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Patient & Staff Satisfaction with Integrated Services at Old Town Clinic: A Descriptive Analysis

Lorretta C. Krautscheid

Patient & Staff Satisfaction with Integrated Services at Old Town Clinic

A Descriptive Analysis

ABSTRACT This quality improvement project provided a descriptive analysis of the patient population that received integrated mental and physical health care at Old Town Clinic, and evaluated patient and staff satisfaction with this model of care. Seventy-three patients and seven staff members were surveyed, using two satisfaction surveys distributed in January 2003. Survey data revealed that the majority of Old Town Clinic patients were homeless. Patients indicated high levels of satisfaction with the clinic's location, ease of accessing care, and health promotion and illness prevention education. Staff satisfaction with this model of care was reported to be moderate regarding accessibility, response time, communication, support, treatment, completeness of care, and education. Recommendations for further research and implications for practice are offered.

Providing mental health care services to marginalized populations, such as homeless individuals, has been difficult for communities since the community mental health movement of the mid 1960s (Caplan, 1966), and the problem continues today. It is estimated that 33% of the homeless population suffers from mental illnesses, and approximately 45% of these individuals are dependent on alcohol or other substances (Kaplan & Sadock, 1998). In particular, people who are both homeless and have mental illnesses are functioning suboptimally due to illnesses that can be adequately managed with current medical and nursing treatment methods.

BACKGROUND

Existing service systems have always had limited resources for reaching out to marginalized populations. In addition, the unique problems of the homeless, mentally ill population challenge communities. Kaplan and Sadock (1998) reported that the "homeless mentally ill are difficult to treat because of their high levels of withdrawal and suspicion, psychopathology, homeless lifestyle, or negative past experiences with the mental health system" (p. 179). The authors also spoke of breaking down barriers to treatment through outreach programs, and providing unique services to meet the special needs of this population.

In Portland, Oregon, Old Town Clinic developed a unique, integrated model of care in 1999. Integrated health care is defined at Old Town Clinic as providing both physical and mental health services to the patient population in one location. According to the Oregon Primary Care Association (2002), in 2001, Old Town Clinic served 3,168 patients through 7,271 patient visits. Nearly 43% of the patients were covered by Medicaid, and 57% were uninsured.

Old Town Clinic began as a primary care clinic placed in an area of the city where many homeless people congregate to enhance access to care for this population. In addition, several low-cost hotels, a homeless shelter, a soup kitchen, and other facilities that support impoverished individuals are located in this area of the city (Central City Concern, 2002).

The concept of integration of mental and physical health care was supported in the literature. Research studies have found that most satisfaction existed among providers and patients when primary care was integrated with mental health care services (Bower & Gask, 2002; Kates, Craven, Crustolo, Nikolaou, & Allen, 1997; Lee & Gask, 1998; Sharma, Wilkinson, Church, & White, 2001). It was generally believed that the Old Town Clinic staff and patients were satisfied with how the integrated model of care was being implemented. However, no empirical evidence supported this belief.

In September 2002, Old Town Clinic approached Oregon Health & Science University (OHSU) School of Nursing for assistance with evaluating the services provided. The authors, who were OHSU graduate students at the time, had no prior relationship with the clinic. We volunteered for the project based on the population, the project questions, and the clinic's request for assistance.

LITERATURE REVIEW

The literature review revealed that primary care providers have expressed dissatisfaction with access to consultation on mental health issues. Kushner et al. (2001) found that primary care providers reported only "moderate access to mental health care for most of their patients" (p. 840). The researchers further reported that patients who were uninsured or covered by Medicare or Medicaid had experienced even less access to mental health care. Communities are seeking better ways to overcome barriers to care and are finding increased provider and patient satisfaction with the integrated model of care (Bower & Gask, 2002; Kates et al., 1997; Lee & Gask, 1998; Sharma et al., 2001).

According to the U.S. Department of Health and Human Services (USDHHS) (2000), "primary care [is] one of the prime portals of entry into treatment—especially for those reluctant to access, or unaware of their need for, mental health services. Primary care was also seen as an opportune site for emphasizing wellness and prevention of mental illness" (p. 1). In addition, according to *Mental Health: A Report of the Surgeon General,* "Public and private agencies have an obligation to facilitate entry into treatment" (USDHHS, 1999,

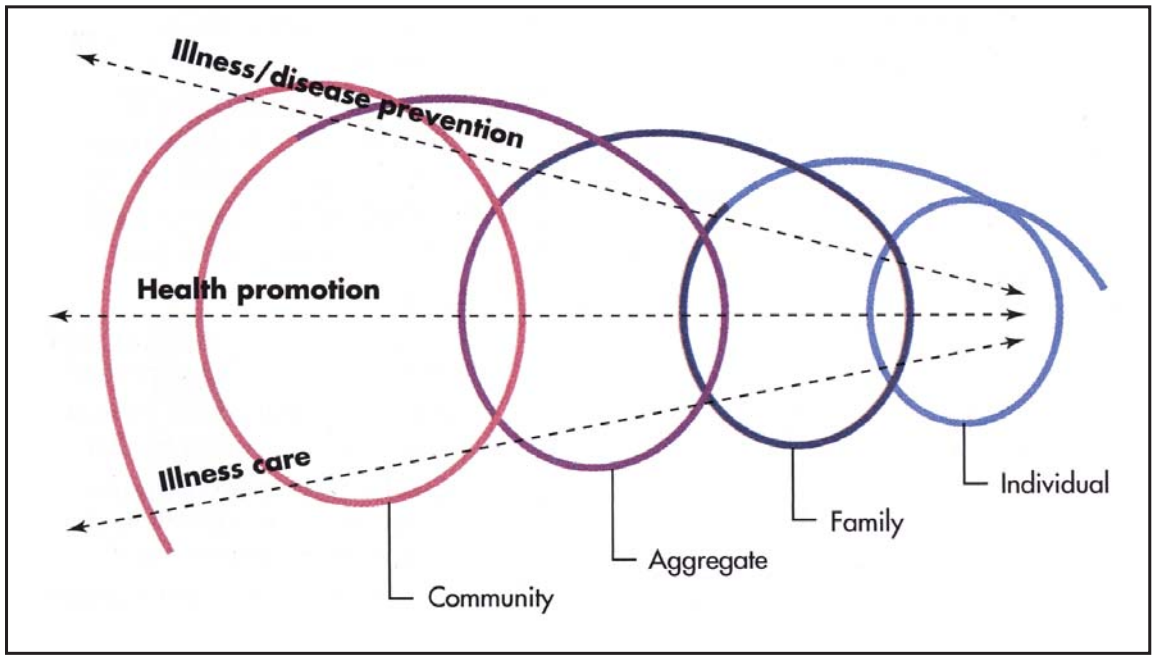

Figure. An integrative model for community health promotion.
Reprinted from Kulbok, P.A., Laffrey, S.C., & Goeppinger, J. (2000). Community health promotion: An integrative model for practice. In M. Stanhope & J. Lancaster (Eds.), *Community and public health nursing* (5th ed.), p. 287, Copyright (2000), with permission from Elsevier.

p. 457) through the multiple "portals of entry," including primary health care, schools, and the child welfare system.

The USDHHS (2000) report encouraged health policy that generated the creation of health care systems that support a balanced community, stating that "A balanced community health system balances health promotion, disease prevention, early detection, and universal access" (p. 1). Such a system could facilitate coordination of illness care, removing the barriers associated with nonintegrated health care systems.

Several studies have reported on the effectiveness of patient management and satisfaction with an integrated model of care (Freed, 2001; Harmon, Carr, & Lewin, 2000; Katon et al., 1996, Roy-Byrne, Katon, Cowley, & Russo, 2001). These studies revealed that integrated health services are effective and produce higher patient satisfaction, compared to nonintegrated services. However, what these studies did not identify is the effectiveness and degree of patient and staff satisfaction with integrated health care services for homeless and low-income populations. Another identified gap included the application of community health promotion models within the context of integrated health care services.

CONCEPTUAL MODEL

Integration of primary and mental health care services is conceptually consistent with several nursing models of care. Laffrey and Kulbok's Integrative Model for Community Health Promotion (Figure) closely resembles the model of health care at Old Town Clinic and was adopted as the conceptual framework for this quality improvement (QI) project (Kulbok, Laffrey, & Goeppinger, 2000, 2004; Laffrey & Kulbok, 1999). Presumably, providing integrated care services, with a community health promotion focus, at one location for homeless and low-income populations, would result in positive satisfaction ratings for both patients and staff.

Laffrey and Kulbok's integrative model included two major dimensions—the client system and the focus of care in community health promotion. The client system reveals how the family, population group, and community affects the individual. Interventions are primarily directed toward health promotion and treatment of the individual, ultimately providing health promotion for families, aggregates, and communities.

The focus of care is a healthier community, which is achieved through health promotion interventions. The three primary tasks within the focus of care are health promotion, illness prevention, and illness care. Kulbok et al. (2000) reported that, while using the Integrative Model for Community Health Promotion, "nursing actions achieve the maximal health potential through an active partnership between the nurse and the client system" (p. 287). The intervention must fit with the patients' lifestyles. The Integrative Model for Community

TABLE 1
RESPONDENT DEMOGRAPHICS

	Sample, By Gender			
Variable	*Total (N = 73)*	*Male (n = 39)*	*Female (n = 32)*	*Not Identified (n = 2)*
Mean age	45	46	42	43
Age range	22 to 67	22 to 61	27 to 67	35 to 50
Homeless	47 (64%)	27 (69%)	19 (59%)	1 (50%)
Non-homeless	26 (36%)	12 (31%)	13 (41%)	1 (50%)
Reason for visit				
Physical health	26	9	17	—
Mental health	8	3	4	1
Drugs and alcohol	1	1	0	—
Combination	38	26	11	1

Health Promotion uses community supports to help patients make necessary life changes that promote health and wellness. Old Town Clinic is an example of how a community clinic uses the focus of care and the client system to provide health care that serves the larger community.

QUALITY IMPROVEMENT PROJECT

Purpose

The goal of this project was to provide a descriptive analysis of the users of the integrated physical and mental health care at Old Town Clinic and to evaluate the satisfaction of staff and patients with this model of care.

Method

We used a descriptive design for this study. The patient sample consisted of 73 patients who received services at Old Town Clinic between January 6 and February 5, 2003. Using a patient satisfaction survey, we collected demographic data for age, gender, living situation, and reason for clinic visit. Nursing theory regarding integrated community health care was used to develop survey questions regarding health promotion, illness prevention, and illness care, while considering the appropriateness of this care for the patient's lifestyle and accessibility of care in the community.

Initial statistical analysis included a descriptive analysis of patient demographics. Further analysis included a description of patient satisfaction in each area assessed and a simple *t* test to assess statistical significance in satisfaction between two patient subsamples (homeless and nonhomeless). There were no standards from which to compare this study; therefore, we compared the results with those of research found in the literature.

Convenience sampling was used to increase the probability of obtaining a sample representative of the target population (i.e., patients who received holistic care from community clinics that provide integrated mental and physical health care services for low-income and homeless patients). Patients who received care from Old Town Clinic and who chose to participate in the survey were the accessible population.

The staff population included providers working in community clinics that provided integrated mental and physical health care services for low-income and homeless patient populations. The accessible population of staff was those who provided integrated health care at Old Town Clinic and who chose to participate in the survey.

Instruments

Two surveys were used to gather the data required for this study. The surveys were modified from those used by Harmon et al. (2000) and Katon et al. (1996). The integrated services provided by Old Town Clinic are representative of the Integrative Model for Community Health Promotion (Laffrey & Kulbok, 1999); therefore, concepts integral to the model were used to design the patient and staff survey questions. For example, questions asking both staff and patients about health promotion, illness prevention, and education that fits the patients' lifestyles were included.

The staff satisfaction survey contained eight questions scored on a Likert scale where 1 represented "not at all satisfied" and 10 represented "extremely satisfied." In addition to questions related to community health promotion, the survey asked about staff satisfaction in the areas of accessibility, response time, communication, support, treatment, completeness of care, and education.

The patient satisfaction survey contained 10 questions scored on a Likert scale where 1 represented "strong agreement" and 5 represented "strong disagreement" with the statement. This survey also contained an area for comments. The survey was designed to obtain patients' perceptions of how Old Town Clinic provided care related to health promotion, illness pre-

TABLE 2
PATIENT SATISFACTION SURVEY RESULTS (*N* = 73)

Statement	Level of Agreement: Strongly Agree n (%)	Agree n (%)	Uncertain n (%)	Disagree n (%)	Strongly Disagree n (%)
1. ACCESS. If I need care, I can get it at Old Town Clinic without any trouble.	27 (37)	18 (25)	23 (32)	4 (6)	1 (1)
2. HOURS. Old Town Clinic should be open for more hours than it is.	17 (23)	19 (26)	21 (29)	12 (16)	4 (6)
3. LOCATION. This clinic is NOT in a good location for me.	5 (7)	4 (6)	13 (18)	25 (34)	26 (36)
4. MENTAL HEALTH CARE. I am able to get mental health care at this clinic when I need it.	15 (21)	17 (23)	34 (47)	2 (3)	5 (7)
5. PHYSICAL CARE. I am able to get physical health care at this clinic when I need it.	30 (41)	27 (37)	11 (15)	4 (6)	1 (1)
6. INPUT. During my visits at Old Town Clinic, I am always allowed to say everything that I think is important.	30 (41)	26 (36)	13 (18)	2 (3)	2 (3)
7. ILLNESS PREVENTION. The health care providers at Old Town Clinic give me advice about how to avoid illness.	24 (33)	31 (42)	15 (21)	0 (0)	3 (4)
8. LIFESTYLE. The advice I received to treat my illness does NOT fit with my lifestyle.	3 (4)	4 (6)	26 (36)	21 (29)	19 (26)
9. REFERRAL. It was easy for me to see another health care provider in this clinic if I needed to (e.g., a mental health care provider).	12 (16)	13 (18)	35 (48)	8 (11)	5 (7)
10. HEALTH PROMOTION. I did NOT receive education to help me live a healthier life.	3 (4)	4 (6)	23 (32)	21 (29)	22 (30)

vention, and illness care, while considering the appropriateness of this care for the patients' lifestyles and the accessibility of this care in the community. To improve reliability, three questions were written in reverse of the expected response.

Pilot testing of the patient survey was conducted during the week of December 16, 2002. Seventeen patients completed surveys during the pilot test. This pilot testing allowed us to refine the questions and the sampling procedure. Following the pilot test, the patient surveys were translated into Spanish to allow Spanish-speaking patients to complete the survey without a translator. Finally, the sampling procedure was refined to allow optimum patient privacy by eliminating patient contact with the health care providers during the survey administration phase.

According to an agreement between OHSU and the OHSU School of Nursing, institutional review is waived for QI studies that meet the following criteria from Reinhardt and Ray (2003):

- Absence of risk to participants.
- The project was an accepted practice or treatment intervention not previously implemented.
- The organization was the primary audience.
- Data were collected from a single organization.

PROCEDURE

Staff Survey

The staff members were identified by the agency sponsor, and a copy of the staff survey was placed in each staff member's mailbox at Old Town Clinic. Each survey included a cover letter that explained the purpose of the sur-

TABLE 3

INDEPENDENT PAIRED *t*-TEST COMPOSITE PATIENT SATISFACTION SCORE: GROUP STATISTICS

Living Situation	N	*Mean*	SD	SE	p
Homeless	47	36.68	5.669	.827	.916
Non-homeless	26	36.69	5.548	1.088	

Note: SD = *standard deviation;* SE = *standard error of the mean.*

TABLE 4

COMPARISON OF SATISFACTION* BETWEEN HOMELESS AND NON-HOMELESS PATIENTS

Satisfaction Category	*Total Sample (N = 73)*	σ	*Homeless (n = 47)*	*Non-Homeless (n = 26)*
Access	3.90	1.02	3.96	3.81
Hours	2.59	1.19	2.55	2.54
Location	3.91	1.17	3.89	3.81
Mental health care	3.54	1.07	3.43	3.58
Physical care	4.17	.95	4.19	3.98
Input	4.09	.97	3.98	4.31
Illness prevention	4.00	.96	4.06	3.88
Lifestyle	3.67	1.05	3.68	3.65
Referral	3.26	1.08	3.28	3.23
Health promotion	3.75	1.08	3.66	3.92

** 1 = not satisfied to 5 = very satisfied.*

vey, provided directions for survey completion, and identified where to seek answers to questions. Staff members completed the survey, sealed it in an envelope, and placed it in a survey box, which was picked up by one of the authors. At the end of the data collection phase, 7 of 10 staff members had returned the survey.

Patient Survey

Patients were asked to participate in the project by completing the survey and were allowed to decline. Patients returned completed surveys to a survey box, which was picked up each week by one of the authors. A convenience sample of 100 patients was desired, and 86 surveys were returned. Surveys were eliminated from the final sample due to lack of complete information or if the patient circled the same number in response to all questions. The final sample was 73 patients.

DATA ANALYSIS

Group statistics for composite patient satisfaction *t*-test values were computed using the Statistical Package for the Social Sciences (SPSS). *T* tests for statistical significance on patient satisfaction for the independent variables between groups were also computed using SPSS.

FINDINGS AND DISCUSSION

Respondent Characteristics

Patients' mean age was 44 (median = 46, mode = 46, range = 22 to 67). Regarding gender, 39 men and 32 women completed the survey. Two respondents did not identify their gender (Table 1). Regarding living situation, 38% of patients reported being homeless, 36% lived in their own home or apartment, 10% lived with a friend, and 16% checked "other living situation." In comparing homeless and non-homeless patients, respondents checking "living with a friend" and "other living situation" were also considered homeless.

The demographic characteristics of respondents in this study are similar to those reported in Harmon et al.'s (2000) study (i.e., mean age = 38, 63% of respondents were women). The similarity in patient populations allowed us to compare the findings of this project with those reported in the literature review.

Twelve percent of the patients reported they came to the clinic for mental health care; 42% reported coming for physical health care; 1% reported coming for drug and/or alcohol problems; and 12% reported coming for a combination of reasons. In addition, 33% of respondents checked "other" as the reason for coming to Old Town Clinic and wrote in responses. Two patients gave no response to this question. Many responses in the "other" category could have been interpreted as physical health promotion or illness prevention care (e.g., patients often wrote that the reason for their visit was "TB testing or flu shot"). We chose to leave this information classified as "other," rather than interpreting the patient's response and catego-

rizing it as either physical or mental health care.

Patient Satisfaction

Following the demographic questions, patients were directed to mark a Likert-type scale (strongly agree to strongly disagree) in response to satisfaction questions. The results are displayed in Table 2. The statistics reported are based on independent, paired *t* tests for two-group comparisons on the continuous variables. The threshold for statistical significance was set at $p < .05$ (Table 3).

Variables

In comparing the satisfaction of homeless and non-homeless patients with services provided at Old Town Clinic, the survey results revealed similar levels of satisfaction between the populations (Table 4), with no statistically significant differences found between the two groups ($p = .91$). Table 4 indicates that the homeless population was slightly more satisfied than the non-homeless population in several areas of care, such as location, illness prevention, and physical care. However, the differences were not significant.

The findings of Katon et al. (1996) closely resemble the findings of this study. Their results showed that patients who received integrated health care services had "good to excellent patient satisfaction" (Katon et al., 1996, p. 925). Roy-Byrne et al.'s (2001) study of treatment of panic disorder in primary care settings revealed that patients were "significantly more satisfied with the care they received for their mental and emotional problems" (p. 873), compared with patients who were referred elsewhere for mental health services. A patient satisfaction study by Freed (2001) showed that 71% of the patients responded with satisfaction to an integrated model of care. This is referred to as the Overall Satisfaction Index (OSI). The calculated OSI for Old Town Clinic was 74%.

Staff Satisfaction

On a scale from 1 (not at all satisfied) to 10 (satisfied), the mean scores for staff satisfaction with the integrated physical and mental health services at Old Town Clinic were:

- Support = 8.00.
- Treatment = 8.00.

Meeting the physical and mental health care needs of marginalized, homeless and low-income populations in the communities where they reside makes the best use of the limited resources available, and according to the results of this project, provides a moderate-to-high level of patient and staff satisfaction.

- Communication = 7.40.
- Overall = 7.30.
- Accessibility = 7.10.
- Completeness of care = 7.00.
- Education = 6.90.
- Response time = 6.60.

Harmon et al.'s (2000) study, which surveyed the satisfaction of general practitioners with integrated health care services, revealed satisfaction rates that ranked moderate to high for all categories assessed. Similarly, three themes emerged in our study:

- Accessibility to care is key for mental health patients.
- Primary care providers must have a trusting relationship with mental health care providers before referrals will be made.
- Successful assessment, planning, and treatment of mental health needs requires collaboration between primary and mental health care providers.

Although our sample was small, the results of this staff satisfaction survey reflect a moderate level of staff satisfaction in the same areas as found in Harmon et al.'s (2000) study, and reflect some common staff concerns regarding integrating models of care.

The results of this QI project support the research findings in the literature, which indicated a moderate-to-high level of patient and staff satisfaction with integrated health care services. Providing integrated primary and mental health care services, with a community health promotion focus, at one location for homeless populations did result in positive satisfaction ratings for both patients and staff.

LIMITATIONS

One purpose of this project was to provide a descriptive analysis of the users of integrated care at Old Town Clinic, with a major demographic focus on the living situations of homeless versus non-homeless patients. This project did provide information about age, gender, living situation, and reason for visit, but did not provide information on ethnicity. Old Town Clinic demographics, published by Central City Concern (2002), indicated that 1% to 2% of the population served spoke English as a second language. In response to this information and with the advice of the agency sponsor, a Spanish transla-

KEY POINTS

1. Providing integrated primary and mental health care services, with a community health promotion focus, in communities where homeless and low-income populations reside, removes barriers associated with access to care for these populations.
2. This study revealed moderate-to-high levels of patient and staff satisfaction with the integrated health care provided at Old Town Clinic.
3. Patients and staff indicated the integrated care model provided accessible care that addressed illness prevention and health promotion in a way that fits with patients' lifestyles.
4. Social policy implications of this study include the need for public and private agencies to collaborate to maximize limited available resources.

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tion of the patient survey was provided. However, no Spanish-language surveys were returned. Therefore, we are not certain if the non-English-speaking population was adequately represented in this project.

The wording of the response choices ("strongly agree" to "strongly disagree") limits the validity of the results of the patient satisfaction portion of the project because we interpreted the response of "strongly agree" to mean the patient was very satisfied. The results of this project reflect patient agreement with the statements as worded on the survey. The project purpose was to measure patient satisfaction, and we assumed that agreement was equated with satisfaction, which may not be true. The staff survey did use the terminology of satisfaction, and results are reported as level of satisfaction.

IMPLICATIONS

For Nursing Practice

Project results revealed moderate-to-high levels of satisfaction with the integrated model of mental and physical health care among both staff and patients at Old Town Clinic. The USDHHS (2000) report called for improved access to mental health care in communities where marginalized populations reside, and our results revealed that Old Town Clinic provides a model of care that meets the needs of this population.

Laffrey and Kulbok's model of integrative community nursing indicates the need to provide accessible care that addresses illness prevention and health promotion in a way that fits with patients' lifestyles. Patient satisfaction results regarding services provided at Old Town Clinic revealed high satisfaction with level of patient input, education, and advice given about illness prevention and health promotion, and indicated that the advice patients received matched their lifestyles. In this study, 64% of the patient sample indicated they do not live in their own home or apartment. Therefore, Old Town Clinic is providing high-quality care, while meeting the needs of this difficult-to-serve population.

Our findings closely replicate those of other studies of integrated models of care (Freed, 2001; Harmon et al., 2000; Katon et al., 1996; Roy-Byrne et al., 2001). It appears that integrated models of mental and physical health care produce high levels of satisfaction across all socioeconomic populations.

For Nursing Research

This project could be replicated with a similar population and in clinics with similar models of care using specific controls over the variable of homeless versus non-homeless populations. While this project revealed high levels of patient satisfaction with integrated physical and mental health care, it does not speak to the effectiveness of the integrated model of care in managing physical and mental health needs. Future research studies could focus on the effectiveness of this model, as well as compare the integrated model with models in which patients either do not receive or are referred to an outside agency for mental health care.

Another area of research interest is the effective use of limited resources. Limited public funding requires clinics, such as Old Town Clinic, to prove the effectiveness of their services as they work in collaboration with local public and private agencies. Future studies could look for trends in service use based on the patients served.

For Nursing Theory

This project strengthens current nursing theory regarding integrated health care services in community settings and with marginalized, difficult-to-serve populations. The model of care provided at Old Town Clinic is a living example of Laffrey and Kulbok's (1999) Integrative Model for Community Health Promotion. Health care providers who work at Old Town Clinic embrace and fulfill the concepts central to the focus of care. This is evidenced by

the patients' high satisfaction ratings on statements regarding receiving advice to avoid illness, advice that fits with their lifestyle, and education that promotes a healthier lifestyle.

This model of health care follows the appeal made by the Surgeon General to increase efforts to reach populations where they can best be served. This project also gives direction to the government regarding the need to develop social policies that promote the development of clinics like Old Town Clinic. Finally, a balanced community health system (USDHHS, 2000), such as Old Town Clinic, facilitates coordination of illness care and removes barriers associated with nonintegrated health care systems.

CONCLUSION

In the current climate of limited financial resources, maximizing the use of available resources in an integrated model of care seems to create the best possible solution. Meeting the physical and mental health care needs of marginalized, homeless and low-income populations in the communities where they reside makes the best use of the limited resources available, and according to the results of this project, provides a moderate-to-high level of patient and staff satisfaction.

Staff at Old Town Clinic demonstrate a sincere dedication to the low-income and homeless populations, evidenced not only through the patient satisfaction surveys, but also through our informal observations. We observed the staff interacting with patients with a variety of health care needs. These interactions confirmed our perceptions that the clinic staff is integrating community health theory with practice by meeting the patients' needs in a way that fits with the patients' lifestyles.

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Ms. Krautscheid is Director, Learning Resource Center, University of Portland, School of Nursing, Ms. Moos is Psychiatric Consult-Liaison Nurse Practitioner, Providence Health Systems, and Ms. Zeller is Psychiatric-Mental Health Nurse Practitioner, Oregon State Hospital and adjunct Clinical Instructor, Linfield-Good Samaritan School of Nursing, Portland, Oregon.

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Address correspondence to Lorretta Krautscheid, RN, MS, 6273 SW 154th Place, Beaverton, OR 97007; e-mail: krautsl@netzero.net.