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ARTICLE

A Qualitative Study: Barriers and Facilitators to Health Care Access for Individuals with Psychiatric Disabilities

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Objective: This qualitative study was conducted as part of a larger randomized trial to examine barriers and facilitators to accessing and providing comprehensive primary health care for individuals with serious mental illnesses. We examined the perspectives of administrators and providers in a behavioral health organization surrounding the use of a nurse practitioner model of delivering primary healthcare. *Methods:* Ten key informant interviews were conducted and analyzed using qualitative data analysis software. Concepts and themes regarding access to and delivery of primary healthcare were inductively derived from the data. *Results:* Results confirmed significant issues related to chronic physical health problems among individuals with psychiatric disabilities and detailed a host of barriers to receiving health care as well as the perceived benefits of the nurse practitioner intervention. Financial challenges played a significant role in the organization's ability to make primary and mental health care integration a sustainable endeavor. In addition, staff faced increased burdens on their time due to adding a focus on physical health to their existing job duties. *Conclusions and Implications for Practice:* A nurse practitioner stationed in a behavioral healthcare setting is viewed by administrators and providers as extremely beneficial in addressing issues of access to comprehensive and integrated primary healthcare for individuals with severe psychiatric disabilities but sustaining such a model of care is not without organizational challenges.

Keywords: physical health, psychiatric disabilities, healthcare access, integrated care

Introduction

There is an accumulating body of evidence documenting the increased prevalence of medical co-morbidities and premature mortality among individuals with serious psychiatric disabilities. These reports provide compelling evidence of a large public health concern. Individuals with psychiatric disabilities experience higher rates of diabetes, obesity, metabolic syndrome, hypertension, cardiovascular disease, pulmonary diseases, HIV, gastrointestinal and acute respiratory disorders when compared to people without psychiatric disabilities of a similar age and insurance status (Allison et al., 2009;

Blank, Mandell, Aiken, & Hadley, 2002; Dickey, Normand, Weiss, Drake, & Azeni, 2002; Dixon et al., 2000; Newcomer, 2008). These disorders are suspected to relate to the elevated rates of premature mortality (not due to suicide) observed among people with psychiatric disabilities within the United States (Capasso, Lineberry, Bostwick, Decker, & Sauver, 2008; Colton, & Manderscheid, 2006; Felker, Yazel, & Short, 1996; Lambert, Velakoulis, & Pantelis, 2003) and throughout the world (Harris & Barraclough, 1998; Makikyro et al., 1998). As observed in the general population, these health disparities may be even greater for racially and ethnically diverse populations (U.S. Department of Health and Human Services, 2001).

Collectively, these findings have led to the adoption of improved physical health as a critical dimension in promoting recovery (Hutchinson et al., 2006; Substance Abuse and Mental Health Services Administration, 2009) and as an important component in the comprehensive treatment of individuals with psychiatric disabilities (Parks, Svendsen, Singer, & Foti, 2006; President's New Freedom Commission on Mental Health, 2003; Thomson, Mitchell, & Williams, 2006). Recent attention has focused on health care access and utilization of primary care as an important factor explaining the incidence of medical co-morbidities and related mortality in this population. People with psychiatric disabilities may not have access to a regular source of primary care (Crews, Batal, Elasy, Casper, & Mehler, 1998; Miller, Druss, Dombrowski, & Rosenheck, 2003) and they may have fewer medical visits than people without psychiatric disabilities, even when primary care is available (Chwastiak, Rosenheck, & Kazis, 2008; Copeland et al., 2009; Cradock-O'Leary, Young, Yano, Wang & Lee, 2002).

Some authors have suggested that regardless of the frequency of contact with primary care providers, quality of care may be compromised for individuals with psychiatric disabilities who do receive health care services, due to a lack of coordination, continuity and the failure to adequately integrate physical and mental health care (Cradock-O'Leary et al., 2002; McCabe & Leas, 2008). Lester and colleagues (Lester, Tritter, & Sorohan, 2005) also found that primary care professionals do not necessarily feel equipped with the specialized knowledge and skills needed to treat the health care needs of individuals with psychiatric disabilities, despite the fact that their patients view primary care as the "cornerstone" of their health care services. Drapalski and colleagues (Drapalski, Milford, Goldberg, Brown, & Dixon, 2008) found that veterans with psychiatric disabilities cited personal or internal barriers to seeking primary care such as experiencing personal crises that prevented them from seeking care, feeling incapable of making or remembering appointments, or feeling like they could not adequately explain their medical problems.

In a qualitative study, Pahwa and colleagues (Pahwa, Chatterjee, Tallen, & Brekke, 2010) identified system and provider level barriers, environmental and individual level barriers to health care and also found stigma a pervasive barrier to accessing health care. Stigma was identified by Van Den Tillaart and colleagues (Van Den Tillaart, Kurtz, & Cash, 2009) as a factor in the incomplete and inconsistent health care provided to individuals with psychiatric disabilities. Negative attitudes towards individuals with psychiatric disabilities have been cited in several qualitative studies as an important factor, leading to poor communication with primary care providers and the provision of less than adequate care (e.g., poor quality of services, lengthy wait times, difficulty getting appointments, low client satisfaction, etc.; Lester et al., 2005; McCabe & Leas, 2008; Pahwa et al., 2010; Van Den Tillaart et al., 2009).

A handful of interventions designed to address barriers to health care and improve the physical health of this population have been studied and have demonstrated some success in addressing the physical health care needs of individuals with psychiatric disabilities. Many of these interventions are based on the perceived advantages of a more integrated system, greater access to services, and the use of education to promote health awareness and self-care (Daumit, Crum, Guallar, & Ford, 2002; Dobscha & Ganzini, 2001; Druss et al., 2010; Felker, Workman, Stanley-Tilt, Albanese, & Short, 1998; Lindenmayer et al., 2009). To our knowledge, the type of intervention examined in this study, that is, the use of a nurse practitioner stationed in the behavioral healthcare setting, has not been the object of significant study.

Thus, we undertook this study to examine barriers and facilitators to accessing and providing primary health care for individuals with psychiatric disabilities from the perspective of administrators and providers in a behavioral health organization.

Methods

This study was conducted as part of a larger randomized trial designed to test the effects of receiving the services of a nurse practitioner who was stationed in the behavioral health setting when compared to individuals randomized to a control condition, which consisted of services-as-usual and an invitation to a monthly "wellness seminar." The behavioral health provider

was (at the time of the study) a large provider of mental health services, including psychopharmacology, outpatient mental health care, residential, and day services for individuals with severe psychiatric disabilities. Branches of the agency where the study took place were located in three medium-sized cities in the northeast. The behavioral health agency is part of a larger, parent healthcare organization with services including inpatient mental health and physical health services.

All individuals recruited into the RCT were individually randomized to the nurse practitioner (NP) condition or to the control condition. In the experimental arm, the nurse practitioner's role was: 1) to insure that each person was receiving comprehensive primary healthcare; 2) to complement (but not replace) any general practitioner care the individual was receiving; 3) to address issues related to the individual's psychiatric condition that were affecting their physical well-being, i.e., to integrate health and mental healthcare; 4) to promote the individual's wellness through lifestyle, nutrition and exercise counseling.

The key informants in this qualitative sub-study were drawn from the behavioral health agency. They were a combination of administrators, providers of care, and the single nurse practitioner involved in the study at the time the interviews were being conducted. All key informants were aware of both the experimental and control arms of the study. We conducted the randomized trial from 2004 to 2009 and this qualitative sub-study in 2009.

The key informants for the sub-study were selected within the RCT sample (Patton, 2005; Crabtree & Miller, 1999) so as to understand the implications of the NP health care model from the point of the agency. During the last year of the RCT, key informants were identified with assistance from a high level administrator in the behavioral health organization who participated in the conduct of the RCT. All individuals who were nominated by the administrator were approached for the interview and agreed to participate. Each interviewee signed an informed consent that was reviewed and approved by the University institutional review board (IRB).

We developed an interview guide (Patton, 2005) after a thorough review of the literature and in keeping with the purpose of the study which was designed to examine informants' perceptions of barriers and facilitators to health access and integration for both clients and the organization, and the benefits of the intervention. Examples of the key informant questions appear in Table 1. The key informant interviews were conducted in face-to-face sessions and tape recorded. Each of the 10 individual interviews (four adult males and 6 adult females) ranged from 45 to 60 minutes and was conducted privately in the key informant's office. Key informants represented organizational administrators (*N*=2), program directors (*N*=4), service providers (*N*=2), the nurse practitioner (*N*=1) and an administrative staff member (*N*=1). Only one

Table 1–Sample Questions from Key Informant Interviews—Barriers and Facilitators to Primary Health Care

1. What do you think are the major barriers to serving people with serious mental illnesses and serious chronic health problems?
2. Do many of the clients with co-morbid physical conditions have difficulty physically accessing services because of physical barriers at your facilities? What do you do if there is a person needing access to your services but for whom there are physical barriers?
3. Does the organization provide clients assistance with understanding their health plans and insurance policies and procedures? If so, please describe the assistance provided.
4. Are health promotion activities available for clients? If so, what types of health promotion activities are available?
5. Is staff encouraged to integrate health promotion in individual sessions with clients? If so, how?
6. How has having a nurse practitioner stationed here at the clinic affected the organization?
7. What benefits do you think the clients experience in having the NP services at this agency?
8. What benefits do you think the staff experience in having the NP services at this agency?
9. What have been the difficulties or drawbacks to having the NP at this agency? Such as, financial difficulties, organizational difficulties, communication problems, insurance reimbursement problems, etc.
10. If you were to plan a model of delivering health services to individuals with psychiatric conditions and serious chronic health problems, what would you think would be the best way of going about that or planning it?

interviewee was of Latino descent, all others were white. Key informants' racial/ethnic backgrounds were similar to agency staff and the community served.

The interviews were transcribed verbatim and analyzed using NVIVO for thematic content. NVIVO is software used specifically for analyzing unstructured data. Two researchers read the transcripts for themes (the postdoctoral fellow who conducted the interviews and an independent graduate research coordinator). Researchers read the transcripts independently and selected text to discuss during meetings to identify potential themes, concepts and resulting codes. During these meetings, the two researchers reached consensus on selected codes and themes. Themes were derived inductively from the data and revolved around service delivery barriers, client barriers, health access facilitators, and the perceived benefits of the intervention.

Results

The key informant interviews provided information about the barriers and facilitators that individuals with psychiatric disabilities face in addressing their physical health and that the organization faces in integrating physical and mental health care. Key informants unanimously stated that although the NP intervention was provided within their organization, community services and issues beyond their control also affected the healthcare access and integration they were able to provide. This section will describe the most salient themes that emerged from the key informant interviews (see Tables 2 through 5 for a complete listing of themes).

Service Delivery Barriers

The most significant service delivery barriers emerged in the areas of finances and staffing. Adequate human resources and infrastructure capacity are critical to the sustainability and success of any service delivery initiative. Insufficient financial resources can be a major barrier for agencies implementing an integrated model of health care. The impact of limited finances was most strongly noted in the demands on staff time. Integrating physical and mental health care added many layers to staff roles that, in a scenario of low staff to client ratio, the demands on staff time made it difficult to optimally address both aspects of care. Demands included the time needed to communicate with outside health care providers, setting up appointments for clients for primary healthcare, and accompanying clients to doctors' appointments. In the case of the NP, being a solo physical health care provider in a mental health agency meant doing everything from drawing blood to making phone calls to other providers within the timeframe of the appointment. The following quote from one of the interviewees provides a sense of the staffing constraints:

Table 2–Organizational Service Delivery Barriers

Financial barriers:
• barriers to hiring nursing and support staff due to the expense, lack of insurance reimbursement for the services of the NP
• state mental health budget cuts
• challenges the organization faces in finding ways to pay for the NP services
Staff barriers:
• additional responsibilities that the staff faces by adding a focus on the physical health of clients to their regular duties
• staff competencies in physical health
• the need for a more diverse staff to serve linguistic minority communities
Administrative barriers:
• challenges of managing a multi-site and multi-city organization with the need to communicate to providers and clients at the different locations about the new services offered
• space limitations for housing medical equipment for the NP
• challenges managing outreach services for those who are unable or have significant challenges getting to the agency
Client Participation barriers:
• the impact of client non-compliance with treatment recommendations
• failure to show for a scheduled appointment
• the impact of a lack of client engagement and motivation on how the agency delivers services

Table 3–Client Barriers to Accessing Services

Personal Barriers to Accessing Services Barriers to Accessing Organizational Services

Planning & Symptom barriers

- difficulty coordinating multiple appointment dates
- feeling overwhelmed by mood and anxiety
- not following through on appointments or missing many appointments
- denial or not wanting to know about health issues
- fear of specific procedures (e.g., dental services)

Problems with Communication include:

- difficulty communicating symptoms and problems reading

Healthy Life Style Choice:

- challenges making healthy life style changes (smoking, nutrition, exercise)
- lack of knowledge about what is good or bad for one's health

Physical Illness Factors:

- limitations posed by a physical illness that prevents individuals from taking action

Barriers to Accessing Organizational Services

Transportation barriers include:

- weather
- being denied transportation services from agencies
- other problems with transportation that prevent clients from accessing services at the organization

Linguistic barriers include:

- lack of providers that speak foreign languages
- needing to use interpreter services because the staff is not fluent in a particular language

Barriers to Accessing Community Services

Entry Services barriers include:

- comprehensive health insurance that is accepted by many providers in the community
- money to pay co-pays transportation services
- familiarity with or access to computers to select a PCP or research health providers

Provider Competency barriers include:

- not being taken seriously by providers
- psychiatric hospitalization resulting from seeking non-psychiatric care
- providers' discomfort and not addressing needs of persons with psychiatric disabilities well
- providers not giving a full range of options
- providers mistrusting pain issues

> Staffing-wise. I have one nurse for 110 clients. And I have three service coordinators. … And a lot of our folks have multiple medical appointments.

A number of factors contributed to the stated financial and resource barriers. Since the NP's supervising physician was not an employee of the agency, many of the services provided by the NP could not be compensated through insurance (Medicaid, Medicare, or private insurance) reimbursement. Further, optimal care often meant that the NP needed to spend a longer amount of time with the client than is dictated by reimbursement guidelines. Also, during the period of the intervention, the agency was affected by many state budget cuts to mental health services.

Client Barriers

As can be seen in Table 3, key informants described client or personal barriers to access and integration of healthcare including problems with planning for medical appointments, difficulty communicating with healthcare providers, and difficulties dealing with health issues in addition to the symptoms of their psychiatric disability. Feeling overwhelmed by anxiety and depression or lacking motivation to pursue health care were the primary barriers cited that affected the ability of clients to follow through on appointments, and carry out activities necessary to maintain insurance and transportation services.

Communication barriers included both cognitive and emotional difficulties that interfered with the individuals' ability to verbally express thoughts and feelings related to their own health and healthcare. Clients who had low literacy and those with communication problems also experienced difficulties. One key informant, for example, described how a client only was able to report back about 30% of what her primary

care provider told her about her heart condition because of her communication problems. The provider was therefore limited in how she could support the client's healthcare without more detail, or without communicating with the healthcare provider directly.

Community providers' attitudes towards and ways of relating with individuals with psychiatric disabilities served as a significant barrier, oftentimes leaving clients discouraged and reluctant to seek services.

> One I think is stigma, and actually just the difficulty in providing services to our clients. Oftentimes the behavior and the presentation of the client doesn't fit well in primary care doctors' offices. So I think that puts both the client and the primary care physician in a position where it's not comfortable for them to provide the service and/or our client to get the service from them...

Table 4–Facilitators to Health Access & Integration

Comprehensive Entry Services and Financial Resources:

- access to comprehensive insurance that is accepted by a majority of providers and pays for needed services
- access to transportation services
- a health care agency that does not turn individuals away for an inability to pay

Convenience of Services:

- having lots of locations of health agencies
- having access to health and mental health services in one location
- increased collaboration and communication between mental health and primary care organizations
- decreased wait times at the mental health organization
- providers that offer a greater frequency of appointments
- access to walk-in services

Supportive Staff Assistance:

- assistance with making appointments
- help completing forms for insurance, prescriptions and transportation
- provision of transportation
- teaching clients how to use public transportation
- helping clients understand health plans
- advocating on behalf of client
- accompanying clients to primary care appointments in the community
- staff patience with client challenges
- helping clients access prescription medications
- educating clients about proper nutrition and grocery shopping
- collaborating with community health providers

Nutrition Resources:

- access to food resources such as food pantry in the community
- being given money for food, and food stamps

Facilitators

Significant barriers to accessing health care services in the community experienced by clients were insurance coverage and transportation. As might be expected, major facilitators were the program staff and services that helped overcome those barriers. Having a comprehensive insurance plan or access to or support around transportation for medical appointments made a difference in the utilization of primary healthcare services. Agency staff played a significant role providing assistance on a number of levels, such as: helping clients with activities necessary to apply for and maintain insurance; assisting the client to keep their medical appointments, transportation or other services; communicating with health care providers; and being available to help with problem solving around healthcare issues. Given client difficulties as described earlier, the flexibility, patience, and concern shown by staff was critical to encourage clients to make use of primary healthcare and to focus on increased health and physical well-being. This was especially true given that many clients spend a significant amount of time on mental health appointments and services.

Benefits of the Nurse Practitioner

Quite interestingly, the NP intervention benefited staff in much the same way that it benefited clients. Both groups felt more comfortable about addressing the primary healthcare needs of their clients due to the presence of the NP. Where the clients are concerned, having the NP stationed in the behavioral healthcare setting also played a role in their accessing services.

> ... gives them more comfortable access to primary care. I think it's really pretty overwhelming for some of our clients to have to go to a primary care physician's office.

Table 5–Benefits of the Nurse Practitioner Intervention

NP Benefits to Clients

Comfort:

- comfort level receiving services in the mental health setting (trust, security, etc.)
- comfort with the NP
- feeling cared for
- feeling that they can rely on the NP

Access:

- more time with the NP
- easier access for clients to get medical attention and not have to seek outside providers
- avoidance of the ER and associated wait time to receive care
- ability to access NP onsite for emergencies
- not having to miss a day of other treatment services in order to attend outside health appointments
- ability to access individuals reluctant to go to primary care office

Consultation and Coordination of Care:

- opportunity to get a second opinion from NP
- reminders by the NP who is able to find clients on site to remind them of appointments
- NP provides clients education about health

Outcomes:

- clients being more interested in health and making changes
- decreased hospitalization
- less client resistance to focus on physical health
- decreased cancellation and increased follow-through on appointments

NP Benefits to Staff

Comfort:

- staff is more comfortable asking NP medical questions than outside providers
- staff feel their opinions are valued and that they are involved in the process
- staff feel reassured that clients are taken care of and get seen

Reduce Demands:

- NP frees up staff time by not having to call providers
- NP helps in cases of unexpected client illness

Consultation and Education:

- consultation and support to staff
- easier access to lab results and understanding of findings
- consultation in emergencies
- training
- education for staff

Staff expressed feeling a greater sense of comfort and collaboration with the NP than with community primary care doctors. The NP gave them an opportunity to ask questions and seek more information, and also reduced staff anxiety in emergency situations.

> … a resource that's really close, someone that we could talk to, someone that we could say, I've got a free hour, let me go down and ask about [this]….It's the resource and the accessibility.

Discussion

Among all the barriers faced by the agency in delivering accessible and integrated health services, financial barriers, not surprisingly, played a central role. The barriers faced by any agency must, however, be considered in the context of the capacity of the local community to support integrated care because the local healthcare context affects the extent to which any mental health agency can promote integration. The general service delivery context of the agency is also an important consideration as health access will affect most aspects of service delivery including staffing, scheduling, communication, facilities, and so forth. The facilitators identified in this study highlight the importance of not only having programs to overcome typical challenges to health care access but also supportive staff that empower individuals with serious psychiatric disabilities to attend to their physical healthcare needs and to see value in improving their physical health status. Empowerment of service recipients, especially to help combat stigma related to health care, is a critical element in system change (Van Den Tillaart et al., 2009).

While the NP intervention helped to significantly reduce some of the challenges in delivering integrated and accessible healthcare by increasing

comfort and ease of access, it highlighted the significant challenges that individuals with psychiatric disabilities face in accessing such services in the community. Effective models for integrating primary and mental healthcare for individuals with serious psychiatric disabilities should attend to the personal challenges related to planning for healthcare, dealing simultaneously with psychiatric symptoms, and communicating around physical healthcare, and at the same time, enhancing primary care providers' skills in relating to individuals with psychiatric disabilities. These issues likely contribute to the reasons why it has been found that even individuals with psychiatric disabilities who have a regular source of medical care continue to have significant unmet health needs (Kilbourne et al., 2006; Miller et al., 2003).

In this study, the compassion, patience, and understanding of staff at the behavioral healthcare agency and the nurse practitioner emerged as significant and often underappreciated factors in health access and integration. These aspects of integrating care are particularly important for individuals with psychiatric disabilities who may have difficulties planning, communicating, and coping with their psychiatric symptoms while trying to pursue primary healthcare.

Clinical and Policy Implications

Although the evidence for integrated care is growing, in order for true integration to take place, there must be system-wide change rather than isolated efforts by providers who then face the burden of having to compensate for a fragmented and underequipped system. From the perspective of providers, there is a need for training to enhance the competencies of mental health specialists in the area of physical health to better serve individuals with psychiatric disabilities (Hutchinson et al., 2006). Primary care providers also need to receive increased training on serving individuals with serious psychiatric disabilities, especially in terms of communicating effectively with these clients and their mental health providers about health issues. This is especially important as some medical doctors have acknowledged their lack of comfort and skill with this group (Lester et al., 2005). The importance of supportive and competent staff that facilitates client utilization of existing healthcare programs and services cannot be overemphasized and, therefore, indicate the need for increased funding. Interpersonal and communication issues must be a vital consideration in designing integrated health interventions for this group. Systemic change should also address the location of services, transportation options, and access to healthy lifestyle choices.

In short, agencies implementing integrated models of health access must continue to consider the personal and community barriers clients face. This is critical even in settings like the Veterans Administration that are structured for greater health access and integration but where individuals with psychiatric disabilities still require assistance in communicating with providers about their healthcare needs (Kilbourne et al., 2006). Ongoing collaboration with community healthcare providers remains critical to improving the health of individuals with serious psychiatric disabilities.

Limitations

Although this qualitative study provides valuable information about health access and integration in the mental health setting, there are several limitations worth noting. First, key informants did not include clients of the mental health agency. Although the larger study did include interviews with clients focusing on barriers and facilitators to health access in the community, those findings are not incorporated here. Another limitation is that the mental health organization that housed the intervention is a large agency with many locations throughout the state. For practical reasons, key informant interviews were conducted with staff at sites most closely connected to the intervention with the exception of one interviewee. Also, community health providers outside of the agency were not interviewed. Thus, it is possible that the views of certain administrators are not reflected in this analysis. We also did not directly query primary healthcare providers in the community; including this group as key informants could have provided another perspective altogether and enhanced this study. Another limitation is that the interview guide did not specifically ask about facilitators, although questions were asked about barriers and benefits of the NP intervention. Facilitator themes emerged from the responses of the interviewees and it is possible that more diverse responses would have been provided if interviewees were specifically prompted to provide facilitators.

Conclusions

Inasmuch as the findings of this study strongly support a model of integrated healthcare service delivery, they point to deficits within the existing health care system that limit the ability of people with psychiatric disabilities to utilize services. Access to integrated health care in the mental health setting for individuals with psychiatric disabilities helps to reduce many of the challenges that individuals face in accessing community healthcare services. It is critical that these interventions be staffed by caring and competent professionals who support the recovery of individuals with psychi-

atric disabilities and realize the central role of optimal physical well-being in that recovery.

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