



Mental Health Services in Rural Long-Term Care: Challenges and Opportunities for Improvement

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Overview

To facilitate quality improvement efforts, more research is needed on the current status of mental health services in rural long-term care. Also needed are new tools promoting the targeted use of provisions in the Affordable Care Act (ACA) to address the mental health needs of rural long-term care (LTC) recipients. Over 10 million chronically disabled Americans require long-term services to assist them with activities of daily living.¹ Mental health comorbidities are common in these long-term care populations. Inadequately treated, these conditions can become debilitating and costly. Yet our long-term care system often fails to deliver necessary mental health care to those it serves, especially in rural areas. In this brief, we explore novel practices that hold promise for enhancing mental health services in rural long-term care. We focus primarily on the needs of rural elders who reside either in nursing facilities or in their own homes in the community.

As background, we note the prevalence of mental health problems in long-term care populations, describe deficiencies in the mental health care afforded to long-term care recipients, and identify barriers that hinder the remediation of these deficiencies in rural settings. Next, we outline a rationale for reform of mental health services in long-term care. We then discuss new approaches that have been proposed or used to further reform, underscoring the potential for synergies between these innovations and provisions introduced under the Affordable Care Act (ACA) of 2010.² Finally, we delineate policy considerations for advancing new mental health service models in rural long-term care settings.

Background

Psychiatric disorders are widespread in the United States long-term care population. Most adults in nursing homes have some clinically significant psychiatric problem, with estimates of prevalence ranging from 65% to 91%.³ Among long-term care recipients in the community, reported rates of psychiatric morbidity exceed 40%.^{4,5} Despite these levels of need, individuals in long-term care often fail to receive appropriate mental health services. For example, misuse of psychotropic medications⁶ and delays in the initiation of care are common in nursing facilities.³ Although relevant research is limited, it appears that few home care providers and home health nursing agencies conduct mental health screening and referrals, and that still fewer offer mental health services to their clients.⁷

The limited evidence suggests that rural long-term care recipients have even more restricted mental health options than their urban counterparts.^{8,9} Rural nursing homes are less likely than their urban counterparts to contract with mental health clinicians,⁸ and Medicare beneficiaries in non-metropolitan nursing homes receive fewer mental

Key Findings

Despite high levels of need, individuals in long-term care often fail to receive appropriate mental health services, especially in rural areas.

Efforts to promote better mental health treatment in rural long-term care face a broad array of challenges, including inadequate funding, workforce limitations, and physical access barriers.

Strong pressures for health care delivery system innovation, supported by provisions in the Affordable Care Act (ACA), have created new opportunities for expanding access to appropriate mental health interventions for rural long-term care populations.

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health services than their peers in metropolitan areas.⁹ Community-dwelling long-term care recipients in rural areas likewise experience the adverse impact of rural-urban disparities in access to community-based mental health care.¹⁰

Efforts to improve mental health treatment in rural long-term care face multiple challenges. Mental health professionals are often scarce in rural communities.^{8,11} Rural primary care providers, who often serve as first-line sources of mental health care, are also in short supply.¹² Moreover, available rural providers may not be optimally qualified to serve the mental health needs of long-term care populations.¹³ Physical barriers, such as long distances and limited transportation services, may reduce access to mental health services for rural long-term care recipients.¹³ Finally, chronically underfunded rural mental health delivery systems^{10,14,15} are coping with recent and anticipated reductions in revenues from state general funds^{16,17} and from federal sources.^{18,19} Thus, these systems have limited resources to devote to improving services for long-term care populations.

Rationale for Improvement Efforts

The inadequacies of mental health services in long-term care harm both consumers and society. Long-term care recipients with psychiatric problems experience greater psychological distress, more severe functional impairment, and worse health outcomes than their counterparts without such problems.^{20,21} Because of their exceptionally poor health status, elderly and disabled people with mental disorders use more health services and incur higher medical costs than their peers without psychiatric diagnoses.²² Appropriate mental health care can alleviate psychiatric symptoms in this population.^{23,24} Moreover, research suggests that delivery models integrating mental health treatment into primary care can reduce overall morbidity for complex patients like those in long-term care^{24,25} while decreasing total per-patient health expenditures.²⁶

Provider organizations, payers, and purchasers are showing intense interest in improving quality and containing costs of health services for people with long-term care needs,^{27,28} chronic comorbid conditions,²⁹ and dual eligibility in the Medicaid and Medicare programs.³⁰ Provisions of the ACA may facilitate such initiatives. Below, we explore novel strategies for improving access to high-quality mental health services for rural long-term care recipients.

Promising Practices

Strengthening the Rural Mental Health Workforce

Recruitment of Professionals to Rural Areas. To encourage redeployment of health workers to underserved areas, the National Health Service Corps (NHSC) grants federal repayment of academic loans to eligible health professionals who agree to serve for two years at an approved outpatient facility in a Health Professional Shortage Area.³¹ The ACA §10503 dedicated \$1.5 billion in new funding to the NHSC over the five years from 2011-2015.² Rural delivery systems could augment their capacity to address the psychiatric needs of local long-term care populations by using NHSC mechanisms to recruit mental health professionals with geropsychiatric expertise. To leverage NHSC resources, interested facilities within a rural region might form a network to act as an approved site, whose members would share the services of an NHSC-sponsored mental health clinician.

Growing an Indigenous Rural Mental Health Workforce.

Rural health care delivery systems might optimize returns on their recruitment investments by developing desired mental health care skills in local residents with long-term commitments to their communities of origin. The Alaska Rural Behavioral Health Training Academy (ARBHTA) adopts this approach. ARBHTA resulted from collaboration between the University of Alaska at Fairbanks (UAF) and Norton Sound Health Cooperative, an agency serving Alaska Native communities in the Bering Strait region.³² These two entities designed a training program for community members interested in delivering mental health care to Norton Sound clients. UAF contributed a curriculum, faculty, and academic credit toward degrees in mental health care for participants. Norton Sound furnished supervisors and clinical practica embedded in its own work flow. Successful ARBHTA graduates become eligible to provide reimbursable services in communities where they trained.²⁸

To create a “home-grown” rural workforce of mental health clinicians equipped to serve local long-term care populations, universities could form consortia with multiple rural mental health provider organizations to establish programs like ARBHTA. University-based geropsychiatric experts could consult with senior clinicians at consortium sites, who could then supervise trainees in providing mental health treatment to long-term care recipients. Participating sites could incorporate successful program graduates into their staff.

Two ACA provisions might support this training model. First, the ACA's State Health Care Workforce program (§5102) awards states up to \$150,000 to design workforce development strategies.² States could use this funding to broker partnerships like ARBHTA. Second, newly created Mental and Behavioral Health Education and Training Grants (§5306(a)) help institutions of higher education to recruit and train students in mental health professions.² Universities could direct these funds toward individuals with interests in rural and/or geriatric mental health. Both §5102 and §5306(a) received specific appropriations through 2013.³³

Building Mental Health Care Competencies in the Rural Health Workforce. Telemedicine programs linking urban-based tertiary care centers to rural sites are used to furnish continuing education to rural health workers.³⁴ Such programs could be employed to help rural providers respond effectively to the mental health needs of long-term care recipients. New and existing telemedicine networks could be leveraged to offer geropsychiatric training to rural mental health professionals and primary care clinicians, and to support direct care staff in identifying and managing mental health issues in long-term care.³⁵ Two ACA initiatives could promote distance learning opportunities along these lines. One provision (§5403) grants funds to Area Health Education Centers to develop infrastructure for workforce education programs; a second (§5302) offers grants for provider organizations to create training curricula for direct care workers in nursing home and community settings.²

Overcoming Physical Access Barriers through Tele-Mental Health

To overcome physical obstacles impeding the access of rural long-term care recipients to mental health care, tele-mental health strategies may prove useful. Limited research suggests that tele-mental health approaches are cost-effective, acceptable to patients, and as likely to improve outcomes as face-to-face clinical contacts.³⁶ The Fletcher Allen Health Care/University of Vermont Telemedicine Program has demonstrated the feasibility and utility of tele-mental health in long-term care. This program contracts with 13 nursing homes in rural Vermont and New York to provide residents with psychiatric services via interactive videoconferencing.³⁷ Although we know of no tele-mental health programs that deliver services to community-dwelling long-term care recipients, such applications appear to be technically feasible, given that the Department of Veterans Affairs (VA)

has successfully used telemedicine to permit clinical contacts between care managers and home-bound, chronically ill veterans.³⁸ Section 3026 of the ACA directs the Center for Medicare and Medicaid Innovation to study the use of telehealth services to treat behavioral issues among people in medically underserved areas.² Although this provision could encourage expanded use of tele-mental health in rural long-term care, its impact is difficult to predict, given that some rural areas still lack the broadband capacity needed to conduct mental health interventions via videoconferencing.³⁹

Integrated Care for Rural Long-Term Care Recipients in the Community

Integrated care initiatives could help bring better mental health services to rural long-term care recipients living in the community, provided that this population is targeted for inclusion in such projects. Here, we describe two such models and the ACA-sponsored programs that support their dissemination.

Home-Based Primary Care for Veterans. The VA's Home-Based Primary Care program (VA HBPC) targets home-dwelling veterans with chronic, potentially disabling conditions, which often include psychiatric disorders. Within VA HBPC, care is delivered in veterans' homes by physician-led, multidisciplinary teams, who devise and execute a unified treatment plan for each patient. Recognizing that proper management of psychiatric comorbidity is essential for maintaining participants' overall health, VA HBPC includes mental health clinicians in its treatment teams.⁴ A national evaluation of VA HBPC showed that while home visits for enrollees increased by 264% over the course of a year, total VA costs for enrollee care declined by 24%.⁴⁰

VA HBPC was the basis for Medicare's Independence at Home Demonstration. This project, authorized by ACA §3024, adapts the HBPC model to the needs of chronically ill Medicare beneficiaries. Teams who realize cost savings receive incentive payments.²

The HBPC model appears well-suited to the needs of rural, community-dwelling long-term care recipients, both because it has proven effective for a population with a similar clinical profile and because it addresses physical access barriers.

Integrating Long-Term Services and Mental Health Care into Medical Homes. Launched in 1998, Community Care of North Carolina (CCNC) is an evolving medical home initiative financed by North Carolina Medicaid. Within CCNC, primary

care practices organize themselves into regional networks, which contract with Medicaid to provide enrollees with medical home services (i.e., primary care, coordination of health care and supports, and chronic disease management). CCNC serves over 800,000 enrollees in both rural and urban areas. In 2008, CCNC expanded to target the aged, blind, and disabled Medicaid population, some of whom receive community-based long-term care. To defray increased costs associated with caring for these complex patients, North Carolina Medicaid grants CCNC networks and participating physicians enhanced per-member per-month payments. To assist practices in addressing this group's special needs, CCNC networks offer training and consultation on issues such as long-term care coordination and mental health integration in medical homes.²⁸

The Medicaid Health Homes Option created under ACA §27032 could foster wider adoption of CCNC's medical home model for medically and psychiatrically vulnerable adults. The option allows states to use Medicaid funds to create primary care practices that coordinate treatment and supports for Medicaid beneficiaries with multiple chronic conditions. States that adopt the Health Homes Option receive federal matching payments of 90% for their first two years of operation. Conditions that qualify patients for participation in health homes include psychiatric and substance abuse disorders, as well as physical illnesses. In addition to providing primary care and care coordination, health homes must offer mental health and substance abuse treatment, long-term care, and linkages to community services. Community-dwelling long-term care recipients are eligible to become health home enrollees, and as such, they could be afforded routine access to integrated mental health interventions.²

Due to limited funds and workforce shortages, rural providers may find it challenging to create and sustain integrated care initiatives with well-developed mental health services for the long-term care population.³⁴ Nevertheless, CCNC's experience suggests that regional cooperation, which could take varying forms depending on the needs of given locales and regions, could help to make rural implementation attainable.

POLICY CONSIDERATIONS

There are many promising models for improving the mental health care afforded to long-term care

populations. Provisions of the ACA, leveraged appropriately, could stimulate further advances along these lines. The challenge for rural health is to ensure that states and provider organizations take up potentially helpful workforce and delivery system innovations and target them to meet mental health needs in rural long-term care.

A key finding of this brief is the paucity of research on mental health problems among long-term care recipients, both generally and in rural areas. Empirical investigations on mental health services for these populations are also scarce. We need further work in these areas to guide reform efforts.

We also need descriptive and evaluative research on the rural implementation and impact of workforce and delivery system innovations like those discussed above. Such research should concentrate on challenges and opportunities confronted by rural mental health and long-term care systems in their attempts to adopt these innovative practices. Key policy and research questions must be framed in ways that allow investigators to tap funding sources supporting the study of issues such as comparative effectiveness and rural health.

The potential for reform in the delivery of mental health services within rural long-term care is significantly enhanced by state efforts, under the ACA, to increase the value of care delivered to high-need long-term care recipients, many of whom suffer from psychiatric problems. Rural health policy leaders at federal and state levels must focus attention on these important initiatives and identify ways to adapt them to meet the mental health needs of rural long-term care populations.

References

1. Kaiser Commission on Medicaid and the Uninsured. *Medicaid and Long-term Care Services and Supports*. Washington, DC: Kaiser Family Foundation; February 2009. Fact Sheet #2186-06.
2. *Patient Protection and Affordable Care Act. 2010*; Pub L. No 111-148. Available at: <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>. Accessed March 5, 2013.
3. Grabowski DC, Aschbrenner KA, Rome VF, Bartels SJ. Quality of mental health care for nursing home residents: A literature review. *Med Care Res Rev.* 2010;67(6):627-656.

4. Edes T. Innovations in homecare: VA home-based primary care. *Generations*. 2010;34(2):29-34.
5. Li LW, Conwell Y. Mental health status of home care elders in Michigan. *Gerontologist*. 2007;47(4):528-534.
6. Reichman WE, Conn DK. Nursing home psychiatry: Is it time for a reappraisal? *Am J Geriatr Psychiatry*. Dec 2010;18(12):1049-1053.
7. Zeltzer BB, Kohn R. Mental health services for homebound elders from home health nursing agencies and home care agencies. *Psychiatr Serv*. 2006;57(4):567-569.
8. Bolda EJ, Dushuttle P, Keith RG, Coburn AF, Bridges K. *Does Access to Mental Health Services for Rural and Urban Nursing Home Residents with Depression Differ?* Portland, ME: University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center; 1998. Working Paper #11.
9. Shea DG, Russo PA, Smyer MA. Use of mental health services by persons with a mental illness in nursing facilities: initial impacts of OBRA87. *J Aging Health*. Nov 2000;12(4):560-578.
10. Reschovsky JD, Staiti AB. Access and quality: does rural America lag behind? *Health Aff (Millwood)*. Jul-Aug 2005;24(4):1128-1139.
11. Office of Shortage Designation, Bureau of Health Professions. *Designated Health Professional Shortage Areas (HPSA) Statistics*. 2013, January 9; http://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry. Accessed January 25, 2013.
12. Doescher MP, Skillman SM, Rosenblatt RA. *The Crisis in Rural Primary Care*. Seattle, WA: WWAMI Rural Health Research Center April 2009. Policy Brief.
13. Bartels SJ, Brewer G, Mays W, Rawlings B. *Community Integration for Older Adults with Mental Illnesses: Overcoming Barriers and Seizing Opportunities*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; 2004. DHHS Publication No. SMA 05-4018.
14. Hartley D, Bird DC, Lambert D, Coffin J. *The Role of Community Mental Health Centers as Safety Net Providers*. Portland, ME: University of Southern Maine, Edmund S. Muskie School of Public Service, Maine Rural Health Research Center; 2002. Working Paper #30.
15. Rathbone-McCuan E. Mental health care provision for rural elders. *J Appl Gerontol*. 2001;20(2):170-183.
16. Larrison CR, Hack-Ritzo S, Koerner BD, Schoppelrey SL, Ackerson BJ, Korr WS. State budget cuts, health care reform, and a crisis in rural community mental health agencies. *Psychiatr Serv*. Nov 2011;62(11):1255-1257.
17. Lutterman T. *Impact of the State Fiscal Crisis on State Mental Health Systems: Fall 2010 Update*. Alexandria, VA: National Association of State Mental Health Program Directors Research Institute 2011.
18. Carey MA. Hospitals, Home Health Care Services Lobby Against Cuts In Deficit Deal. *Capsules: The KHN Blog* 2012, November 15; <http://capsules.kaiserhealthnews.org/index.php/2012/11/hospitals-home-health-care-services-lobby-against-cuts-in-deficit-deal/>. Accessed November 20, 2012.
19. Viebeck E. Nursing Homes to Congress: Stop Looming Medicare Cuts. *Healthwatch: The Hill's Healthcare Blog* 2012, November 12; <http://thehill.com/blogs/healthwatch/medicare/267301-nursing-homes-to-congress-stop-looming-medicare-cuts>. Accessed November 20, 2012.
20. Aschbrenner KA, Cai S, Grabowski DC, Bartels SJ, Mor V. Medical comorbidity and functional status among adults with major mental illness newly admitted to nursing homes. *Psychiatr Serv*. Sep 2011;62(9):1098-1100.
21. Hoover DR, Siegel M, Lucas J, et al. Depression in the first year of stay for elderly long-term nursing home residents in the USA. *Int Psychogeriatr*. Nov 2010;22(7):1161-1171.
22. Unutzer J, Patrick DL, Simon G, et al. Depressive symptoms and the cost of health services in HMO patients aged 65 years and older. A 4-year prospective study. *JAMA : the Journal of the American Medical Association*. May 28 1997;277(20):1618-1623.
23. Bartels SJ, Dums AR, Oxman TE, et al. Evidence-based practices in geriatric mental health care. *Psychiatr Serv*. Nov 2002;53(11):1419-1431.
24. Hunkeler EM, Katon W, Tang L, et al. Long term outcomes from the IMPACT randomised trial for depressed elderly patients in primary care. *BMJ*. Feb 4 2006;332(7536):259-263.

25. Butler M, Kane RL, McAlpine D, et al. *Integration of Mental Health/Substance Abuse and Primary Care*. Rockville, MD: Agency for Health Research and Quality; 2008. Evidence Report/Technology Assessment Number 173.
26. Unutzer J, Katon W, Callahan CM, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA : the Journal of the American Medical Association*. Dec 11 2002;288(22):2836-2845.
27. Engquist G, Johnson C, Johnson WC. *Medicaid-Funded Long-Term Supports and Services: Snapshots of Innovation*. Hamilton, NJ: Center for Health Care Strategies, Inc.; May 2010.
28. National Advisory Committee on Rural Health and Human Services. *The 2009 Report to the Secretary: Rural Health and Human Services Issues*. Rockville, MD: Health Resources and Services Administration, Office of Rural Health Policy, NACRHHS; 2009.
29. Silow-Carroll S, Rodin D. Health Homes for the Chronically Ill: An opportunity for states. *States in Action Archive 2011*; <http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Jan/December-2010-January-2011/Feature/Feature.aspx>. Accessed September 18, 2012.
30. U.S. Department of Health and Human Services. *New Flexibility for States to Improve Medicaid and Implement Innovative Practices*. Washington, DC: US DHHS; April 14 2011.
31. National Health Service Corps. *Full-Time Loan Repayment Program*. n.d.; <http://nhsc.hrsa.gov/loanrepayment/fulltimeprogram/index.html>. Accessed January 30, 2013.
32. Roberts M, Smith J, McFaul M, et al. Behavioral health workforce development in rural and frontier Alaska. *JRMH*. 2011;35(1):10-16.
33. Redhead CS, Colello KJ, Heisler EJ, Lister SA, Sarata AK. *Discretionary Spending in the Patient Protection and Affordable Care Act (ACA)*. Washington, DC: Congressional Research Service; October 1 2012. R41390
34. American Telemedicine Association. *Telemedicine in the Patient Protection and Affordable Care Act (2010)*. 2010; <http://www.americantelemed.org/docs/default-source/policy/telehealth-provisions-within-the-patient-protection-and-affordable-care-act.pdf>. Accessed September 18, 2012.
35. Semansky R, Willging C, Ley DJ, Rylko-Bauer B. Lost in the rush to national reform: Recommendations to improve impact on behavioral health providers in rural areas. *J Health Care Poor Underserved*. May 2012;23(2):842-856.
36. Richardson LK, Frueh BC, Grubaugh AL, Egede L, Elhai JD. Current directions in videoconferencing tele-mental health research. *Clin Psychol (New York)*. Sep 1 2009;16(3):323-338.
37. Rabinowitz T, Murphy KM, Amour JL, Ricci MA, Caputo MP, Newhouse PA. Benefits of a telepsychiatry consultation service for rural nursing home residents. *Telemed J E Health*. Jan-Feb 2010;16(1):34-40.
38. Hogan TP, Wakefield B, Nazi KM, Houston TK, Weaver FM. Promoting access through complementary eHealth technologies: recommendations for VA's Home Telehealth and personal health record programs. *J Gen Intern Med*. Nov 2011;26 Suppl 2:628-635.
39. National Broadband Map. *Broadband Statistics Report: Broadband Availability in Urban vs. Rural Areas*. 2012; <http://www2.ntia.doc.gov/files/broadband-data/national-broadband-map-broadband-availability-in-rural-vs-urban-areas.pdf>. Accessed February 14, 2013.
40. Beales JL, Edes T. Veteran's Affairs home based primary care. *Clin Geriatr Med*. Feb 2009;25(1):149-154, viii-ix.