HSU Student Health Center QI Study
[5/16/2018]

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1. Purpose Statement

Student Health and Well Being Services (SHWB) of Humboldt State University launched a health psychology rotation (HPR) in the fall 2017 semester, gearing toward an integrated model of college health care services. Multiple staff members from Counseling and Psychological Services (CAPS) and Student Health Services (SHC) were involved. Unfortunately, the HPR ended in two months because of a low utilization rate. This report aimed at revisiting the HPR, as part of the Quality Improvement Committee work. First, the initiation of the HPR was reviewed in the context of the integration of mental health with physical health services. Second, data pertaining to the implementation and utilization of the HPR were collected and analyzed. Third, the experiences of staff members who were involved in the HPR were explored. If the HPR is to be re-introduced, the findings and suggestions of this report may provide a guideline to help administration and staff better prepare for the HPR and to avoid the similar issues.

2. Performance Goal

Needs for Integrated Health Care Services

The launch of the HPR may be better understood in the context of integrated health care, i.e., the integration of mental health care with physical health care. It has been well-documented that majority of primary care visits are related to mental health issues; some argue for as many as 70% of the visits (Hunter et al., 2009). According to the Spring 2016 NCHA-ACHA report, university students identified stress, anxiety, sleep problems, depression, and cold/flu/sore throat as the top five health problems affecting their academic performance, which was almost identical to the reports of students at Humboldt State University who reported stress (41.1%), anxiety (33.1%), sleep problems (30.3%), depression (26.5%), and cold/flu/sore throat (22.5%) as their top (NCHA-ACHA, Spring 2016).

Because of the high prevalence of mental health issues at primary care settings, integrated health care has shown to improve the quality of services, patients' satisfaction, and cost-effectiveness in primary care settings (as cited in Peek et al., 2014). Some studies provided support for the better outcomes at college/university health care settings (Funderburk et al., 2012). There have been various approaches to the practice of integrated health care. For instance, in 2007, a group of medical professional associations (AAFP et al., 2007) proposed the Patient-Centered Medical Home (PCMH) model aiming to provide accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective primary care. In 2014, the PCMH model has further evolved to incorporate behavioral, or mental health, care into primary care (The Working Party Group, 2014). The integrated PCMH model was endorsed by other mental health professional associations including NSWA, AAMF, and APA, with some concerns about the physician leadership model (Whitaker, 2014, Doherty et al., 2014; Anderson et al., 2014).

Integrated Health Services in University Health Care

Similarly but independently from the integrated PCMH model, college/university health services have experienced the need for an integrated model for health care services on campus (Alschuler et al., 2008). A recent study reported that integrated health care of 9 university health centers was associated with lower primary care utilization of college students who have a mental health diagnosis when compared to standard (non-integrated) health care of 11 university health centers (Turner et al., 2108). Because of the clear needs for and benefits of integrated health care, the number of universities adopting integrated health care model appears to be on the rise.

According to the 2007 annual report by the Association for University and College Counseling Center Directors (AUCCCD, Rando et al., 2007), there were 16% of college counseling centers (n=57) that were "fully integrated" (i.e., offices are in the same building). In 2010, the AUCCCD annual survey was revised to ask the levels of integration of counseling services with health services. Twenty four percent of counseling centers (n=101) were reportedly "administratively integrated." Similarly, in 2012, there were approximately 24% of counseling centers (n=98) "administratively integrated" (Mistler et al., 2012). However, in 2016, there were 31.7% of counseling centers (n=159) were "administratively integrated." Of course, it is unclear whether the increase is statistically significant. In the 2017 annual report, the term, *integrated*, disappeared. Instead, a new word, *collaboration*, was used to describe how counseling centers worked with student health care centers. Fifty six percent of the counseling center directors (n=275) reported that they reported to the same supervisor as their medical counterparts did, indicating administrative integration, and 34.9% of the centers (n=125) shared the front desk staff. Although the 2017 AUCCCD survey tapped into various forms of collaboration, the use of HPR has not been reported.

In fact, the HPR may indicate a higher level of integrated health care, or collaboration, than simply reporting to the same supervisor or sharing the front desk. According to the Association of Psychology Postdoctoral and Internship Centers (APPIC), which takes charge of the national matching program that places psychology postdoctoral and doctoral trainees in full time residency training. As of April, 2018, there were 791 training sites participated in the national match for 2018. Among them, 591 centers/agencies described their sites as offering the HPR and 59 of them were university counseling centers offering training opportunities in *health psychology*. For the list of the 59 universities (Appendix A).

Performance Goal

Overall, it is clear that integrated health care at a university counseling center can bring various benefits to students, to health service providers, and to university administration. Consequently, the more universities are adopting the integrated model. However, no current data is available, to our knowledge, regarding the HPR training among the 59 universities, which makes it difficult for a counseling center like HSU CAPS to set a performance goal. Thus, in this report, it was decided to not develop a performance goal that can be compared to. Instead, it was decided to incorporate qualitative data pertaining the experiences of staff involved in the HPR.

3. Description of Data

The HPR at Humboldt State University was discussed at staff meetings in Spring 2017, implemented for two months starting from August 28, 2017, and discontinued on October 27, 2017. The HPR was originally initiated by both directors of CAPS and SHC, with three broad reasons, or purposes. First,

medical providers at SHC were spending unexpectedly more time on dealing with mental health issues. Thus, introducing the HPR was expected to decrease medical providers' clinical hours dealing with mental health issues. Second, the HPR was expected to create an easy access and immediate referral path from SHC to CAPS. From time to time, medical providers had to walk students presenting mental health issues to CAPS for crisis intervention only to find that there was no services immediately available. In this regard, the HPR could play a liaison role smoothly connecting services between SHC and CAPS. Third, the HPR as post-graduate or postdoctoral training was expected to attract more candidates looking for further training in integrated health care. The introduction of the HPR could appeal to more candidates as the HPR has become essential part of training in 59 university counseling centers.

The HPR started in the last week of August. For almost two months, two staff psychologists (Stephanie McGrath, PsyD; Pio Kim, PhD), one psychotherapist (Shannen Vong, PhD), one post-doctoral resident (Dayn Menardo, PsyD), and two post-master's residents (Kristin Smith, MA; Moe Eubank, MA) were involved in the HPR, from two to four hours a week, covering most afternoons from 12:00 pm to 4:00 pm. In total, 152 hours were scheduled for the HPR and 24.5 hours were utilized for direct clinical services; twenty six students were served in the form of Health Psych Triage, Health Psych Assessment, Health Psych Session, Let's Talk, CAPS Intake, and CAPS Crisis. The utilization rate was 16.12% including all direct services hours. When only the first three HPR-related hours were counted (14.5 hours, 19 students), the utilization rate dropped to 9.5%. Because of this low utilization rate, the HPR was decided to discontinue before the end of October.

4. Evidence of Data Collection

The data described above were collected by manually counting the HPR-related appointments of the six counselors' schedule on Titanium, an electronic medical record program that HSU CAPS uses.

5. Data Analysis & Interpretation

Because the current data was frequency-based, descriptive analysis was good enough and there was no need for using inferential statistical methods.

6. Comparison

Experiences of Staff Involved in the HPR

In this section, quantitative data were compared to qualitative data. In addition to the utilization rate review (a quantitative approach), the experiences of staff members involved in the HPR could provide valuable hindsight (a qualitative approach). To give a voice to staff members' experiences, a survey was conducted. The purpose of the survey was to explore, without bias, the actual experiences of medical providers and counselors involved in the HPR. An anonymous survey was sent to five CAPS staff members who were involved in Health Psychology Rotation and to seven medical providers and two nurses at SHC on 4/20. The CAPS and SHC staff members were encouraged to click the link and share their opinions about the HPR with the following four questions until 5/04/2018. As of 5/05, ten members responded, with a response rate of 71%.

1. How did you want to utilize health psychology rotation?
2. How did you actually utilize the health psychology rotation?

3. Was there any that you could have done better or differently?
4. Please add any comment here.

Overall, staff at CAPS and SHC wanted to utilize the HPR as a "faster" "quick" "warm hand-off" and "ready access" in "acute mental health" situations with "minimal delay" to "the best expertise." Some also wanted "consulting" and "getting opinion" with/from each other and "training [opportunities] for residents." The HPR was also expected to provide "case management" and "links to resources." However, there were reportedly "very few referrals" actually made and counselors from CAPS "rarely saw students." It was partly because the HPR service was "not available" especially in the morning or staff at SHC "did not have a patient in urgent need." When there was no urgent need, medical providers would "recommend" counseling at CAPS. Although there were only a few cases, some staff utilized the HPR as they wanted. One respondent described the difficulties related to the HPR as follows:

> One stressful thing was a consistent lack of supplies (not enough consent forms, dry erase markers, paper, group lists, etc). I wished the role had more structure. Medical personnel told me they didn't know how to utilize us. The office location was removed from medical personnel, so I never got to talk to attending doctor. I frequently would just have a student at my door with no information or documentation and would spend 5 of our 15 minute triage trying to locate/create a file for them in Titanium. Multiple students told me they didn't know why they had been referred to me and without seeing any sort of intake paperwork or medical chart, I was at a loss for what to tell them. It often felt like I was trying to do an intake in 15 minutes with no intake paperwork.

This response well summarized other responses indicating the lack of "training" among both SHC and CAPS staff involved in the HPR, the problem of the HPR "location" limiting the proximity between medical and mental health providers, and the difficulty in medical record sharing or forwarding. Despite the difficulties, almost half of the staff members agreed that the HPR was "a good idea," "could be useful" and "would be helpful for future for residents." As some summarized, the utilization of the HPR was "unpredictable." However, "there is still room for improvement in trying other models for closer collaboration," one staff member stated.

7. Implementation

Integrated health care has emerged as a model in primary care and university health care for quality improvement, patients' satisfaction, and cost reduction. Likewise, at Humboldt State University, the health psychology rotation (HPR) initially intended to reduce medical providers' clinical hours dealing with mental health issues, to provide easy and immediate access to counseling services, and to provide training opportunities regarding integrated health care. The HPR was implemented for two months before its discontinuation because of low utilization. Staff members who were involved in the HPR pointed out the lack of training/education and operational planning as main factors contributing to the discontinuation.

The difficulties pertaining to the implementation of the HPR may not be uncommon. There have been discussions with regard to many hurdles to cross, including redefining terms, such as collaborative care vs. integrated care vs. shared care or clarifying a model for the integration, such as referral-based vs.

consultant-based (Miller et al., 2009). More importantly, clinicians involved in providing integrated health care often had to clarify clinical, operational, and financial logistics (Miller et al., 2009; Peek et al., 2014).

The formal and informal responses from staff disclosed several areas for further improvement. First, need assessment at various levels may improve the re-introduction of the HPR; the HPR is an integrated health care model in primary care and thus medical providers' needs for immediate psychological consultation or referral are crucial for the success of the HPR. Most medical providers answered "No" to Question 3 "Was there any that you could have done better or differently?" which suggested a low level of need for the HPR among medical providers. As mentioned, there were 10 university counseling centers offering training in health psychology in 2018. Humboldt State University was the smallest one among them. Other nine universities were at least twice larger than HSU by student enrollment. This small student enrollment may possibly be a factor contributing to the low need among medical providers. On the other hand, counselors at CAPS welcomed the HPR but pointed out a lack of training. Second, planning could have been more measurable. Although the initiation of the HPR had the nature of a pilot study, operational planning and goals were less measurable, such as how to direct the flow from medical to the HPR, what utilization rate the HPR aimed at, and what symptoms at what severity the HPR would deal with. Third, proximity and close interaction between CAPS and SHC staff can be improved. Some wondered whether it was because there were too many involved in the HPR on the CAPS side, creating a kind of bystander effect. Someone asked informally, "who was the lead?" One suggested in an email, "a single individual with specific training in case management may be able to fulfill this role more effectively, and is an important next step in supporting the desired collaboration." The same person also pointed out the proximity issue with a building design, "reshaping flow in an existing building already pushing capacity limits is challenging; future building design should consider integration and collaboration in design from the time a student walks in the door to the time they leave."

8. Re-Measurement

Because this report is a review of the HPR that was once implemented not re-introduced yet, there has not been a second round of data collection for re-measurement.

9. Implementation of Corrective Actions

Fortunately, there are institutes and agencies providing training/education in terms of integrated health care, such as the AIMS Center at the University of Washington (Advancing Integrated Mental Health Solutions, http://uwaims.org), the Academy for Integrating Behavioral Health and Primary Care (Agency for Healthcare Research and Quality, http://integrationacademy.ahrq.gov), and the SAMHSA-HRSA Center for Integrated Health Solutions (Substance Abuse and Mental Health Services Administration, http://www.integration.samhsa.gov), just to name a few. In addition, there are text books (e.g., Hunter et al., 2009), articles related to training (e.g., Belar, 1997), and free webinars from the Society of Health Psychology. Further, there must be a lot to learn from other university counseling centers that have successfully employed the HPR. Assessment of the level of integration can be monitored by using a validated instrument, such as the Practice Integration Profile (Kessler et al., 2016); at least the items of this instrument may provide an insight into what can be improved further. Last, but not least, a full-time clinician with a specialty in health psychology can improve the HPR in multiple ways at multiple levels, including planning, operating, training, and case-managing.

10. Communication

The draft of this QI report was prepared on 5/11/2018, was sent to those who were involved in the HPR (CAPS, SHC, and administration of SHWS) for their review, and revised to reflect their ideas and suggestions. This final version was submitted to the Quality Improvement Committee (Chair: Jessica Van Alsdale, MD, M.PH) on 5/16.

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APPENDIX A

LIST OF UNIVERISITY COUNSELING CENTERS OFFERING HEALTH PSYCHOLOGY TRAINING

	Site / Department
1	Arizona State University/Counseling Services
2	Baruch College, City University of New York/Student Health Center/ Counseling Center
3	Bowling Green State University/Counseling Center
4	**California State University, Long Beach/Counseling and Psychological Services**
5	**California State University, Northridge/University Counseling Services**
6	Cleveland State University /Counseling Center
7	Counseling and Psychiatric Services, University of Georgia/University Health Center
8	Florida International University/Counseling and Psychological Services
9	Georgia Southern University /Counseling Center
10	Georgia State University/Counseling & Testing Center
11	Georgia State University/Counseling and Testing Center
12	Georgia Tech Counseling Center/Division of Student Life
13	Grand Valley State University/University Counseling Center
14	Hofstra University/Student Health and Counseling Center
15	**Humboldt State University/Counseling and Psychological Services**
16	Iowa State University/Student Counseling Services
17	Keene State College/Counseling Center
18	Lake Forest College/Health & Wellness Center
19	Lehigh University /University Counseling and Psychological Services
20	Loyola Marymount University/Student Psychological Services
21	Memorial University of Newfoundland/University Counselling Centre
22	Montana State University, Bozeman/Counseling and Psychological Services
23	New Mexico State University/Aggie Health & Wellness Center
24	Northern Arizona University/Counseling Services
25	Northwestern University/Counseling and Psychological Services
26	Norwich University/Student Counseling and Psychological Services
27	Ohio State University/Counseling and Consultation Service
28	Rutgers Health Services - CAPS/Counseling, ADAP & Psychiatric Services
29	**San Jose State University, Counseling and Psychological Services /Counseling and Psychological Services**
30	Southern Illinois University/Counseling and Psychological Services
31	State University of New York at Albany/University Counseling Center
32	Suffolk University/Counseling, Health, & Wellness
33	Temple University/Tuttleman Counseling Services
34	Texas A&M University/Student Counseling Service
35	Texas Tech University/Student Counseling Center
36	The Catholic University of America/Counseling Center
37	**University of California - Los Angeles/Counseling and Psychological Services**
38	**University of California, Berkeley/Counseling and Psychological Services**
39	**University of California, Berkeley/University of Health Services**
40	**University of California, Davis/Student Health and Counseling Services**
41	**University of California, Irvine/Counseling Center**
42	**University of California, San Diego /Counseling and Psychological Services (CAPS)**
43	University of Idaho/Counseling & Testing Center
44	University of Iowa/University Counseling Service

University of Kentucky /Counseling Center: Consultation and Psychological Services
University of Miami/Counseling Center
University of New Hampshire/Psychological and Counseling Services (PACS)
University of New Hampshire/Psychological and Counseling Services (PACS)
University of Notre Dame/University Counseling Center
University of Oregon/Counseling and Testing Center
University of Pittsburgh/Counseling Center
University of Puget Sound/Counseling, Health and Wellness Services
University of Rochester/University Counseling Center
University of San Diego/Counseling Center
University of South Carolina/Student Health Services, Counseling & Psychiatry
University of Southern California/Student Counseling Services
University of Washington Tacoma /Office of Student Success, Student Counseling Center
University of Wisconsin- Whitewater/University Health & Counseling Services
Virginia Tech/Thomas E. Cook Counseling Center at Virginia Tech

APPENDIX B

SURVEY RESPONSES

Question 1: How did you want to utilize health psychology rotation?

	Response
1	Seeing cts in distress, developing relationships and consulting with SHC personnel, learning more about behavioral psych and SHC processes
2	connect students with counseling faster, use short term counseling to stabilize situations, Get opinion about diagnosis and safety in complex cases
3	I had hoped it would save time by allowing psych cases to be seen by therapists and only referred to SHC if they needed medication.
4	To be able to send patients directly to see a therapist for quick assessment and follow up plan with links to resources
5	for collaborative care between the Health Center and CAPS. Also for training for residents.
6	Wanted ready access to a counselor when a pt in distress related to mental health issue came through acute cinic (Gold)
7	referrals and warm hand off for patieints in need
8	I wanted to use the Behavioral Health Specialist when there was a student who had symptoms of depression, anxiety or mental health issues or concerns. If pt needed meds - send pt to Gold clinic or schedule appt in Green clinic.
9	I wanted an integrated medical/behavioral health model that provided care appropriately directed to the best expertise
10	I'd like students who have acute mental health issues presenting in medical clinic to have access to counseling support with minimal delay.

Question 2: How did you actually utilize the health psychology rotation?

	Response
1	Mostly catching up on case doc, occasionally triaging students. There were very few referrals. Of the students I met with over the course of the rotation, two followed up on referrals to CAPS for groups/individual counseling (one of the two was a preexisting CAPS ct). I primarily counseled students having panic attacks or wanting information on CAPS services.
2	Tried to use as above
3	During my 2-hour time block downstairs, I rarely saw students (they were not often referred.) When I did, they typically no-showed our follow-up appointments at CAPS, which was frustrating and made me think they never really wanted to see a therapist in the first place (otherwise they themselves would probably have gone to CAPS to begin with?) The two hours were spent writing my case notes, prepping skillshops, and returning emails. I was never "bored" :) And the "extra" two hours prevented me from having to work through my lunch break daily, which has become a reality this spring.
4	I did not end up using it due to the fact that the therapist was only available during certain hours. The therapist was not available during the times when I had a patient who could benefit.
5	for warm hand-offs
6	Used as above
7	When patients needed to talk to someone right away or had case managment issues. Also if there were more less acute issues that did not need a long term follow up.
8	I would send them for further self care measures
9	I would recommend students meet with a therapist (to better evaluate need and resources from CAPS/BSS) after seeing patients in medical for mental health evaluation. I would like most students to be seen by a therapist before starting long-term med management and exhaust other modalities if applicable
10	I didn't have a patient in urgent need of psych services during the time the HP rotation was active.

Question 3: Was there anything that you could have done differently?

	Response
1	One stressful thing was a consistent lack of supplies (not enough consent forms, dry erase markers, paper, group lists, etc). I wished the role had more structure. Medical personnel told me they didn't know how to utilize us. The office location was removed from medical personnel, so I never got to talk to attending doctor. I frequently would just have a student at my door with no information or documentation and would spend 5 of our 15 minute triage trying to locate/create a file for them in Titanium. Multiple students told me they didn't know why they had been referred to me and without seeing any sort of intake paperwork or medical chart, I was at a loss for what to tell them. It often felt like I was trying to do an intake in 15 minutes with no intake paperwork.
2	no
3	I think more planning and receiving input from the entire team before creating the office would have been helpful.
4	No
5	Perhaps do a training at the beginning of the semester for staff as to what the rotation was about and the role each person plays.
6	can't think of anything
7	Not really but would be nice to have case managment and a person we could do a warm hand off for those who are not suicidal or really acute but just need a prefesssional to help them sort out some acute emotions on the spot.
8	Please let me know.
9	Not that I can think of
10	No; fate simply didn't send an appropriate patient my way.

Question 4: Please add any comment here.

	Response
1	I thought this was a really good idea, but it was not structured or utilized in a way that worked. For this to work, more communication/training with upstairs AND downstairs people together needs to occur. As a therapist, I would like some way to look at the student's medical chart or at least speak with the doctor before seeing the student. When working in a different space (downstairs), I need to know there will be enough supplies to meet with possibly multiple students.
2	The number of complex cases seemed to increase over time but not one per hour. Location did not seem efficient for psychologist
3	I wonder if the SHC receptionists could give a spiel about CAPS when students schedule depression/anxiety appointments with SHC. That could help with directing students to the proper place, in the proper order (aka start with therapy for anxiety rather than PRN anxiety meds.)
4	I still think the idea is a good one and would like to see us try a model where the therapist is available more than a half day.
5	I think the rotation would be helpful for future residents.
6	I realize that utilization of services was unpredictable and not necessarily good use of the couselor's time as they were often in office with no pts to see
7	
8	Looking forward to hearing your findings
9	I think there is still room for improvement in trying other models for closer collaboration.... we are getting better
10	While having a counselor downstairs could be useful, the need for urgent intervention is unpredictable. We need to figure out how to offer ready availability without having counselors sitting around idle waiting for a suitable patient to arrive randomly.