

Critical Access Hospitals: Mental Health Services Assessment

May 2005

Access to mental health services was identified by Iowa Critical Access Hospitals (CAHs) as a key issue facing rural communities in Iowa. An Internet-based survey of 66 Iowa CAH Administrators was conducted by Rural Health Solutions, St. Paul, MN in the spring of 2005 as part of the Iowa Medicare Rural Hospital Flexibility (FLEX) Program. Forty-eight CAHs (72%) responded to the survey. The intent of the survey was to:

- Further the mental health services research that is underway in Iowa,
- Understand access to mental health services in CAH communities,
- Identify any trends or specific access issues related to rural mental health services,
- Enable the Iowa FLEX program to focus its efforts, and
- Assist CAHs in formulating an approach to addressing the mental health needs of the communities they serve.

Mental Health – The United States

Mental health is identified as part of Healthy People 2010 as one of the top 10 high-priority public health issues in the United States.¹ Its level of importance is further reflected in the fact that major depression is the leading cause of disability worldwide among persons age 5 and older²; suicide was the 11th leading cause of death in the U.S. in 2000³; and an estimated 22.1% of Americans age 18 and older suffer from a diagnosable mental disorder in a given year.⁴

In addition, according to the National Institute of Mental Health (NIMH), nearly 60 million Americans living in rural and frontier areas have mental health issues. The prevalence of mental illness, substance abuse and disability in rural areas is equal to or greater than in urban populations.

While mental health is an issue, so is access to mental health services. Rural areas, which lack mental health providers (e.g. psychiatrists, psychologists, social workers), also have higher rates of poverty, lower health insurance enrollment rates, a disproportionate share of the elderly, less anonymity when seeking health services, and minimal or non-existent transportation services. All of these factors add to the complexity of rural America's state of mental health. As stated in the National Rural Health Association's 1999 report, *Mental Health in Rural America*, only 79.5 percent of non-metropolitan counties in the United States have any mental health services (1990) and the average number of specialty mental health organizations in non-metropolitan counties is substantially lower than the average number in metropolitan counties. That same report went on to say, "current data show consistently lower availability of hospital-based inpatient and outpatient services, both psychiatric and substance abuse, in rural areas".

"Mental Health is the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to change and to cope with adversity." – Surgeon General's report 1999

¹ <http://www.healthypeople.gov/LHI/Priorities.htm>

² <http://www.nimh.nih.gov/publicat/burden.cfm>

³ <http://www.nimh.nih.gov/publicat/harmsway.cfm>

⁴ <http://www.nimh.nih.gov/publicat/numbers.cfm>

Mental Health Services – Iowa

According to the Iowa Consortium for Mental Health Service Training and Research at the University of Iowa, “Systems of mental health service organization in Iowa are primarily county based.” There are 33 community support programs (CSPs) that are affiliated with one of the state’s 36 Community Mental Health Centers that serve a catchment area of one to nine counties in Iowa. In addition, there are four long-term psychiatric hospitals in the state (Cherokee, Clarinda, Independence, and Oakdale), one alcohol and other chemical dependency hospital (Mount Pleasant), and two institutions that serve people with mental disabilities (Glenwood and Woodward).⁵ These seven long-term specialty hospitals have 1,030 beds.⁶

In 2000, approximately \$276 million was spent by counties and the state of Iowa on mental health services. This can be compared to 2003, when approximately \$273 million was spent by counties alone on mental health services in Iowa.⁷

Iowa CAHs and Mental Health Services

An Internet-based survey of 66 Iowa CAH administrators was conducted from March 21 – April 8, 2005 to identify the following:

- primary and specialty care providers providing mental health services in rural Iowa,
- the most common mental health issues presented in CAHs,
- referral patterns and issues, and
- factors that are having the greatest impact on mental health care services in the communities that CAHs serve.

Forty-eight CAHs (72%) responded to the survey. The majority of survey respondents were CAH administrators while Directors of Nursing, Quality Assurance Coordinators, Mental Health Services Managers, and others also completed the survey.

Health Care Providers: 1575 practitioners are working at survey respondent CAHs. This includes an average of 6.03 physicians, 1.16 nurse practitioners, 1.6 physician assistants, 33.01 nurses, .47 psychiatrists, .26 psychologists, 1.61 social workers, and 1.33 pharmacists per CAH.

Mental Health Care Providers: Of the 48 survey respondents, 58% indicated that their CAH provides some mental health services (e.g. inpatient, outpatient, referral or other services). Two hospitals have physicians and nurse practitioners, three have registered nurses, and one has a clinical nurse specialist that specializes in mental health. In addition, 17 psychiatrists, 9 psychologists, 61 social workers, and one mental health clinical nurse specialist practice in CAHs. CAHs also indicated that mental health counselors, educators and outreach psychiatrists work in their facilities.

Of the 1575 practitioners practicing in respondent CAHs, 43.36 FTEs or an average of 1.12 FTEs per CAH are dedicated to mental health; however, 46% of rural mental health practitioners are working in two CAHs and 19 CAHs have mental health staff. Removing the data for the two CAHs reveals a different picture of average FTEs working at CAHs as displayed in Table 1.

⁵ Iowa Hospital Association, Profile of Services, p. 7, April 2005.

⁶ Ibid.

⁷ http://www.dhs.state.ia.us/dhs2005/mhdd/statistical_info/county_dataservices.html

Table 1: CAH’s Total Mental Health Provider FTEs and Average FTEs

	CAHs with MHP*	CAHs with MHP* (remove top two CAHs by quantity)
Total FTEs	43.5	23.8
Average FTE per CAH	1.12	.64

* Indicates mental health providers

Ninety percent of survey respondents indicated they are not recruiting mental health practitioners, 4% indicated they are recruiting and 6% indicated they do not know. Those being recruited include two part-time psychiatrists, three full-time Master of Social Work therapists, and one part-time nurse. Sixty-one percent of respondent CAHs do not provide mental health continuing education programs for staff, 28% provide this education and 11% do not know whether their hospital provides this training for staff.

Services: Twenty-one CAHs (45%) provide outpatient mental health services. The majority of these services (76%) are contracted and provided on-site, while 19% are provided by the hospital and 14% are provided via contract off-site. One CAH reported providing mental health services using telemedicine and one CAH indicated they have an attached inpatient mental health dementia unit. This dementia unit has six beds, an average daily census of four, serves those that are 65-84 years in age, and has an average length of stay of 1 – 2 weeks.

Twenty-three percent of respondent CAHs plan to expand their mental health services. Service expansion plans include: adding a child psychiatrist, investigating mental health services options, expanding a service area of two counties into two additional counties, and adding psychiatrist time. One CAH indicated they will be eliminating mental health services due to Medicaid issues that have a negative impact on the CAH’s financial status.

Thirty-one (65%) CAHs indicated that non-hospital based mental health services are available in their community.

Nursing Home Care: Thirty percent of respondent CAHs indicated a nursing home is associated with their hospital. Six of these CAHs provide dementia specialty care, two provide Alzheimer’s disease specialty care, and one specializes in senior mental and neurological health. Eighty-nine percent of respondent CAHs indicated nursing home care - not affiliated with the CAH - is available in their community. Of these, 23 indicated that dementia specialty care is provided, 24 indicated that Alzheimer’s disease specialty care is provided, and one indicated that care related to mental disabilities is provided.

Assisted Living Care: Sixty-seven percent of respondent CAHs indicated that assisted living services are available in their community. Eleven of these services provide dementia specialty care, seven provide Alzheimer’s disease specialty care, and one provides mental disability specialty care.

Home Health Care: Eighty-five percent of respondent CAHs indicated that home health care is provided by a service provider in the community that they are located. Fourteen of these home health care providers offer Alzheimer’s disease specialty services and 14 provide dementia specialty care services.

Treatment: CAHs most commonly treat patients for depression (79%), anxiety and panic disorders (58%), dementia (56%), drug use (46%), Bi-polar disorder (42%), attention deficit disorder (42%), self-inflicted injury (19%), and other (17%).

Mental Health Referrals: CAHs were asked where they refer patients for mental health outpatient and inpatient services and the average number of referrals made per month. Approximately 35 outpatient referral sites were identified by respondent CAHs including sites in Nebraska and South Dakota. The most common outpatient referral sites included: Mercy Medical Center of North Iowa, Mason City; North Central Iowa Mental Health, Fort Dodge; and Seasons Center Community Health, Spencer. Wait times for outpatient services were reported most commonly as 1-2 weeks (43%), followed by 1 week or less (36%), 3-4 weeks (14%), 4-6 weeks (5%), and 8-12 weeks (2%). Most CAHs are unaware of the number of outpatient referrals made per month. For those that reported referrals, they ranged from 30 per month in one CAH to .5 in another, with the average number of referrals being 3.44 per month.

When asked about inpatient referral sites, CAHs reported referring to approximately 37 inpatient referral sites, including sites in Nebraska and South Dakota. The most common inpatient referral sites included: Allen Memorial, Waterloo; Covenant Hospital, Waterloo; Jennie Edmundson, Council Bluffs; Mary Greeley Medical Center, Ames; University of Iowa Hospital and Clinics, Iowa City; Mercy Medical Center – North Iowa, Mason City; St. Lukes Hospital Cedar Rapids; Iowa Lutheran Hospital, Des Moines. CAHs also reported their experiences related to referral wait times for inpatient services. They reported: 20% of referral sites always have availability, 27% usually have availability, 33% sometimes have availability, 18% typically do not have availability, and 2% never have availability.

Access Issues and Barriers: CAHs were asked to identify and rate barriers to accessing mental health services in the communities that they serve. Table 2 identifies key factors affecting access to mental health services and the percentage of respondent CAHs that identify each factor as an access issue. In addition, each factor is rated on a scale of 1 (low) – 5 (high) indicating whether it is a low level barrier or a high level barrier. Referring to Table 2 we see that 89% of CAHs believe that insurance coverage is a barrier affecting access to mental health services in their communities. In addition, 87% believe recruitment and retention of mental health providers and reimbursement are factors affecting access to mental health services. CAHs rated reimbursement (58%), insurance coverage (53%), and availability of inpatient mental health services (50%) highest in terms of the level of barrier presented.

Table 2: Factors Affecting Access to Mental Health Services in CAHs

Factors Affecting Access to Mental Health Services	Barrier		Level of Barrier in the Community				
	Yes	No	1 (low)	2	3	4	5 (high)
Recruitment and Retention of Mental Health Providers	87%	13%	2%	7%	24%	29%	38%
Reimbursement	87%	13%	2%	5%	12%	23%	58%
Availability of Inpatient Mental Health Services	85%	15%	5%	10%	14%	21%	50%
Availability of Outpatient Mental Health Services	59%	41%	11%	8%	27%	16%	38%
Stigma Related to Mental Health	84%	16%	8%	20%	28%	23%	23%
Insurance Coverage	89%	11%	2%	5%	19%	21%	53%
Quality of Mental Health Services	36%	64%	32%	13%	13%	19%	23%
Confidentiality in Obtaining Mental Health Services	24%	76%	37%	26%	19%	11%	7%
Lack of Telemedicine	27%	73%	37%	26%	22%	4%	22%

When CAHs were asked to identify and rank the top three barriers affecting access to mental health services in their community, 58% indicated reimbursement, 47% identified recruitment and retention of mental health care providers, and 47% reported availability of inpatient mental health service. When a point allocation process was used to score each barrier rated in their top three (e.g.

three points for those ranking as the greatest barrier, two for the next greatest, and one for the third greatest) a slightly different ranking of the barriers appears. Using this scoring method, Table 3 shows recruitment and retention of mental health providers as the highest ranking barrier affecting access to mental health services in CAH communities.

Table 3: Ranking of Barriers Affecting Access to Mental Health Services in CAHs

Barriers to Accessing Mental Health Services	Score
Recruitment and Retention of Mental Health Providers	49
Reimbursement	44
Availability of Inpatient Mental Health Services	37
Availability of Outpatient Mental Health Services	34
Stigma Related to Mental Health	23
Insurance Coverage	23
Quality of Mental Health Services	6
Confidentiality in Obtaining Mental Health Services	6

Other Considerations

CAHs reported other factors affecting access to mental health services in rural Iowa, including:

- Dual diagnosis (mental health/substance abuse) issues are a growing concern. For example, it is increasingly difficult to find available inpatient services for dual diagnosis clients, in particular those patients who are intoxicated.
- Transportation (including the financial and staffing burden placed on ambulance services) both for people seeking services and providers transferring patients to other service providers. Substance abuse is also having an increasing impact on transportation of patients.
- Placement of those under the age of 18.
- One CAH noted that since they hired a nurse practitioner specializing in psychiatry, mental health hospitalization costs for the county have decreased by \$20,000 annually.
- One CAH reported that they have plans to open two additional community mental health center satellite offices.
- One CAH expressed a lack of access to mental health services in their community with an interest in assessing options related to integrating mental health into the specialty services being offered.
- Some CAHs lease space in their hospital to mental health service providers or groups of providers (typically a combination of psychiatrists, social workers, and/or psychologists) making services available on a scheduled basis (e.g. weekly). In these instances, CAH staff are unaware of the patient diagnosis, referrals for additional inpatient and outpatient services, and the access issues that are most evident.

FLEX Program Opportunities

Based on the CAH mental health services survey, there appear to be some key FLEX Program opportunities to foster increased access to rural mental health services in Iowa. Examples include:

- Dedicating a CAH Peer User Group meeting to discussing mental health access issues and priorities.
- Creating a CAH Peer User Group Subcommittee that includes representatives of CAHs and inpatient and outpatient mental health services providers to discuss issues and barriers and identify strategies to improve access and the referral and transfer of patients.

- Partnering with the Iowa Consortium for Mental Health Service Training and Research at the University of Iowa to gather rural relevant data, include rural as a primary research area in mental health services studies, and promote policy that meets the needs of rural communities and the providers that serve them.
- Encouraging networks and CAHs to share and conduct joint mental health continuing education programs with CAHs.

FLEX Program Next Steps

The Iowa FLEX Program has taken steps and plans to move forward in addressing rural mental health access issues. Initial activities include:

- Hosting a rural mental health round table discussion at the Iowa Flex Conference.
- Sharing FLEX Program sponsored mental health studies with other mental health services stakeholders in the state, including: CAHs, University of Iowa, and Iowa Department of Public Health, Division of Behavioral Health and Professional Licensure.
- Making this document available on the Iowa FLEX Program website.

The FLEX Program

The Medicare Rural Hospital Flexibility (FLEX) Program was established through the Balanced Budget Act of 1997. It is a national program that includes 45 states, including Iowa. In essence, the FLEX Program is comprised of two components – federal grants to assist states in implementing state specific program activities and an operating program that provides cost-based Medicare reimbursement to hospitals that convert to Critical Access Hospital (CAH) status. Six FLEX Program priority areas have been established for states implementing the program, they are:

- Creating and implementing a state Rural Health Plan;
- Designating facilities as CAHs;
- Fostering and developing rural health networks;
- Enhancing Emergency Medical Services (EMS);
- Improving the quality of health care; and
- Evaluating FLEX Program activities and related outcomes.

The Iowa Department of Public Health, Bureau of Health Care Access, FLEX Program administers the program in Iowa. Iowa has 72 CAHs and has obtained approximately \$428,275 per year to address all of the FLEX program priority areas. It is within this context that Iowa’s FLEX Program will begin to address access to mental health services in rural Iowa. For additional information contact Marvin Firch, Program Coordinator at 515/281-4808, e-mail at mfirch@idph.state.ia.us, or visit the Iowa FLEX Program on the Internet at http://www.idph.state.ia.us/hpcdp/flex_program.asp



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