM)*</b>			<b>1,726</b>	<b>11,884</b>	<b>14.5%</b>
York County Community Action Corp.	York County Community Action Corp.	York	127	1,830	6.9%
<b>TOTAL (sites with complete data only)</b>			<b>9,809</b>	<b>158,749</b>	<b>6.2%</b>

Note: Subtotals are by grantee organization. Only sites with both # assessed and panel size data are included in these rows in order to compute the overall participation rate for the grantee organization.

**Table 5. Estimated Proportion of Maine Residents Who Receive Care at Integrated Sites (n = 45/62 with Complete Data) During Grant Period**

County	# People who Receive Care at 45 Participating Sites*	County Population 2010 Census	Percent of Population
Androscoggin Total	7,582	107,702	7.0%
Aroostook Total	19,280	71,870	26.8%
Cumberland Total	25,853	281,674	9.2%
Franklin Total	486	30,768	1.6%
Kennebec Total	29,071	122,151	23.8%
Knox Total	30,000	39,736	75.5%
Oxford Total	26,996	57,833	46.7%
Penobscot Total	16,521	153,923	10.7%
Washington Total	1,130	32,856	3.4%
York Total	1,830	197,131	0.9%
<b>Maine Grand Total**</b>	<b>158,749</b>	<b>1,328,361</b>	<b>12.0%</b>

\* This column represents the total panel size of the 45 sites by county. It does not include integrated care sites in the county that were not participating in the MeHAF grant project.

\*\* The Counties of Piscataquis, Somerset, Hancock, Waldo, and Lincoln did not have integrated care sites.

This estimate assumes that integration sites only serve people within the county they are located. However, in reality the population served by participating sites may expand beyond the county borders. For example, Pen Bay Healthcare, located in Knox County, serves approximately 30,000 people, but some portion of these may be drawn from surrounding counties such as Lincoln and Waldo.

➤ **How Representative are Participating FQHC Practices of all FQHC Practices in Maine?**

Another way to examine reach is to examine whether the participating *practices* in the integration initiative are representative of primary care practices in the state of Maine overall. Unfortunately, demographics of private practices across the state are not available. However, the 2010 UDS system does provide this information for Maine FQHCs. Of the 62 implementation sites with CDE data, 14 were FQHCs and about half of all participants accessed integrated services at FQHCs. Thus, we examine practice representativeness in this very important subgroup of participating sites.

In 2010, there were 18 FQHCs in the State of Maine and they served a total 175,180 patients. FQHCs participating in the Integration Initiative served 113,483 patients in 2011, so that 65% of the total FQHC population had potential access to integrated care services (top of sections 2 and 3 of Table 6). Between 2008 and 2012, 5,346 (5%) participating FQHC patients actually accessed integrated care services (top of section 1 of Table 6). It is important to note that this number is likely an undercount of total integrated patients served, as in some cases such as Penobscot Community Health Center, integration services spread beyond the MeHAF funded project to include all their other practice sites but those data were not reported.

As would be expected, Maine’s FQHCs serve a higher proportion of uninsured and Medicaid-insured patients than is found in the state’s population overall. While 11% of people receiving care at participating FQHCs were uninsured (vs. 16% statewide), 30% of those who accessed IBH at FQHCs were uninsured. The large majority (73%) of patients of IBH patients were middle-aged adults (18-64 years). As noted earlier (page 4, table 1, figure 1), FQHCs enrolled relatively more older adults than private practices (excepting Rosscare). However, older adults were still under represented in IBH compared to their numbers receiving care at FQHCs (10% in IBH, 15% at participating FQHCs, 16% at all Maine FQHCs). Women were more likely to access integrated services than men. Sixty-three percent (63%) of the individuals receiving integrated care were women while 55% of all FQHC patients in the state were women.

**Table 6. Demographic Comparison of FQHCs Participating in MeHAF Integration Initiative to All Maine FQHCs**

	Demographics of People who Accessed Integrated Care at Participating FQHCs, 2008-2012		Demographics of People who Received Care at Participating FQHCs, 2011		Demographics of People who Received Care at All Maine FQHCs, 2010	
Total # of People	5,346		113,483		175,180	
Insurance Status	# people	% of total	# people	% of total	# people	% of total
Uninsured	1602	30%	13,026	11%	27,950	16%
Medicaid	1581	30%	34,383	30%	53,589	31%
Medicare	787	15%	22,704	20%	32,541	19%
Private	1269	24%	43,370	38%	60,738	35%
Unreported	106	2%	0	0%	0	0%
Gender	# people	% of total	# people	% of total	# people	% of total
Females	3361	63%	N/A	N/A	95,887	55%
Males	1980	37%	N/A	N/A	79,293	45%
Unreported	5	0%	N/A	N/A	0	0%
Age Range	# people	% of total	# people	% of total	# people	% of total
0 to 18 years	909	17%	27,898	25%	43,443	25%
19 to 64 years	3882	73%	68,614	60%	103,116	59%

65 years and over	528	10%	16,971	15%	28,621	16%
Unreported	27	1%	0	0%	0	0%

## Analysis of Referral Reasons

To better understand why people used integrated services, each quarter sites provided the top 5 reasons integrated providers referred patients for additional services after the initial visit. Typically those services were provided on-site, often by the same provider or practice team; as needed, referrals were made to other providers in the community. Our analysis is limited by the fact that not all sites provided reasons, and sites used their own language to describe referral reasons rather than formal ICD-9 or -10 diagnoses or procedure codes. The terms and counts in the following tables list the number of times a condition was a “top 5 reason for referral”; a qualitative description of the needs of patients. Appendix A lists how the referral reasons were grouped if multiple reasons were put into a single category.

Even with the limitations of the data, it is clear there was a wide range of reasons why patients were referred for additional services (394 unique referral reasons listed in the CDE were then classified into 53 broader categories of referral reasons). We examine only the most common reasons in this section of the report. Across all grantees, anxiety/panic/PTSD and depression/mood disorder were the most common referral reasons. Behavioral issues and relationships/marital issues/domestic abuse followed at about half the frequency of the depression and anxiety categories.

**Table 7. Top 5 Overall Reasons for Referral**

<u>Referral Reason</u>	<u># of times listed as a top 5 reason</u>
1. Anxiety/Panic/PTSD	171
2. Depression/Mood Disorder	152
3. Behavioral Issues	78
4. Relationships/Marital Issues/Domestic Abuse	63
5. Developmental Disorder	60
6. Medication Management	59
7. Therapy	56
8. Case/Care Management	55
9. Counseling	49
10. Other Mental Health Condition	42

## Comparison of Adult and Children’s referrals

Depression and anxiety were frequent “Top 5” referral reasons for both adults and children. However, there were differences in frequency (Table 8). Depression and mood disorder was the most frequent “Top 5” referral reason for adults, as compared to anxiety/panic/PTSD in children. Adult and pediatric practices shared many of the same top referral reasons; however, the adult practices referred patients more often for therapy, chronic disease management, and mental health conditions (e.g., bipolar,

psychosis) whereas the pediatric practices referred patients more often for development disorders (e.g., ADD, autism spectrum disorders), school issues, and diagnostic evaluation.

**Table 8. Top 5 Reasons for Referral, by Adult versus Pediatric Practices**

<u>Adult Practice</u>	<u>#</u>	<u>Pediatric Practice</u>	<u>#</u>
1. *Depression/Mood Disorder	119	*Anxiety/Panic/PTSD	67
2. *Anxiety/Panic/PTSD	104	*Behavioral Issues	50
3. *Relationships/Marital Issues/Domestic Abuse	50	Developmental Disorder	47
4. Therapy	50	*Depression/Mood Disorder	33
5. *Medication Management	48	*Case/Care Management	21
6. Chronic Disease	38	School Issues	18
7. *Behavioral Issues	37	*Counseling	14
8. *Counseling	35	*Relationships/Marital Issues/Domestic Abuse	13
9. *Case/Care Management	34	Diagnostic Evaluation	12
10. Other Mental Health Condition	34	*Medication Management	11

*\* indicates common referral reasons across all participants*

### **Comparison in Referrals by Federally Qualified Health Center (FQHC) practices compared to Non-Federally Qualified Health Center Practices**

Analysis of “Top 5” referral reasons of FQHCs showed distinct differences in the types of referrals being made. FQHC’s were more likely to refer patients to behavioral health for chronic disease, and this was the most frequent “Top 5” referral reasons. In addition, FQHC’s top 5 referrals often included relationships/marital issues/domestic abuse. In comparison, the non-FQHCs had a greater number of referrals for mental health diagnosis of anxiety/panic/PTSD and depression/mood disorder.

### **Comparisons in Referral Reasons across Funding Years**

There were three rounds of funding over the course of the Integration Initiative. The types of organizations funded during each cycle varied, and this was reflected in the “top 5” referral reasons. One example of this is that substance abuse was not identified as a top 5 referral reason for either the 2007 or 2008 grantees but was identified as the fifth most frequent “top 5 referral” for the 2009 grantees, probably because of one site that targeted their services specifically to patients with substance abuse conditions.

## **Conclusion**

The MeHAF Integration Initiative had an impact in reaching a broad distribution of the Maine population both by age, gender, and geography. During 2009-2012, an average of six percent of the patients at the clinical practice sites received integrated care. The clinical providers involved in the initiative served about 12% of the population of Maine, meaning that more than one in ten Maine residents accessed services from a provider who offered integrated behavioral and medical services. The primary referral

reasons for integrated services spanned mental health diagnosis such as anxiety and depression, chronic disease management, developmental concerns for children, and relationship concerns for adults. The full “reach” of the program is broader than what is captured here, as many of the clinical sites expanded their integration to additional clinical sites after their grant funding ended.

The Integration Initiative was successful in reaching those without insurance or who were low income (as measured by proxy of Medicaid). Although over 4,000 men accessed services, other research has shown that there may be under-identification of depression and anxiety in men. Access to integrated care for older adults was not uniform across sites; half of non-FQHC practices did not have any participants over the age of 65 years. While we cannot determine from the data whether the clinical implementation grantees identified the "correct" number of men and older adults, future programs should give consideration to gender and age differences in accessing integrated primary care-behavioral health services. Furthermore, the FQHC's participating in the Initiative were representative of FQHCs in Maine in terms of patient demographics. This indicates that their experience may be generalized to the larger FQHC population.

Overall, the MeHAF Integration Initiative clearly had a statewide impact, making services available across much of the geography of Maine, in both rural and urban areas.

**Appendix A: Definition of Categories within the Referral Reasons Take out categories not listed in the tables. I highlighted what I didn't find in tables.**

<u>Referral Reason Category</u>	<u>CDE Referral Reasons</u>
<b>ADJUSTMENT</b>	ADJUSTMENT
	ADJUSTMENT CHALLENGES - LCSW
	ADJUSTMENT DISORDER
	ADJUSTMENT TO FACILITY
	ADJUSTMENT TO TRAUMATIC CHANGE
	ADULT ADJUSTMNET AFFECTING RELATIONSHIP/CHILDREN
	LIEF STAGE CHANGES
<b>ANXIETY/PANIC/PTSD</b>	ADULT W/ POST TRAUMATIC ISSUES, TROUBLE PARENTING
	AGITATION – LCSW
	ANXIETY
	ANXIETY – LCSW
	ANXIETY / PANIC
	ANXIETY DISORDER
	GENERALIZED ANXIETY
	OCD
	PANIC
	PANIC DISORDER
	PTSD
	<b>BEHAVIOR CHANGE</b>
BEHAVIORAL HEALTH MOD	
BEHAVIORAL HEALTH MODIFICATION	
SMOKING CESSATION	
SMOKING CESSATION SUPPORT	
WEIGHT LOSS	
WEIGHT MANAGEMENT	
<b>BEHAVIORAL ISSUES</b>	AGGRESSION/BEHAVIOR PROBLEMS
	BEHAVIAL ISSUES
	BEHAVIOR - NOT MINDING
	BEHAVIOR - RELATED TO GRIEF/LOSS
	BEHAVIOR (CONCERN ABOUT NEGLECT IN PAST)
	BEHAVIOR / DEVELOPMENTAL CLINIC
	BEHAVIOR CONCERNS
	BEHAVIOR ISSUES
	BEHAVIOR MANAGEMENT
	BEHAVIOR, POOR SLEEP, QUESTION SENSORY INTEGRATION
	BEHAVIORAL / DEVELOPMENTAL CLINIC
	BEHAVIORAL ISSUES
	BEHAVIOURAL/DEVELOPMENTAL CLINIC
	BEHAVORAL ISSUES
	BXS PROHIBITING D/C TO APPROPRIATE LEVEL OF CARE
	CHALLENGING BEHAVIORS (List only once and not with the qualifiers]
	CHALLENGING BEHAVIORS - LCSW
	CHALLENGING BEHAVIORS - SELF
	CHALLENGING BEHAVIORS -LCSW

	CHALLENGING BEHAVIORS- LCSW
	CHALLENGING BEHAVIORS- SELF
	CONCERNS W/BEHAVIOR, TANTRUMS, HISTORY OF NEGLECT
	CONDUCT DISORDER
	DEFIANCE
	DISRUPTIVE BEHAVIORS, UNSTABLE /VOLATILE ENVIRONME
	FOLLOW UP VISITS RE: BEHAVIOR
	ODD
	OPPOSITIONAL DEFIANT DISORDER
<b>BEHAVIORAL ISSUES (CHILD)</b>	BEHAVIOIR - "CHILD BOLTING",EASILY FRUSTRATED
	BEHAVIOR, ESPECIALLY ABOUT TANTRUMS AT HOME
	BEHAVIOR, TANTRUMS AT HOME AND CONCERNS AT SCHOOL
	BEHAVIORAL ISSUES IN SCHOOL
	BEHAVIORS, TANTRUMS AND QUESTION OF SENSORY ISSUES
	CHILD BEHAVIOR
	PARENTAL CONCERN ABOUT BEHAVIOR
	PARENTAL CONCERN ABOUT MOOD SWINGS
	REPORTS OF HAVING TROUBLE WITH BEHAVIOR AT SCHOOL
<b>CARE COORDINATION/LINKAGES TO CARE</b>	ASSIST W/REMINDER/COORDINATION OF APPTS
	ASSIST WI/COORDINATION OF APPTS
	ASSISTANCE WITH COORDINATING MEDICAL REFERRAL/APPT
	CARE FACILITATION
	CONSOLIDATION OF SERVICES
	IDENTIFYING COMM RESOURCES: EXERCISE, HOME CARE
	LINKAGES
	LINKING W/ COMM RESOURCES
	NEED FOR A NEW CARE SETTING
	NEED FOR A NEW CARE SETTING - LCSW
	NEED FOR NEW CARE SETTING - LCSW
	PATIENT NAVIGATION OF MULTIPLE REFERRALS
	RESOURCE LOCATION
	RESOURCE LOCATOR
	RESOURCES
	SPECIALIST REFERRAL AND SCHEDULING
	WRAPAROUND
	WRAPAROUND SERVICES
<b>CASE/CARE MANAGEMENT</b>	CARE MANAGEMENT
	CARE/CASE MANAGEMENT
	CASE / CARE MANAGEMENT
	CASE MANAGEMENT
	CASE MANGEMENT
	CASE/CARE MANAGEMENT
	CASE/CARE MANAGEMETN
	CONTINUED CASE MGMT CDS, CPS, CHS, FF
	OTHER CASE MANAGEMENT/PEER SUPPORT
<b>CHILD DEVELOPMENT SERVICES</b>	CDS
	CDS EDUCATION-EARLY INTERVENTION
	CDS-SCHOOL



	CHILD DEVELOPMENT SERVICES
	DHHS/CDS
<b>CHRONIC DISEASE</b>	ASTHMA
	ASTHMA TREATMENT
	CHONIC DISEASE MANAGEMENT
	CHRONIC DISEASE
	CHRONIC DISEASE MANAGEMENT
	CHRONIC DISEASE MGT
	CHRONIC DISEASE SELF MNGMNT
	DIABETES FOLLOW-UP
	DIABETES SELF MGT FOLLOW-UP
	HYPERTENSION
	HYPTERTENSION
	NEW CHRONIC ILLNESS DIAGNOSIS
	OUTREACH SUPPORT FOR CHRONIC DISEASE SELF MGMT
	OUTREACH/SUPPORT FOR CHRONIC DISEASE SELF-MGMT
	RECENT DIAGNOSIS OF CHRONIC ILLNESS
<b>CHRONIC PAIN</b>	CHRONIC PAIN
	CHRONIC PAIN MANAGEMENT
	CHRONIC PAIN MGT
	PAIN MANAGEMENT
	PAIN PROGRAM
	STRESS RELATED TO CHRONIC PAIN
<b>COUNSELING</b>	1:1 COUNSELING
	COUNSELING
	COUNSELING (AFTER BEH. MOD.)
	COUNSELING (AFTER BEHAVIOR HEALTH MOD)
	COUNSELING (OUTSIDE SPECIALTY REFERRAL)
	COUNSELING (OUTSIDE/AFTER BEHAV HEALTH MOD)
	COUNSELING (OUTSIDE/AFTER BEHAV. HEALTH MOD)
	COUNSELING (OUTSIDE/AFTER BEHAVIORAL HEALTH MOD)
	COUNSELING REFERRAL
	COUNSELING REFERRALS
	COUNSELING SERVICES
	COUNSELING/PSYCH REFERRALS
	FAMILY COUNSELING CHCS
	MENTAL HEALTH COUNSELING
	ONGOING COUNSELING - FAMILY SUPPORT
	OUTPATIENT COUNSELING
SUPPORT / COUSELING	
<b>CRISIS</b>	CRISIS
	CRISIS INTERVENTION
<b>DEMENTIA</b>	DEMENTIA
	DEMENTIA - LCSW
<b>DENTAL</b>	DENTAL
<b>DEPRESSION/MOOD DISORDER</b>	DEPRESSION
	DEPRESSION - LCSW
	DEPRESSION - LCSW & PSYCH

	DEPRESSION COUNSELING
	DEPRESSION -LCSW
	DEPRESSION- LCSW
	DEPRESSIVE DISORDER
	DEPRESSIVE SYMPTOMS
	MOOD DISORDER
	MOOD DISORDER NOS
	MOOD DISTURBANCE
	MOOD INSTABILITY
<b>DEVELOPMENTAL DISORDER</b>	ADD
	ADHD
	ADHD CLINIC
	ASPERGERS
	ASPERGERS/AUTISM SPECTRUM
	AUTISM
<b>DEVELOPMENTAL ISSUES</b>	DEVELOPMENTAL DELAYS
	DEVELOPMENTAL ISSUES
	DEVELOPMENTAL PROGRAM
	DEVELOPMENTAL/BEHAVIOR EVALUATIONS
<b>DIAGNOSTIC EVALUATION</b>	DIAGNOSIS IN COMPLEX PATIENTS
	DIAGNOSTIC
	DIAGNOSTIC AND EVALUATION RELATED
	DIAGNOSTIC EVALUATION
	DIAGNOSTIC EVALUATIONS
	DIAGNOSTIC QUESTION
	DIAGNOSTIC QUESTIONS
	DIANOSTIC QUESTION
	INIAL ASSESSMENT
	INITIAL ASSESSMENT
	MENTAL HEALTH EVALUATION
	MENTAL HEALTH EVALUATION DC 0-3
	NEUROLOGY
	NEUROPSYCH TESTING
	NEW DIAGNOSIS OR TREATMENT
	PEDIATRIC EVALUATIONS
	PYSCHOLOGICAL EVALS
	REQUEST ADDITIONAL PSYCHIATRIC ASSESSMENT
	RULE OUT MAJOR MENTAL ILLNESS
	SCREENING
<b>DIAGNOSTIC EVALUATION (CHILD)</b>	CHILD PSYCHOLOGY EVALUATION
<b>FOLLOW UP BEHAVIORAL HEALTH</b>	BEHAVIORAL HEALTH
	BEHAVIORAL HEALTH FOLLOW UP
	FOLLOW UP APPOINTMENTS
	FOLLOW UP BEHAVIORAL HEALTH
	FOLLOW -UP BEHAVIORAL HEALTH
	FOLLOW UP BH
	FOLLOW-UP (BH)
	MENTAL HEALTH NEEDS

	OUTPATIENT PSYCH
	REFERRAL FOLLOW-UP
	REFUSES TO GO TO MENTAL HEALTH AGENCY
	REFUSES TO GO TO MENTAL HEALTH AGENCY (MCMHC)
	REFUSES TO GOTO MENTAL HEATHLH AGENCY
	STABILIZATION
<b>GENETIC DISORDER</b>	DOWN'S SYNDROME
<b>GRIEF</b>	BEREVEMENT
	GRIEF
	GRIEF AND LOSS
	GRIEF AND LOSS ISSUES
	GRIEF R/T LOSS OF INDEPENDENCE ESP. @ YOUNG AGE
	GRIEF/LOSS
<b>HEARING EXAM</b>	HEARING EXAM
<b>IN CONJUNCTION WITH PEDIATRICIAN</b>	IN CONJUNCTION WITH PEDIATRICIAN
<b>INTERPRETING</b>	INTERPRETING
<b>MEDICAL CARE</b>	FOLLOW-UP WITH PCP
	INJURY OF ILLNESS
	INJURY OR ILLNESS
	INJURY/ILLNESS
	MAJOR HEALTH DIAGNOSIS
	MEDICAL CARE
	MEDICAL CONDITIONS
	MEDICAL FACILITY OR HOME
	MEDICAL FACILITY/ PCP, N.P., OR P.A.
	MEDICALLY COMPLICATED
	NO PCP
	PCP
	PCP/ OUTPATIENT
<b>MEDICATION MANAGEMENT</b>	ASSIST W/ PRESCRIPTION ASSISTANCE PROGRAMS
	FOLLOW-UP REGARDING ADHERENCE
	MED MANAGEMENT
	MEDICAITON MANAGEMENT
	MEDICATION ADHERENCE
	MEDICATION CONSULTATION
	MEDICATION FOLLOW-UP
	MEDICATION MANAGEMENT
	MEDICATION MANAGEMENT MEDICATION MANAGEMENT
	MEDICATION MANAGEMENT (PSYCHIATRIST)
	MEDICATION MANAGEMENT SUPPORT
	MEDICATION MGT
	MEDICATION QUESTIONS
	MEDICATION/DIAGNOSTIC QUESTIONS
	PRESCRIPTION ASSISTANCE
<b>N/A</b>	0
	N/A
	NO REFERRALS THIS QUARTER
	NONE

	UNKNOWN
<b>OCCUPATIONAL THERAPY</b>	OCCUPATIONAL THERAPY
<b>OTHER</b>	HEALTHY MAINE PARTNERSHIP
	INDIVIDUAL
	OTHER
	OTHER - INDIVIDUAL TX
	OUR OFFICE
	REFERRED BY DR. CONOVER
	REFERRED BY PRIVATE PARTY
<b>OTHER MENTAL HEALTH CONDITION</b>	BIPLOAR
	BIPOLAR
	BIPOLAR DISORDER
	CONVERSION DISORDER
	DELERIUM/PSYCHOSIS - LCSW
	EXTREME DEPRIVATION / POSSIBLE SPECTRUM DISORDER
	HISTORY OF MENTAL ILLNESS
	HISTORY OF MENTAL ILLNESS - LCSW
	PSYCHOSIS
	PSYCHOSOCIAL COMPLICATIONS
	SIGNIFICANT CHANGE IN MENTAL STATUS
	SIGNIFICANT CHANGE IN MENTAL STATUS - LCSW
	SOMATIZATION DISORDER
<b>PARENT -CHILD RELATIONSHIP ISSUES</b>	PARENT -CHILD RELATIONSHIP ISSUES
	PARENT CONCERNS
	PARENT-CHILD REALTIONAL PROBLEM
	PARENT-CHILD RELATIONAL PROBLEMS
	PARENTING ISSUES / CONCERNS
	PARENTING ISSUES/CONCERNS
	RESIDENTIAL PARENTING PROGRAM - DHHS
<b>PEER SUPPORT</b>	CHOW
	ISSUES RELATED TO PRIMARY SUPPORT GROUP
	PEER SUPPORT
	PEER SUPPORT ( MAINE WARM LINE)
<b>PSYCHIATRIC CONSULTATION/DIAGNOSTIC EVALUATION</b>	PSYCHIATRIC
	PSYCHIATRIC CONSULTATION
	PSYCHIATRIC EVALS
	PSYCHIATRIC EVALUATION
	PSYCHIATRIC EVALUATION/REFERRALS
	PSYCHIATRIC EVALUATIONS
	PSYCHIATRIC REFERRAL/EVALUATIONS(DIAGNOSIS)
	PSYCHIATRIC/BEHAVIORAL HEALTH ORGANIZATION
	PSYCHIATRY REFERRAL
	PSYCHOLOGICAL
	PSYCHOLOGICAL EVALUATION
<b>PUBLIC HEALTH NURSING</b>	PUBLIC HEALTH NURSING
<b>RELATIONSHIPS/MARITAL ISSUES/DOMESTIC ABUSE</b>	DIVORCE
	DOMESTIC ABUSE
	DOMESTIC ABUSE/RELATIONSHIP STRESSORS

	DOMESTIC VIOLENCE
	DOMESTIC VIOLENCE/DIVORCE
	FAMILY CHANGES
	FAMILY CONFLICTS
	FAMILY CRISIS
	FAMILY ISSUES
	FAMILY STRESS
	FAMILY STRESSORS
	FAMILY STRESSORS/DIVORCE
	FAMILY SUPPORT
	MARITAL ISSUES
	MULTIPLE FAMILY ISSUES
	PEER ISSUES
	RELATIONAL PROBLEMS
	RELATIONSHIP ISSUES
	RELATIONSHIP ISSUES/DOMESTIC VIOLENCE
	RELATIONSHIPS/DOMESTIC VIOLENCE
	ROOMATE CHALLENGES
<b>RISK OF HARM TO OTHERS</b>	VIOLENCE
	VIOLENCE - LCSW
	VIOLENT
<b>SCHOOL ISSUES</b>	ACADEMIC STRUGGLES
	BEHAVIOR (TANTRUMS OR TROUBLE IN SCHOOL)
	BEHAVIOR ISSUES - SCHOOL RELATED
	CONCERNS ABOUT SCHOOL; LEARNING DIFFICULTY
	DECLINING SCHOOL PERFORMANCE
	OTHER SCHOOL BASED
	OTHER SCHOOL BASED SERVICE
	OTHER SCHOOL-BASED
	SCHOOL FUNCTIONING
	SCHOOL ISSUES
	SCHOOL PERFORMANCE
<b>SELF MANAGEMENT</b>	SELF MANAGEMENT
	SELF MANAGEMENT FOLLOW-UP
	SELF MGT FOLLOW-UP
	SELF MGT GOALS FOLLOW-UP
<b>SLEEP ISSUES</b>	INSOMNIA
	POOR SLEEP PATTERN, DISRUPTIVE BHV, FAMILY DISSENT
	SLEEP DISTURBANCE
<b>SOCIAL CONSTRAINTS/BARRIERS</b>	SOCIAL CONSTRAINTS/BARRIERS
<b>SOCIAL SERVICES</b>	APPLYING FOR DISABILITY
	ELDER RESOURCES
	HOUSING RETENTION
	TRANSPORTATION
<b>SPEECH THERAPY</b>	SPEECH
	SPEECH THERAPY
<b>STRESS</b>	LIFE STRESSORS
	MAJOR LIFE STRESSORS

	RECENT STRESSORS
	STRESS
	STRESS MANAGEMENT
	STRESS MGT
<b>STRESS/ANXIETY/DEPRESSION</b>	ANGER
	ANXIETY - STRESS
	ANXIETY AND DEPRESSION
	ANXIETY/DEPRESSION
	ANXIETY/DEPRESSION ONGOING TREATMENT
	DEPRESSION/ANXIETY
	STRESS/ANXIETY/DEPRESSION
	STRESS/ANXIETY/DEPRESSION MGT
<b>SUBSTANCE ABUSE</b>	ALCOHOL & SUBSTANCE ABUSE DISORDER BRIEF INTERVENT
	ALCOHOL AND SA DISORDER BRIEF INTERVENTION
	ALCOHOL/SA DISORDER (PT REQUEST EXTERNAL REFERRAL)
	ALCOHOL/SUBSTANCE ABUSE DISORDER BRIEF INTERVENTIO
	DETOX
	OPIATE DEPENDECE
	OPIATE DEPENDENCE
	OPIOID DEPENDENCE
	PREGNANT MOM WITH SUBSTANCE ABUSE
	SUBOXONE THERAPY
	SUBSTANCE ABUSE
	SUBSTANCE ABUSE FACILITY/SHELTER (MILESTONE FND
	SUBSTANCE ABUSE ISSUES
	SUBSTANCE ABUSE/DEPENDANCE
	SUBSTANCE USE
	SUBSTANCE USE ISSUES
<b>SUICIDE/RISK OF HARM</b>	RISK OF HARM TO SELF OR OTHERS
	RISK OF HARM TO SELF/OTHERS
<b>SUICIDE/RISK OF HARM TO SELF</b>	SUICIDE
	SUICIDE ATTEMPT
	SUICIDE ATTEMPT OR RISK - LCSW
	SUICIDE RISK - LCSW
<b>THERAPY</b>	BEHAVIORAL HEALTH THERAPY
	BRIEF THERAPY
	BRIEF TREATMENT
	FAMILY THERAPY & RECOMMENDATION
	FAMILY THERAPY & RECOMMENDATIONS
	FAMILY THERAPY AND RECOMMENDATIONS
	FOLLOW UP BRIEF THERAPY
	FOLLOW UP TO BRIEF THERAPY
	FOLLOW-UP BRIEF THERAPY
	FOLLOW-UP TO BRIEF THERAPY
	INITIATE THERAPY
	MENTAL HEALTH THERAPY
	ONGOING THERAPY AND MED MANAGEMENT
	PROBLEM SOLVING

	PROBLEM SOLVING - PST-PC
	PST-PC
	THERAPY
	THERAPY FOLLOW UP
<b>THERAPY (CHILD)</b>	SCHOOL BASED THERAPY
<b>THERAPY/COUNSELING</b>	BRIEF THERAPY/COUNSELING REFERRAL
	COUNSELING/THERAPY
<b>THERAPY/MEDICATION MANAGEMENT</b>	BRIEF THERAPY/ MED MANAGEMENT TOGETHER
	BRIEF THERAPY/MED MANAGEMENT TOEGETHER
	BRIEF THERAPY/MED MANAGEMENT TOGETHER
<b>TRAUMA</b>	TRAUMA
	TRAUMA EXPOSURE

[Just a note: It's surprising that chronic pain and Behavior Change weren't listed as frequent reasons for referral, isn't it?]