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Improving mental health services for rural seniors

Building an integrated service network

By Mark Holub, MD

In 2011, the first of the baby boomers will reach the age of 65. This will start a dramatic graying of the American population that will result in an increase from the current 20 million to over 40 million Americans 65 years and older by 2030. It has been estimated the number of mentally ill elderly will grow to 15 million by 2030.

Although 13 percent of our population is over the age of 60, their utilization of mental/behavioral health services is much less than expected. Elderly account for only 7 percent of all inpatient psychiatric services, 6 percent of community mental health services, and 9 percent of private psychiatric care. Less than 3 percent of all Medicare reimbursement is for the psychiatric treatment of older Americans. Clearly, this population's needs for mental health services are not being met. Perhaps most alarming is the suicide rate in the elderly. Men over 65 years have the highest rate of suicide of any demographic, and a staggering 17 seniors die from suicide each day in America.

There are multiple barriers to elderly and rural patients gaining access to adequate mental/behavioral health services. A significant stigma relating to having mental illness remains in this population. I frequently see patients in my practice who think they should just "gut it out" and resist getting treatment. They often view the decreased energy, poor concentration, sad mood, poor sleep, and social isolation of depression as part of the normal aging process. They frequently see the memory loss and disorientation that accompany pseudodementia as a response to the many losses experienced in later life.

Rural challenges and barriers

Rural elderly present unique challenges to providers of mental health services. Rural communities tend to have higher percentages of elderly in their populations, as younger people move to urban areas to work while the elderly "age in place." Rural elderly are more likely to stay in their homes than their urban counterparts. This results in rural elderly being further isolated from extended family and needed mental health services.

Rural elderly also have higher rates of poverty than urban elderly—and estimates of poverty in the rural elderly likely are underestimated because they exclude health care costs. Medicare forces patients to pay more for their mental/behavioral health care than they do for their other health care. Only 62.5 percent of allowable charges are covered by Medicare for mental health treatment. This results in elderly people not getting the treatment they need because they cannot afford it. Many elderly patients in my practice need to decide which of their multiple medications they can afford each month.

There is a significant shortage of mental health professionals providing service to elderly patients throughout the country. These shortages are greater in rural areas than in urban areas, according to the Minnesota Center for Rural Mental Health Studies. Patients often find psychiatric clinics are not taking new patients or have waiting lists of several months to see the physician. Some practitioners take only limited or no Medicare patients because of low reimbursements for mental/behavioral services. This shortage often forces patients to travel long distances to receive treatment. The cost and limited availability of transportation reinforce the barriers to mental health care.

Even when patients are able to access care, they often encounter the most frustrating barrier of all: the lack of communication and coordination among providers. Elderly patients may receive their antidepressant medication from their primary care provider, therapy from local community mental health center, home care from another agency, and social services from county agencies. In some cases, symptoms become extreme and psychiatric hospitalization is needed. This may add yet another provider and further fragmentation, as each

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agency has a separate chart and treatment plan. The primary care providers often adjust medications without the benefit of the observations of the therapist or social worker. Many times, a patient presents to primary care for medication adjustments before the discharge summary arrives from the recent psychiatric hospitalization.

Overcoming treatment barriers

Lakewood Health System (LHS) in Staples, Minn. (pop. ~3,100), serves a population that includes many patients who are both poor and old, spread across four rural Minnesota counties. In 2007, LHS began an effort to overcome some of the barriers to mental health treatment of elderly patients. The effort began with the opening of a 10-bed inpatient geriatric psychiatric unit, known as Lakewood Reflections. After I joined Lakewood Health System as its first psychiatrist, the process of training staff and developing procedures began. The unit takes referrals from around the state, but mainly treats patients from local communities. A treatment team of nursing, family medicine, psychiatry, and social services was developed to care for the medical and psychiatric needs of the most disabled elderly needing acute hospital care. A second psychiatrist was recently added to increase our capacity.

A doctoral-level psychologist joined the team in November 2008 and has become a valuable asset. She provides therapy for our patients and performs psychometric testing. The therapy is often needed to help the elderly cope with the multiple losses they have experienced. The psychometric testing is valuable in the diagnosis of dementia and other mental disorders. Repeat testing can help monitor the progression of dementia and is very useful for caregivers to guide appropriate placement and level-of-care decisions.

In an effort to provide services for patients who struggle in the community and are at risk for acute hospitalization, we initiated a structured outpatient program that provides up to 11 hours a week of psychotherapy for elderly patients. The psychiatrist handles medication management on a monthly basis. Many of these patients have recently been in the acute care unit, have lost a spouse, or are caring for a family member with dementia. To reduce transportation barriers to treatment, a Care Van picks patients up and returns them home.

Psychiatric and medical care is integrated for outpatients through a consultation practice that supports the primary care providers. Psychiatric consultations are provided to patients at the request of the primary care provider. A depression screening is conducted by primary care providers at a Lakewood Health System clinic to further assist providers in identifying Medicare patients in need of psychiatric assessment. Recommendations for treatment are provided to the primary care providers, who then prescribe the medications and provide ongoing care. Ongoing consultation with a psychiatrist is available and frequently utilized. By not providing the ongoing care, the psychiatrist is able to provide consults in a timely manner, with some appointments available the week they are requested. With the assistance of the psychiatrist, the primary care providers are able to manage more complicated patients, reducing the need for patients to travel long distances to receive care. The provision of ready access to psychiatric consultation also increases the comfort level of the primary care physician in treating mental illness. This results in more patients being able to receive care in their home community from providers with whom they can develop trusting, long-term relationships.

We recently added an advance practice nurse who specializes in mental health treatment. She currently provides mental health services in local nursing homes, which allows us to provide follow-up services for some of our inpatients after discharge. By seeing the patients in a Lakewood facility, better coordination is possible and behavioral observation with subsequent interventions can more readily be accomplished. This often results in reduced use of psychotropic medications. For example, at our memory care unit, only two of our 16 patients are currently on antipsychotic medications. Patients are placed in this setting due to significant behavior problems. A recent state surveyor indicated that Lakewood is far below the state average for using these medications. This has been accomplished through staff training and leadership that focuses on behavioral observation and modification, coupled with in-house psychiatric services.

The psychiatrist, advance practice nurse, psychologist, and primary care provider are all able to access the same patient chart. Information from all programs and providers is placed in the medical record, much of it electronic. To protect the privacy of the patients, these documents are locked so that only authorized personnel can access them.

Reductions in fragmentation, cost of care

It has been our experience that we can provide the best mental/behavioral health services to elderly patients by building an integrated service model in a rural community hospital and clinic. The ability to share information electronically among multiple providers has reduced fragmentation. Making mental health services available in a rural community through primary care providers reduces the patient's resistance to getting treatment. The cost of care is reduced by eliminating repeat labs and other testing and reducing travel.

While we are proud of our accomplishments, we still face many challenges. Reimbursement from Medicare is set to increase over the next several years until it is equal with other medical care. Yet, the funding remains problematic and creates an ongoing barrier to care. In spite of ongoing education efforts, the stigma of mental illness unfortunately persists for many people. We have been fortunate to attract outstanding mental health professionals for our programs and look forward to future growth.

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