THE MRS. B DILEMMA: HOW CAN WE GET ELDERLY PEOPLE OF COLOR MORE ACCESS AND ENCOURAGEMENT TO USE MENTAL HEALTH SERVICES?

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Mental health is a topic that has been at the forefront of medical and legal scholarship for the past few decades. For many elderly people of color, however, mental health and mental illnesses seem like a "personal weakness," something they can get through on their own, or a medical issue that they simply cannot afford to treat. This Note explores the clear disparities in why elderly people of color have less access to mental health treatment options, why they may be less likely to seek mental health treatment options, and what can be done to assist people in gaining more access and awareness to these options in their communities. The avenues of Medicare, Medicaid, housing vouchers, nursing home training, and the collaborative care model are all explored. This Note recommends reforms in Medicare, the expansion of Medicaid, reforms in Section 8 housing vouchers, improvements in identifying mental health issues in nursing homes, expansion in the usage of and research into the collaborative care model, and a nationwide awareness campaign as ways to combat this ever-growing issue for elderly communities of color.

I. Introduction

Mrs. B, an eighty-one-year-old, African American widow, who lived in a senior apartment, was asked to describe her experience with depression and the lowest points of her life, among other questions

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about her mental and physical health.[1] When asked about the worst time in her life, she answered that it was the present; she was feeling sad that she left behind her beautiful apartment and friends in Chicago to live near her son in Philadelphia, who seemed too busy to see her.[2] She often wondered about her purpose in life and said that when she prays, she asks God: "Please tell me what you want me to do in this life."[3] When asked how she could be relieved of her feelings of sadness and depression, she answered:

> I guess if I had somebody to talk to or share my problems with. Sometimes I feel ashamed because I feel like God is blessing me each day. So I ask God, 'What are you trying to tell me? What am I doing that's not right? What should I be doing?'[4]

This testimonial, one of multiple given in a study done on elderly African American women, gives a harrowing look into the struggle that elderly people of color ("POC") experience regarding their mental health and the difficulty they have in coping with these issues in their everyday lives.[5]

Mental health issues and the usage of mental health services have come to the forefront of modern scholarship on health and wellness.[6] In 2019, the National Institute of Mental Health reported that nearly one in five U.S. adults live with a mental illness.[7] It should come as no surprise then that mental illness plagues the elderly population of this country. In fact, between 5-10 million Americans aged sixty-five years or older suffer from depression. Another five million suffer from more severe forms of depression.[8] Additionally, around one in five older adults in the U.S. experience a mental illness, substance use disorder,

1. Helen K. Black et al., *The Lived Experience of Depression in Elderly African American Women*, 62 J. GERONTOLOGY, SERIES B: PSYCH. SCIS. & SOC. SCIS. 392, 394 (2007).

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.* at 394–97.

6. *See generally*, *The Prevalence and Treatment of Mental Illness Today*, HARV. MENTAL HEALTH LETTER, Nov. 2005 at 4, available at: https://clas-pages.uncc.edu/wp-content/uploads/sites/268/2013/09/Prevalence-of-Mental-Disorders-2005.pdf.

7. *Mental Illness*, NAT'L INST. MENTAL HEALTH [hereinafter *Mental Illness*], https://www.nimh.nih.gov/health/statistics/mental-illness (last visited Oct. 28, 2021).

8. Anita Everett, *Bringing Awareness to the Mental Health of Older Adults*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (May 20, 2019), https://blog.samhsa.gov/2019/05/20/bringing-awareness-to-the-mental-health-of-older-adults.

or both.[9] This issue has the potential to get much worse. Assuming that the one-in-five ratio still exists in 2030, it will equate to approximately fifteen million people,[10] as the number of Americans aged sixty-five and older is projected to double by 2060.[11]

While many elderly people experience mental illness and mental health issues, this is an even bigger problem for communities of color, as demonstrated in the testimonial above.[12] These groups do not have enough access to and/or are not utilizing available services to assist them with their mental health struggles.[13] The Agency for Healthcare Research and Quality reports that racial and ethnic minority groups in the U.S. are less likely to have access to mental health services, less likely to use community mental health services, while being more likely to use emergency departments and receive lower quality care.[14] This is largely due to not only racial inequality that exists within healthcare systems, like biases and stereotypes that lead doctors and physicians to neglect or actively discriminate against patients, but also, to outside factors.[15] For example, economic disparities between racial groups make it more costly to get insurance, which prevents people of color from receiving medical care.[16] Thus, individuals who have lower forms of insurance—if any at all—tend to receive a lesser quality of care.[17] Latinos are three times as likely to be uninsured and African Americans are twice as likely to be uninsured in comparison to whites, so low quality

9. Memorandum from George Dicks, Chair of Mayor's Council on African American Elders, on Mental Health & Cmtys of Color (on file with author) [hereinafter Dicks].

10. *See* Mark Mather et al., *Fact Sheet: Aging in the United States*, 70 POPULATION REFERENCE BUREAU 1, 3 (Dec. 2015), available at https://www.prb.org/aging-united-states-fact-sheet/.

11. Dicks, *supra* note 9.

12. Black, *supra* note 1, at 394.

13. Daniel E. Jiminez et al., *Disparities in Mental Health Service Use Among Racial/Ethnic/Minority Elderly*, 61 J. AM. GERIATRIC SOC'Y 18–25 (2013) [hereinafter Jimenez, *Disparities*].

14. *Minority Mental Health*, AM. HOSPITAL ASS'N, https://www.aha.org/bipoc-mental-health (last visited Oct. 28, 2021).

15. *Racism in Healthcare: What you need to know*, MEDICAL NEWS TODAY, https://www.medicalnewstoday.com/articles/racism-in-healthcare#how-racism-impacts-health (July 28, 2020).

16. *Id.*

17. Diana Ro, *Minority Mental Health: How Can We Improve Access to Care?*, PINE REST BLOG, https://www.pinerest.org/minority-mental-health-improve-access-to-care-blog/ (last visited Oct. 28, 2021).

of care or no care at all is clearly an issue in these populations.[18] There is also an underrepresentation of people of color in mental health research and communities of color experience more disability burdens from mental illnesses than do whites.[19] At the root of these issues is a great distrust of the healthcare system from communities of color regardless of age.[20]

This Note will discuss the efforts that have been made by various lawmakers, legislators, and health professionals to give elderly people of color the resources they need. It also will demonstrate how more needs to be done to fix this issue, specifically through the avenues of housing laws, Medicare and Medicaid, and nursing home behavioral health care, among others. Part II will provide background information on the definition of mental health, how mental health issues affect elderly communities, and specifically, how they affect elderly communities of color. Part III will discuss various efforts that have been taken to eradicate this issue, primarily through the avenues of Medicare and Medicaid, nursing home care, Section 8 housing vouchers, and the need for an integrated care or collaborative care model to assist elderly minorities in their care issues. Part IV recommends reforms to Medicare, Medicaid, Section 8 housing vouchers, and a call for a national awareness campaign, as well as requests for more research to be done in the avenue of the collaborative care model and its effect on older people of color, as well as wider implementation of the model.

II. Background

A. Mental Health Defined

What is mental health? Its definition is incredibly broad, but essentially, it "includes our emotional, psychological, and social well-being. It also helps determine how we handle stress, relate to others, and make choices."[21] Additionally, "many factors contribute to mental health problems, including biological factors—such as genes or brain

18. Margarita Alegria et al., *The Role of Public Policies in Reducing Mental Health Status Disparities for People of Color*, 22 HEALTH AFFS. 51, 53 (2003).

19. Dicks, *supra* note 9.

20. *Mental Health Disparities: Diverse Populations*, AM. PSYCHIATRIC ASS'N [hereinafter *Mental Health Disparities*], https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts (last visited Oct. 28, 2021).

21. *What Is Mental Health?*, MENTALHEALTH.GOV, https://www.mentalhealth.gov/basics/what-is-mental-health (May 28, 2020).

chemistry—life experiences—such as trauma or abuse—and family history of mental health problems."[22] Experiences related to other ongoing chronic medical conditions, use of drugs and/or alcohol, having trouble making friends, and having feelings of loneliness and isolation all can negatively contribute to a person's mental health and can cause a person to develop a mental illness.[23]

Some examples of mental illnesses include: anxiety disorders, which could be social anxiety, general anxiety, or panic disorder, among others; mood disorders, which include depression and bipolar disorders; psychotic disorders, such as schizophrenia; and personality disorders, which include obsessive-compulsive personality disorder and paranoid personality disorder.[24] Again, this is not an all-encompassing list; there are many more brain disorders that are classified as mental illnesses.[25] Additionally, while the terms mental health and mental illness are often used interchangeably, they are not the same.[26] A person can experience poor mental health and not be diagnosed with a mental illness.[27] Conversely, someone who has been diagnosed with a mental illness can experience periods of mental, physical, and emotional well-being.[28]

Unfortunately, mental health issues are quite common, regardless of age.[29] The National Institute of Mental Health estimated that in 2017, nearly forty-seven million Americans experienced a mental illness.[30] Of

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22. *Id.*

23. *Learn About Mental Health*, CTRS. FOR DISEASE CONTROL & PREVENTION [hereinafter *Learn About Mental Health*], https://www.cdc.gov/mentalhealth/learn/index.htm (Jan. 26, 2018).

24. Jennifer Casarella, *Types of Mental Illness*, WEBMD (Apr. 21, 2021), https://www.webmd.com/mental-health/mental-health-types-illness#2.

25. *Mental Illnesses and The Family: Recognizing Warning Signs and How to Cope*, MENTAL HEALTH AM., https://www.mhanational.org/recognizing-warning-signs# (last visited Oct. 28, 2021); *see generally*, *Information about Mental Illness and the Brain*, NAT'L INSTS. HEALTH (2007) [hereinafter *Information about Mental Illness and the Brain*], https://www.ncbi.nlm.nih.gov/books/NBK20369/# (discussing information about mental illness and the brain, and that "not all brain diseases are categorized as mental illnesses").

26. *Information about Mental Illness and the Brain*, supra note 25.

27. *Learn About Mental Health*, *supra* note 23.

28. *Id.*

29. *See Mental Illness*, MAYO CLINIC (June 8, 2019), https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968#.

30. *Mental Health 2020: A Presidential Initiative for Mental Health*, AM. PSYCHIATRIC ASSOC. [hereinafter *Mental Health 2020*], https://www.psychiatry.org/File%20Library/Psychiatrists/Advocacy/Federal/Mental-Health-2020-A-Presidential-Initiative-for-Mental-Health.pdf (last visited Oct. 28, 2021).

the forty-seven million, eleven million were estimated to be living with a serious mental illness,[31] which is defined as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities."[32] This number equates to a ratio of roughly one in five adults experiencing a mental illness.[33] Deaths by suicide have taken a sharp increase in the twenty years spanning from 1996–2016.[34] In twenty-four states, this increase has ranged from 31–58 percent.[35] Depression causes more lost workdays than arthritis, back pain, diabetes, or asthma.[36] Annually, depression alone costs the U.S. economy an estimated $210.5 billion.[37]

After a person realizes that they may have a mental health issue, the best way to be able to get treatment is to be diagnosed with a mental illness.[38] Unfortunately, there is no "medical test" that can be used to diagnose a mental health issue.[39] It usually starts with a person going to a primary care physician or a health care professional, who may conduct a physical exam and long-term monitoring to rule out medical conditions that could be causing symptoms.[40] Once other medical issues are ruled out, the person will be referred to a mental health care professional, who will use the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5").[41] The DSM-5 lists criteria like feelings, behaviors, and symptoms over a period time that a person must meet to be diagnosed with a mental illness.[42] This process requires the care and collaboration of various doctors, proper medical coverage, and even, the realization that a person has a mental illness in the first place.[43] Thus, it is difficult to get proper treatment without first having been diagnosed.[44]

31. *Id.*
32. *Mental Illness*, *supra* note 7.
33. *Mental Health 2020, supra* note 30.
34. *Id.*
35. *Id.*
36. *Id.*
37. *Id.*
38. *Understanding Your Diagnosis*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/Your-Journey/Individuals-with-Mental-Illness/Understanding-Your-Diagnosis (last visited Oct. 28, 2021).
39. *Id.*
40. *Id.*
41. *Id.*
42. *Id.*
43. *Id.*
44. *Id.*

There are various ways that a mental illness can be treated, once diagnosed.[45] These include psychotherapy, medication, case management, hospitalization, support groups, complementary & alternative medicine, self-help plans, peer support, and other treatments like electroconvulsive therapy and art therapy.[46] According to Mental Health America, psychotherapy, which is a therapeutic treatment of mental illness provided by a medical professional, paired with medication is the most effective way to promote recovery from a mental illness.[47] A treatment's effectiveness, however, can also depend on the individual, as different regimens work for different people.[48]

Therapy, hospitalization, and other methods of treatment are regrettably costly and time-consuming.[49] Many people with mental health disorders do not receive treatment because it is too costly and/or they do not have insurance coverage.[50] In the twelve-month period from 2004–2005, three out of five adults with a recently diagnosed mental health disorder did not receive care either from a mental health specialist or primary care provider.[51] Forty-seven percent of respondents with a mood, anxiety, or substance abuse disorder cited cost or lack of health insurance as a reason for not receiving care, even though they thought they needed it.[52] By way of example, in 2020, the cost of a single therapy session can range from $60-$120 per session, with the average American paying between $20-$250 an hour depending on how many sessions are booked and if the therapy is covered by their health insurance—assuming they even have it.[53] So, hypothetically, if you were paying $100 out of pocket for a single session and attending therapy once a month, that would be $1,200 a year. Of course, different therapy models require different time frames, but commonly, it is recommended to see a therapist once a week for a few months consecutively when beginning therapy for mental health issues, which would end up

45. *Mental Health Treatments*, MENTAL HEALTH AM., https://mhanational.org/mental-health-treatments (last visited Oct. 28, 2021).

46. *Id.*

47. *Id.*

48. *See id.*

49. Lea Winerman, *By the Numbers: The Cost of Treatment*, 48 AM. PSYCH. ASS'N. 80 (2017).

50. Kathleen Rowan et al., *Access and Cost Barriers to Mental Health Care by Insurance Status, 1999 to 2010*, 32 HEALTH AFFS. 1723, 1723–30 (2013).

51. *Id.*

52. *Id.*

53. *How Much Does Therapy Cost?*, THERVO.COM, https://thervo.com/costs/how-much-does-therapy-cost# (last visited Oct. 28, 2021).

costing even more.[54] This is a price many low-income Americans with mental health issues cannot afford to pay.

B. Mental Health in Elderly Populations

While mental health issues span broadly in various communities,[55] the elderly population often goes unnoticed. According to the Centers for Disease Control, it is estimated that twenty percent of people fifty-five years or older experience some form of mental health concern.[56] The most common mental health conditions elderly people experience are mood disorders (like depression or bipolar disorder), anxiety, and severe cognitive impairment.[57] Even more jarring is the fact that older men have the highest suicide rate of any age group.[58] A 2008 study found that men eighty-five years and older had a suicide rate of 45.23 per 100,000, compared to a rate of 11.01 per 100,000 across all age groups.[59]

There are many reasons for these numbers, one of which is that our population is aging rapidly.[60] Between 2015 and 2050, the proportion of the world's older adults is estimated to almost double from around 12–22 percent.[61] There are risk factors for mental health issues in all stages of life, but older people, in addition to experiencing common stressors, also experience stressors that may occur more frequently later in life.[62] For example, many elderly people experience an ongoing loss in their functional abilities and capacities such as reduced mobility, chronic pain, or even a drop in socioeconomic status after retiring.[63] Older adults are also especially vulnerable to abuse.[64] An estimated one

54. Jor-El Caraballo, *How Often Should You Talk to Your Therapist to Feel the Benefits?*, TALKSPACE (July 29, 2019), https://www.talkspace.com/blog/therapist-talk-how-often/.

55. *See Mental Health 2020*, *supra* note 30.

56. *The State of Mental Health and Aging in America*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/aging/pdf/mental_health.pdf (last visited Oct. 28, 2021).

57. *Id.*

58. *Id.*

59. *Id.*

60. *Mental health of older adults*, WORLD HEALTH ORG. (Dec. 12, 2017), https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults.

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

in six older people experience elder abuse.[65] With this combination of stressors, it is evident that mental health problems in the elderly community are relatively salient.

The lack of usage of mental health services can be greatly attributed to the stigma in elderly communities about mental health.[66] Seniors are hesitant to reach out for help when it comes to their emotional health.[67] Paul Gionfriddo, the President and CEO of Mental Health America, reported that only one-third of elderly adults who took a depression screening test on their website said that they were going to do anything with their results.[68] Gionfriddo added:

> People often just don't know how to start having this conversation. They don't know whether they want to bother their primary care doctor with it. That's one side, but the other is that people think they can make themselves a little happier. They think they've managed their whole lives and gotten this far, they should be able to manage without getting into a big thing.[69]

Many older people are afraid to get psychiatric care or go to a specialized clinic because they think they will be labeled as a psychiatric patient, a label that still holds a lot of shame within older communities.[70] Older people are not comfortable saying "I'm depressed" because mental health issues are still so stigmatized in these communities.[71]

C. Mental Health in Elderly POC/African American Populations

While it is clear that mental health issues are prevalent in the elderly community, in elderly communities of color, the problem is even worse.[72] This is not just because there are many elderly people of color that suffer from mental health issues, but also, because resources may not be available to them, or they are unaware that they have a mental illness or do not think they need help. It has been reported that African American adults are twenty percent more likely to suffer serious

65. *Id.*

66. Audrey Meinertzhagen, *Addressing the Stigmas of Ageism and Mental Health*, HOME CARE ASSISTANCE, https://homecareassistance.com/blog/addressing-stigmas-ageism-mental-health (last visited Oct. 28, 2021).

67. Johnathon S. Bor, *Among the Elderly, Many Mental Illnesses Go Undiagnosed*, 34 HEALTH AFFS. 727, 727–31 (2015).

68. *Id.* at 729.

69. *Id.*

70. *Id.*

71. *Id.*

72. *See* Rick Harrison, *HEA NOTES: For Racial and Ethnic Minorities, Older Adults Report More Severe Depression*, YALE SCH. MED. (Apr. 7, 2020), https://medicine.yale.edu/whr/news-article/23757/.

psychological distress than Caucasian adults.[73] Another study identified that older African Americans with mental disorders are more likely than whites to seek care from a general practitioner, which can be problematic because general practitioners may not have specialized knowledge in mental health issues.[74] Among older adults living in public housing, most of whom were African American,[75] over half of those in need of care had not received any mental health treatment over the preceding six months.[76] Black and African American people are more often diagnosed with mood disorders compared to white people despite having the same symptoms.[77] Additionally, African Americans are offered medication or therapy at lower rates than the general population.[78]

This issue impacts elderly people across racial and ethnic backgrounds. Asian American women over sixty-five have the highest suicide rate of all U.S. women aged sixty-five and older.[79] A 2011 study found that older Latinos had higher twelve-month rates of major depressive episodes compared to non-Latino whites.[80] This study also found that there is a prevalence of psychiatric disorders in foreign-born minorities, more so than American-born minorities.[81] For instance, immigrant Asians had more than twice the rate of any current anxiety disorder than their American-born Asian-American counterparts.[82]

The stigmatization of mental health issues is greatly prevalent in these elderly communities of color.[83] Mental Health America conducted a survey and found that sixty-three percent of African Americans believe that depression is a "personal weakness."[84] In the Black

73. Ro, *supra* note 17.
74. Harold W. Neighbors, et al., *Mental Health Service Use Among Older African Americans: The National Survey of American Life*, 16 AM. J. GERIATRICS PSYCHIATRY 948, 949 (June 27, 2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4846982/.
75. *Id.*
76. *Id.*
77. *Black And African American Communities and Mental Health*, MENTAL HEALTH AM., https://www.mhanational.org/issues/black-and-african-american-communities-and-mental-health (last visited Oct. 28, 2021).
78. *Id.*
79. Ro, *supra* note 17.
80. Daniel E. Jimenez et al., *Prevalence of Psychiatric Illnesses Among Ethnic Minority Adults*, 58 J. AM. GERIATRICS SOC'Y 256, 256 (2010).
81. *Id.*
82. *Id.*
83. *See* Daniel E. Jimenez et al., *Stigmatizing Attitudes towards Mental Illness among Racial/Ethnic Older Adults in Primary Care*, 28 INT'L J. GERIATRIC PSYCHIATRY 1061, 1062 (2013) [hereinafter Jimenez, *Stigmatizing Attitudes*].
84. Ro, *supra* note 17.

community, it is often hard to come to terms with psychological difficulties.[85] Even if one acknowledges their struggles, spiritual strategies, like religious coping, pastoral guidance, and prayer, are often the most preferred coping mechanisms.[86] The basis of the study done with Mrs. B and other African American women was the belief that depression was an illness affecting "feminine, middle-class white women," which seems to be a common theme in the elderly Black community.[87] Additionally, in Asian and Latino communities, a study found that in comparison to non-Latino whites, these two groups expressed a greater shame or embarrassment in having a mental illness or alcohol abuse problem.[88] Asian Americans especially felt greater difficulty in engaging in mental health treatment if others were aware, experienced high discomfort in speaking about their mental health issues with their primary care physician, and had a greater difficulty than other groups in seeking mental health treatment in a specialized setting.[89] This is largely due to the cultural norms and attitudes related to family expectations in Asian communities.[90] Mental illness is perceived as a threat to the family unit and thus, having a family member with a mental illness brings disappointment and shame to the family.[91] Similarly, in Latina communities, previous research has shown that older Latinas, much like their Black counterparts, see depression as a sign of weakness, are afraid of disappointing their families, and fear placing an undue burden on them.[92]

There are also systemic barriers that help explain the disparity in the usage of mental health services among these communities.[93] According to the surgeon general, "African American physicians are five times more likely than Caucasian physicians to treat African Americans."[94] Additionally,

> Minority populations are less likely to receive treatment. Studies have shown that people of color are more likely to drop out of

85. Thomas A. Vance, *Addressing Mental Health in the Black Community*, COLUMBIA U. DEP'T PSYCHIATRY (Feb. 8, 2019), https://www.columbiapsychiatry.org/news/addressing-mental-health-black-community.
86. *Id.*
87. Black, *supra* note 1.
88. Jimenez, *Stigmatizing Attitudes*, *supra* note 82, at 1066 tbl.2.
89. *Id.* at 1066.
90. *Id.*
91. *Id.*
92. *Id.*
93. *See* Ro, *supra* note 17.
94. *Id.*

> treatment because they do not feel fully understood or feel that the professionals are being biased. Studies found that heterosexual health care providers preferred heterosexual clients. Despite much advancement of research and programs, there is still a lack of culturally sensitive understanding and training.[95]

These barriers and mistreatment are a significant reason that elderly people of color continue to reject the idea of getting help with their mental health issues.[96] A 2013 study noted that Latinos, in comparison to white and Black Americans, experienced issues with longer duration of appointments, increased number of visits, and higher expenditures.[97] Prior studies have shown that, in comparison to whites, Black people are more likely to believe that antidepressants are addictive and ineffective.[98] Therefore, whites are more likely to have appointments with only medication fills as opposed to Black people, who were more likely to have outpatient visits, which explains their greater expenditures.[99] The study asserted that "available mental health treatments may not match the preferences, values and beliefs of older racial/ethnic minorities which can lead to the decision not to access mental health treatment."[100] This statement explains much of why there is such a problem with access to and usage of mental health services in these elderly communities.

III. Analysis

Mental health is a problem in the United States and even more so among our elderly communities of color.[101] Medicare and Medicaid coverage, nursing home mental health care, legislative action (like Section 8 housing vouchers), and integrated care have each been deployed in some capacity to address this problem.[102] Each of these strategies, however, are ineffective in their own right; whether that is because they

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95. *Id.*
96. *See generally id.*
97. Jimenez, *Disparities*, *supra* note 13, at 22.
98. *Id.*
99. *Id.*
100. *Id.*
101. *See generally id.*
102. *See* Martha Burt et al., *Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices From the Field*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Aug. 19, 2014), https://aspe.hhs.gov/reports/medicaid-permanent-supportive-housing-chronically-homeless-individuals-emerging-practices-field-1 (examining the use of Medicaid to cover services for individuals experiencing chronic homelessness).

are in serious need of reform, they are underused, or there is not enough attention being given to mental health issues in certain facilities.[103]

A. Previous Efforts to Address Mental Health Issues in Elderly Populations

While there has been no national initiative taken to address the mental health of elderly people of color,[104] there have been a few steps taken to assist elderly people of all races with their mental health struggles. For example, Medicare and Medicaid both cover mental health services in their own capacity.[105] Because Medicaid is a federal-state program, federal law sets certain coverage and population requirements and leaves others optional.[106] Each state has the responsibility to make policy and operational decisions in deciding who can enroll, which services to cover, and how to establish payments to providers.[107] Unfortunately, these programs only can help those who are enrolled in them.[108] Medicare creates more issues on this front than Medicaid, because Medicare is essentially a trust system that users pay into yearly, whereas Medicaid has stipulations and income requirements that must be met for a person to qualify.[109]

103. *See* Terry Fulmer et al., *Actualizing Better Health and Health Care for Older Adults*, 40 HEALTH AFFS. 219, 219–25 (2021), https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01470 (identifying ways to improve care and quality of life for older Americans).

104. *See* Thomas McGuire & Jeanne Miranda, *Racial and Ethnic Disparities in Mental Health Care: Evidence and Policy Implications*, 27 HEALTH AFFS. 393–403 (2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3928067/ (discussing the evidence for disparities in mental health care).

105. *Health Insurance and Mental Health Services*, MENTALHEALTH.GOV [hereinafter *Health Insurance and Mental Health Services*], https://www.mentalhealth.gov/get-help/health-insurance (last updated Mar. 18, 2020).

106. *Federal Requirements and State Options: How States Exercise Flexibility under a Medicaid State Plan*, MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N (2018), https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Medicaid-Requirements-and-State-Options-How-States-Exercise-Flexibility-Under-a-State-Plan.pdf.

107. *Id.*

108. Alegria, *supra* note 18, at 53.

109. *See What is the Difference Between Medicare and Medicaid?*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html (last updated Oct. 2, 2015).

1. MEDICARE COVERAGE

Minority Americans account for fourteen percent of the nation's elderly and sixteen percent of the total Medicare population.[110] Additionally, African American and Latina beneficiaries are more likely than their white counterparts to rely on Medicaid to supplement Medicare.[111] Thus, it is crucial to understand what Medicare offers and how it can be improved in terms of mental health, because a large portion of the elderly minority population is affected.[112]

Medicare offers a range of services in terms of mental health. Medicare Part A, which is hospital insurance, covers inpatient mental health care services that you receive in a hospital setting, including room, meals, and nursing care.[113] Part B, which is medical insurance, covers mental health services outside of a hospital, like visits to a psychiatrist, psychologist, and lab tests.[114] Part D, which covers prescription drugs, helps cover prescription medications that may be necessary to treat a mental health condition.[115] Each Part D plan has its own list of covered drugs.[116]

There are limits to Medicare coverage, however. Medicare beneficiaries are limited to 190 days of inpatient psychiatric hospital care in their lifetime, which is a stricter limit than the ninety-day pay per benefit period on general medical hospitalizations.[117] Inpatient psychiatric hospitals specialize in treating mental illnesses; this provision makes it even more difficult to have that specific type of care covered.[118] Additionally, no other Medicare inpatient specialty service has this type of

110. *Medicare and Minority Americans*, KAISER FAM. FOUND. [hereinafter *Medicare and Minority Americans*], https://www.kff.org/wp-content/uploads/2013/01/medicare-and-minority-americans-fact-sheet.pdf (last visited Oct. 28, 2021).

111. *Id.*

112. *See generally id.*

113. *Health Insurance and Mental Health Services*, *supra* note 105.

114. *Id.*

115. *Id.*

116. *Id.*

117. Beth McGinty, *Medicare's Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement*, THE COMMONWEALTH FUND (July 9, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities.

118. *The Issue: Medicare 190-Day Lifetime Limit*, NAT'L ALL. ON MENTAL ILLNESS [hereinafter *The Issue: Medicare 190-Day Lifetime Limit*], https://www.nami.org/Advocacy/Policy-Priorities/Improve-Care/Medicare-190-Day-Limit (last visited Oct. 28, 2021).

cap on benefits.[119] This is a problem for those with chronic mental illnesses, as that lifetime 190-day limit will likely be exceeded quickly.[120] This is also an issue for people who do not qualify for dual eligibility through Medicaid,[121] which means that a person qualifies for and is enrolled in both Medicare and Medicaid.[122] To qualify for Medicare, applicants must be sixty-five or older and must be U.S. citizens or legal residents for at least five years.[123] Medicaid, as stated, is a state and federal program.[124] The parameters of the program are set federally, but each state sets their own rules within the guidelines.[125] There are income and asset limits, which also vary by state.[126] Not having dual eligibility creates issues because Medicaid programs supplement inpatient services for dual-eligible beneficiaries who have exceeded the 190-day limit under Medicare.[127] Medicare Advantage beneficiaries also often lack access to in-network mental health care providers and are forced to go out of network for their care at a much higher cost.[128] Medicare also does not reimburse licensed professional counselors and it also requires that clinical psychologists be supervised by a psychiatrist to be able to reimburse in outpatient facilities, partial hospitalization programs, and any other setting besides a psychologist's own office.[129] Also, there is a lack of coverage for serious mental illness, like psychiatric rehabilitation, peer support services, or assertive community treatment, which is specialized care delivered by an integrated care team.[130] Many of these services are covered through Medicaid for those who are dually eligible,[131] but often, that is not the case.

While there have been reforms made regarding mental health coverage, it is clear that more still needs to be done. These gaps in

119. *190-Day Lifetime Limit*, NAT'L ASSOC. FOR BEHAVIORAL HEALTHCARE, https://www.nabh.org/policy-issues/medicare/190-day-lifetime-limit/ (last visited Oct. 28, 2021).

120. *Id.*

121. McGinty, *supra* note 117.

122. *Dual Eligibility for Medicare and Medicaid: Requirements & Benefits for Long Term Care*, AM. COUNCIL AGING, https://www.medicaidplanningassistance.org/dual-eligibility-medicare-medicaid/ (Jan. 28, 2021).

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.*

127. McGinty, *supra* note 117.

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.*

coverage can affect all ages, but especially impact elderly minorities and their likelihood to seek out help if services are not covered by their plan.[132]

2. MEDICAID COVERAGE

Medicaid coverage varies from state to state, as it is income based.[133] By way of example, Illinois's coverage of mental health may be different than other states' coverage.[134] As of March 2021, 2.978 million Illinois residents were enrolled in Medicaid.[135] The most recent data from 2015 has indicated that there were 214,022 elderly people enrolled and 1,607,015 of the total number enrolled were minorities.[136] This number surely has grown, as in 2014, Illinois adopted and implemented expanded Medicaid coverage to cover additional uninsured low-income adults.[137] In the vein of mental health, Illinois requested a waiver in 2016 to use existing Medicaid funds to test different approaches to treating Medicaid enrollees who required mental health and/or substance abuse treatment.[138] Under the terms of the waiver, Illinois is running ten pilot projects that provide coverage for services not previously covered by Medicaid, like job coaching, short-term inpatient substance abuse treatment, and others.[139]

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132. *Id.*

133. *See Policy Basics: Introduction to Medicaid*, CTR. ON BUDGET & POL'Y PRIORITIES, https://www.cbpp.org/research/health/introduction-to-medicaid (last updated Apr. 14, 2020) (explaining that "each state operates its own Medicaid program within federal guidelines").

134. *See Mental Health and Substance Use Disorder Parity*, ILL. DEP'T OF INS., https://www2.illinois.gov/sites/GetCovered/Resources/pages/Mental-health-parity.aspx (last visited Oct. 28, 2021).

135. *March 2021 Medicaid & CHIP Enrollment Data Highlights*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last visited Oct. 28, 2021).

136. Rachel West & Katherine Gallagher Robins, *Who Receives Medicaid? A State-by-State Breakdown*, CTR. FOR AM. PROGRESS (July 20, 2017, 9:00 AM), https://www.americanprogress.org/issues/poverty/news/2017/07/20/436243/receives-medicaid-state-state-breakdown/.

137. *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Nov. 5, 2021) [hereinafter *Status of State Medicaid Expansion Decisions: Interactive Map*], https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

138. Louise Norris, *Illinois and the ACA's Medicaid expansion*, HEALTH INSURANCE.ORG (Sept. 12, 2020), https://www.healthinsurance.org/medicaid/illinois/.

139. *Id.*

As of November 2021, there are still twelve states that have not expanded Medicaid to cover health care for people with limited access to employer coverage and limited access to purchase their own.[140] Medicaid expansion has led to more people with serious mental illness utilizing mental health services and fewer people delaying or skipping necessary care.[141] A study published in the American Journal of Public Health found that in twenty-eight of the states that have expanded Medicaid, the prevalence of receiving mental health treatment among Medicaid-only enrollees with serious mental illnesses was 30.1% greater than their uninsured counterparts.[142] This is because Medicaid expansion removes barriers for people with mental illnesses by allowing them to qualify for care based on income and not on disability determination.[143]

Medicaid is less likely to be used by elderly minority adults because it was specifically designed for those under the federal poverty level to assist low-income families.[144] This does not mean that an elderly person of color cannot be eligible, but statistics show that more elderly minorities are enrolled in Medicare programs.[145]

3. NURSING HOME ASSISTANCE

A large population of elderly African Americans and Latino individuals live in nursing homes and assisted living facilities.[146] According to a study in the American Journal of Public Health, higher amounts of African American elders live in nursing homes compared to those in residential care and assisted living centers ("RC/AL centers").[147] This is because most nursing home facility revenues nationally come from

140. *Status of State Medicaid Expansion Decisions: Interactive Map*, *supra* note 137.

141. *Medicaid Expansion*, NAT'L ALL. ON MENTAL ILLNESS [hereinafter *Medicaid Expansion*], https://www.nami.org/Advocacy/Policy-Priorities/Improve-Care/Medicaid-Expansion (last visited Oct. 28, 2021).

142. Beth Han et al., *Medicaid Expansion Under the Affordable Care Act: Potential Changes in Receipt of Mental Health Treatment Among Low-Income Nonelderly Adults with Serious Mental Illness*, AM. J. PUB. HEALTH (Sept. 10, 2015), https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302521?journalCode=ajph.

143. *Id.*

144. MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, June 2015 Report to Congress on Medicaid and CHIP 106–07 (2015), https://www.macpac.gov/wp-content/uploads/2015/06/June-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

145. *See Medicare and Minority Americans*, *supra* note 109.

146. *See* Daniel L. Howard et al., *Distribution of African Americans in Residential Care/Assisted Living and Nursing Homes: More Evidence of Racial Disparity?*, 92 AM. J. PUB. HEALTH 1272, 1272–75 (2002).

147. *Id.* at 1274.

Medicaid and nursing homes' reliance on Medicaid reimbursement ensures access for poor elderly African Americans.[148] RC/AL centers are financed much differently and there are variations in the way services are funded across facility types.[149] In terms of other elderly minority groups, between 1999 and 2008, the number of elderly Latinas and Asians in nursing homes grew by 54.9% and 54.1%, while the number of elderly Black residents increased by 10.8%.[150]

Thus, these numbers bring us to consider: what is being done for the elderly in terms of mental health care, especially in nursing homes where there is a high prevalence of minority groups? Unfortunately, not much. The prevalence of depression in nursing home residents is three to five times higher than in older adults from the same community.[151] According to a study published in the Arizona Geriatric Society Journal, there is a clear need for reform in nursing homes in regard to evaluating and diagnosing symptoms of depression and other mental health issues.[152] When residents are admitted to nursing homes, they are evaluated using the Minimum Data Set ("MDS") assessment. The MDS assessment is a federally mandated, comprehensive assessment instrument that is completed within fourteen days of arrival, quarterly, and also, if there are any changes in the condition of the resident—for example: making negative statements, anger, irritability, repetitive anxious complaints, and crying or tearfulness, to name a few.[153] The study found the MDS assessment to be quite unreliable, however, as eight of twenty depressed intervention residents in the study did not have a treatment plan to address depression, demonstrating that nursing home staff failed to detect depressive symptoms.[154] The study suggested a quality improvement initiative focused on training nursing assistants to identify and report targeted observations to nurses and nurses who used validated assessment measures for depression could make a great difference in detection and treatment of this issue.[155]

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148. *Id.* at 1276.
149. *Id.*
150. Zhanlian Feng et al., *Growth of Racial and Ethnic Minorities in US Nursing Homes Driven by Demographics and Possible Disparities in Options*, 30 HEALTH AFFS. 1358, 1358 (2011).
151. Neval L. Crogan & Bronwynne C. Evans, *Quality Improvement in Nursing Homes: Identifying Depressed Residents Is Critical to Improving Quality of Life*, 13 ARIZ. GERIATRICS SOC'Y J. 1, 1 (May 2008).
152. *Id.* at 6.
153. *Id.* at 1.
154. *Id.* at 5.
155. *Id.*

That study was conducted in 2008 and not much improvement has occurred since.[156] In a 2019 nationwide study, it was reported that one-third of nursing home facilities admitted that they were unable to completely meet their residents' behavioral needs.[157] The study found that providing basic behavioral health services was rated "difficult" or "very difficult" at 20–40% of all nursing home facilities nationwide.[158] It also was reported that little has changed since the implementation of the Nursing Home Reform Act in 1987, a regulatory overhaul that included provisions to bring better behavioral healthcare to nursing homes.[159] The 2019 researchers reported that surveys conducted in the last thirty years have shown meager improvements at best.[160]

In all likelihood, elderly people of color who are in nursing homes are not getting the adequate behavioral health treatment they need or worse, are not even aware that they have depression, anxiety, or the like.[161] Improvements need to be made to offering behavioral health resources in nursing homes, which will be discussed in Part IV.[162]

4. LEGISLATIVE ACTION

While legislative action may not assist directly in helping elderly POC get access to treatment options, it could help to lessen the load of stressors on these communities, indirectly helping with mental health issues.[163] Alegria et al. analyzed three different public policies—Section 8 housing vouchers, the Earned Income Tax Credit, and the Individuals with Disability Education Act—found that even though none of these three policies were not originally designed to ameliorate mental health status inequalities, there is evidence that people of color benefited from these policies, as they are overrepresented in the populations these policies affect.[166] These policies are specifically designed for people with low socioeconomic status, which has a causal relationship with

156. *See* Alex Spanko, *Even as Demand Rises, Nursing Homes Face Major Behavioral Health Hurdles*, SKILLED NURSING NEWS (June 10, 2019), https://skillednursingnews.com/2019/06/despite-demand-nursing-homes-face-major-behavioral-health-hurdles/.

157. *Id.*

158. *Id.*

159. *Id.*

160. *Id.*

161. *See generally id.*

162. *See id.*

163. *See* Alegria, *supra* note 18.

166. *Id.*

psychiatric disorders and mental health issues.[167] People of color are more likely to have lower household incomes tan whites; the most likely minority being African Americans, with 'Latinos having only slightly more wealth than African Americans and Asian American/Pacific Islanders being slightly above both the other two demographic groups.[168] There is a racial wealth disparity at all ages, even in elderly people of color.[169] According to the National Community Reinvestment Coalition, white families accumulate more wealth over their lives than Black or Latino families and are thus, more prepared for retirement.[170] Statistically, eighty-three percent of African American senior households and ninety percent of Latina households are predicted to have insufficient funds to live out their years after retirement, compared to only fifty-three percent of whites.[171] Having less money to live out one's elderly days has a direct effect on poverty levels and the way a person is living, because as people get older, they have an obvious lessened ability to earn income.[172] This can contribute to a plethora of stresses, which can culminate in mental health issues.[173] While the analysis of public housing policies in Alegria et al.'s article was not focused on an elderly population specifically, it may be helpful when trying to figure out how to, not only alleviate elderly people of color of their mental health issues, but also, create a tangible solution to a serious problem.[174] As Alegria et al. stated in their paper, "if social conditions affect health and mental health, public policies that improve those conditions for minorities should improve their mental health as well."[175]

When analyzing these social policies, Alegria et al. stated that two conditions had to be satisfied to determine if social policy could be

167. *Id.* at 53–54.

168. Angela Hanks et al., *Systematic Equality: How America's Structural Racism Helped Create the Black-White Wage Gap*, CTR. FOR AM. PROGRESS (Feb. 21, 2018, 9:03 AM), https://www.americanprogress.org/issues/race/reports/2018/02/21/447051/systematic-inequality/.

169. *See* Neil Bhutta et al., *Disparities in Wealth by Race and Ethnicity in the 2019 Survey of Consumer Finances*, BD. GOVERNORS FED. RSRV. SYS. (Sept. 28, 2020), https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-and-ethnicity-in-the-2019-survey-of-consumer-finances-20200928.htm.

170. Sabrina Terry, *Poor Old People: The Graying of Racial and Gender Wealth Inequality*, NAT'L CMTY REINVESTMENT COAL. (Nov. 20, 2019), https://ncrc.org/poor-old-people-the-graying-of-racial-and-gender-wealth-inequality/.

171. *Id.*

172. *See id.*

173. *See* Alegria, *supra* note 18, at 54.

174. *See id.* at 5657.

175. *Id.* at 55.

defined as effective in reducing mental health disparities.[176] First, "the policies must be effective in changing social conditions," and second, "the policies must work the same or better for minorities than they do whites."[177] The authors used these factors to analyze the effectiveness of Section 8 housing vouchers and the relationship between the usage of these vouchers and mental health issues (in populations of various ages, not just elderly).[178] Since, according to the article, there is strong evidence of the association of neighborhood characteristics and incidence of cognitive disease, housing policies can play a huge part in affecting the context of poor minorities and disparities in mental health.[179] The federal government has intervened in creating subsidized housing for low-income families, the elderly, and the disabled through Section 8 vouchers, which then, are administered locally.[180] Low-income individuals can apply to their public housing authority ("PHA") for vouchers that cover all but thirty percent of their rent in the private market.[181] A U.S. Housing and Urban Development ("HUD") demonstration project examined the outcomes from moving residents from high- to low-poverty areas in a program called: Moving to Opportunity ("MTO").[182] The experimental group members who received vouchers to be used in an area with less than ten percent of residents living under the federal poverty level reported improved mental health and less anxiety in contrast to the control group.[183] Thus, as Alegria et al. stated, the impact of a relocation policy on mental health disparities among people of color is seemingly promising, as there is about a one percent difference in the percentage of non-white Hispanics to the percent of people of color who are able to lease a unit through Section 8 vouchers.[184]

Another study that discussed the MTO program found that adults who moved into the higher income areas with Section 8 housing vouchers experienced long term mental health benefits as well as physical

176. *Id.* at 54.
177. *Id.*
178. *Id.* at 5657.
179. *Id.* at 56.
180. *Housing Choice Vouchers Fact Sheet*, U.S. DEP'T HOUS. & URB. DEV., https://www.hud.gov/topics/housing_choice_voucher_program_section_8# (last visited Oct. 28, 2021).
181. *See* Alegria, *supra* note 18, at 56.
182. *Id.*
183. *Id.*
184. *Id.* at 57.

health benefits, like reductions in obesity and diabetes.[185] There are various environmental factors associated within homes that are correlated with poor physical health, which in turn affect mental health.[186] Substandard housing conditions such as water leaks, poor ventilation, dirty carpets, and pest infestation have been correlated to poor health outcomes, and greatly affect those with asthma.[187] Additionally, in the context of the elderly, exposure to high or low temperatures is correlated with cardiovascular issues in older populations.[188] Overcrowding in housing also has been linked to physical illness and psychological distress.[189] With all this in mind, it is crucial to make affordable and safe housing available to elderly POC to help their physical and mental health.[190]

While housing measures may not give direct care to elderly, they do increase morale, help the elderly feel more confident about their lifestyle, and be proud of their homes, which eradicates some relatively common stressors.[191] Although these programs are promising, they have issues and necessary improvements, which will be discussed in Part IV.

5. INTEGRATED CARE

While prior sections have discussed steps that have been taken to assist elderly people in their mental health struggles, one avenue that has been consistently explored, but not widely applied, is the idea of "integrated care," more specifically, the "collaborative care model."[192] Integrated care is defined as a broad service of health interventions that are intended to blend primary care services as well as mental health services.[193]

185. Lauren Taylor, *Housing and Health: An Overview of the Literature*, HEALTH AFFS. (June 7, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/.
186. *See id.*
187. *Id.*
188. *Id.*
189. *Id.*
190. *Id.*
191. *See* Alegria, *supra* note 18, at 55.
192. *Dissemination of Integrated Care Within Adult Primary Care Settings: The Collaborative Care Model*, AM. PSYCHIATRY ASS'N (2016) [hereinafter *Dissemination of Integrated Care*], available at: https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn.
193. *Id.*

The collaborative care model was designed to improve access to mental health treatments for primary care patients.[194] The collaborative care model is different from other integrated care services because of "the replicated evidence supporting its outcomes, its steady reliance on principles of chronic care delivery, and attention to accountability and quality improvement."[195] The four main elements of collaborative care models are: "1) team driven, 2) population focused, 3) measurement-guided, and 4) evidence based."[196] What makes this model different is that it prioritizes these four elements to create more well-rounded care and gives people mental health services within a primary care setting.[197] To elaborate, the "team driven" element means it is led by a primary care physician with support from a care manager and a psychiatrist who gives consultations on treatments plans if the patient is not achieving clinical goals.[198] The "population focused" element means there is a registry to monitor response to care and treatment engagement.[199] "Measurement guided" means that the model uses consistent dedication to patient-reported outcomes, and "evidence based" means using evidence to achieve said outcomes.[200] The model is also patient-centered, which means it works to engage, coordinate services, and promote self-management/adherence to treatment.[201]

Studies have shown that integrating care using the collaborative care model has helped patients get access to mental health care, as well as normalizing the experience of seeking behavioral health services.[202] Dr. Livesey, an architect of the Penn Integrated Care, stated that screening for mental health increases the comfort level. "The framing and the language and the context increase the likelihood that a patient will be open for some of these interventions."[203] That "framing" includes

194. *Id.*
195. *Learn About the Collaborative Care Model*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn (last visited Oct. 28, 2021).
196. *Dissemination of Integrated Care, supra* note 190.
197. *Id.*
198. *Id.*
199. *Id.*
200. *Id.*
201. *Id.*
202. *Collaborative care model for mental health, addiction treatment*, AM. MED. ASS'N (Dec. 30, 2020) [*hereinafter Collaborative Care Model*], https://www.ama-assn.org/delivering-care/public-health/collaborative-care-model-mental-health-addiction-treatment.
203. *Id.*

simply asking about mental health in a primary care context when a person goes to get a yearly checkup.[204] This type of framing has been helpful; the integrated care program at Penn Medicine currently has a close to fifty percent depression and anxiety remission rate.[205] The collaborative care model could be extremely helpful in the context of elderly people of color because lessening the stigma around mental health issues/services is paramount.[206] By combining the primary care setting with a screening for mental health every time a person goes in, it normalizes mental health screenings and makes it part of the collaborative healthcare process.[207] According to the Penn Integrated Care program, the referral process happens quite seamlessly, as the "primary care physician in the Penn Medicine program can easily connect patients to the 'front door' of care, where follow up is optimized for his or her clinical condition, geographic location, insurance status, and availability of psychiatrists and other providers."[208]

The Penn Integrated Care Program found a close to a fifty percent depression and anxiety remission rate, meaning participants did not have clinical symptoms of depression and anxiety as measured by evidence-based self-reported assessments.[209] Additionally, in the Penn Program, the collaborative care is no longer financially dependent on grants and now has a way to financially support itself through new current procedural technology ("CPT") codes.[210] These CPT codes "allow for reimbursement for a set of indirect supervision through their primary care provider through medical insurance."[211] The target audience of these codes are actually Medicare-Fee-For-Service Program Providers and as of January 2017, Medicare makes separate payments to physician and non-physician practitioners for behavioral health services they give to beneficiaries.[212] Thus, there seems to be a plan in place to give coverage to those who are on Medicare.[213]

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204. *Id.*
205. *Id.*
206. *Addressing the Stigmas of Ageism*, *supra* note 65.
207. *Collaborative Care Model*, *supra* note 201.
208. *Id.*
209. *Id.*
210. *Id.*
211. *Id.*
212. *Behavioral Health Integration Services*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 2019), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf.
213. *See generally id.*

There does not seem to be much research, however, on how collaborative care can help elderly people of color, let alone people of color generally.[214] There has been research on the integration of collaborative care in veteran communities,[215] but according to a Journal of the Society for Social Work and Research study, there has been limited research on populations of color participating in studies on the efficiency of integrated care.[216] The data reported in a few of the randomized control trials ("RCTs") this study examined, found that integrated care can improve health outcomes and care over usual-care strategies.[217] Five out of seven studies identified better outcomes with integrated care, yet, there was no evidence of benefit for those with serious mental illnesses because no studies were identified in that area.[218] Because there are so few RCTs on the effectiveness of integration in improving healthcare outcomes for people of color, the benefit remains unclear.[219] Thus, there needs to be more research done in this area,[220] which will be discussed further in Part IV.

IV. Recommendation

A. Necessary Improvements to Existing Initiatives

1. EXPAND MEDICAID IN ALL FIFTY STATES

Expanding Medicaid would allow access to mental health services in some states where people may not currently qualify for Medicaid.[221] Currently, thirty-nine states (including D.C.) have expanded Medicaid since the Supreme Court decided in *NFIB v. Sebelius* that a state's

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214. Linda Sprague Martinez et al., *Behavioral Health, Primary Care Integration, and Social Work's Role in Improving Health Outcomes in Communities of Color: A Systematic Review*, 10 J. SOC'Y FOR SOC. WORK & RSCH. 441, 452 (2019).

215. *See generally* Mark S. Bauer et al., *Effectiveness of Implementing a Collaborative Chronic Care Model for Clinician Teams on Patient Outcomes and Health Status in Mental Health*, 2 JAMA NETWORK OPEN 1 (2019).

216. Martinez et al., *supra* note 213.

217. *Id.*

218. *Id.*

219. *Id.*

220. *See id.*

221. *The Issue: Medicaid Expansion*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/Advocacy/Policy-Priorities/Improve-Care/Medicaid-Expansion (last visited Oct. 28, 2021).

decision to expand Medicaid was optional, not mandatory.[222] Even though Medicaid expansion is optional, states should feel compelled and should expand Medicaid to give more people access to mental health services.[223] According to the National Alliance on Mental Illness ("NAMI"), Medicaid is the lifeline for many people with mental illnesses, as it is the largest payer of mental health and substance abuse services.[224] One in four adults with serious mental illnesses have Medicaid coverage.[225] By allowing people to qualify for coverage based on income and not based on disability, Medicaid expansion would remove barriers to access for many people with mental illnesses and allow them to get the care they need.[226] Also according to NAMI, in the thirty-nine states that already have expanded Medicaid, people are less likely to skip out on medications due to their cost, more likely to seek regular care for their ongoing health conditions, and report that their overall health has improved.[227] Additionally, adults covered by Medicaid expansion are more likely to receive substance abuse treatment in conjunction with mental health treatments.[228] Medicaid is the primary payer for essential long-term services and supports and it fills other gaps in Medicare benefits.[229]

If state governments are worried about the downsides to expanding Medicaid, studies have shown that there are few, if any.[230] According to a Health Affairs study, Medicaid expansion was associated with increases in quality of care, coverage, service use, and Medicaid spending.[231] Notably, expansion also was associated with increased insurance coverage among all eligible individuals, including major racial/ethnic and age groups.[232] Additionally, there were reductions in self-reported

222. *Id.*; *see also Status of State Medicaid Expansion Decisions: Interactive Map*, *supra* note 137.
223. *Id.*
224. *Id.*
225. *Id.*
226. *Id.*
227. *Id.*
228. *Id.*
229. *Medicaid Works for Seniors*, CTR. ON BUDGET & POL'Y PRIORITIES (Jan. 19, 2018), https://www.cbpp.org/research/health/medicaid-works-for-seniors.
230. Allison Inserro, *Medicaid Expansion Under ACA Found to Have More Positive Than Negative Effects*, AM. J. MED. CARE (June 4, 2018), https://www.ajmc.com/view/medicaid-expansion-under-aca-found-to-have-more-positive-than-negative-effects.
231. *Id.*
232. *Id.*

rates of poor mental health and psychological distress.[233] These findings are among the many reasons why it is crucial for Medicaid to be expanded to all fifty states. Doing so will ensure that elderly POC (among many others) can get the treatment and mental health care they need.

2. MEDICARE REFORM

Since Medicare is also a provider for the health care of many elderly POC, its reforms need to be addressed as well to help POC get the mental health services they need.[234] The absolute first step in reforming Medicare, in terms of mental health services, is getting rid of the 190-day lifetime limit of inpatient psychiatric hospital care.[235] This is an absolute lifetime limit and NAMI has stated that it is a way to discriminate against people with mental illness.[236] If a person has a serious mental illness, as mentioned previously in the beginning of Part III, they will likely go over this 190-day limit and will suffer from the cessation of coverage before they recover.[237] If a Medicare recipient has various mental illnesses, they are going to need long term care for many years; much more than the 190-day limit allows.[238] Thus, to further the usage and accessibility to mental health treatments, there needs to be a way to expand this limit or get rid of the limit altogether.[239] There has been legislative action in this regard. In June 2020, Representative Paul Tonko introduced the Medicare Mental Health Inpatient Equity Act of 2019 in the House of Representatives.[240] The bill aimed to reform the Social Security Act and remove the 190-day limit on inpatient psychiatric hospital services under Medicare.[241] Senator Susan Collins also introduced a companion bill in the Senate; however, both bills died without receiving a vote.[242] This Note urges legislators to take the effort to

233. *Id.*

234. *Medicaid Expansion Has Helped Narrow Racial Disparities in Health Coverage and Access to Care*, CTR. ON BUDGET & POL'Y PRIORITIES (Oct. 21, 2020), https://www.cbpp.org/research/health/medicaid-expansion-has-helped-narrow-racial-disparities-in-health-coverage-and.

235. *The Issue: Medicare 190-Day Lifetime Limit*, *supra* note 117.

236. *Id.*

237. *Id.*

238. *Id.*

239. *See id.*

240. Medicare Mental Health Inpatient Equality Act of 2019, H.R. 7323, 116th Cong. (2020), available at: https://www.congress.gov/bill/116th-congress/house-bill/7323?s=1&r=8.

241. *Id.*

242. *Id.*; Medicare Mental Health Inpatient Equality Act of 2020, S. 3864, 116th Cong. (2020), available at: https://www.govtrack.us/congress/bills/116/s3864.

remove the 190-day limit seriously, by reintroducing this bill in the current session of Congress or appending it onto an omnibus bill.[243] Legislative action is the most effective way to reform Medicare and this step is necessary not just for elderly people of color, but for all people covered by Medicare to receive sufficient mental health care.

Additionally, as discussed in Part III, Medicare struggles in their support of psychiatrists and psychological treatment and there is a lack of coverage for serious mental illnesses.[244] Unfortunately, this problem is not going to get any better. According to the American Psychological Association ("APA"), the Centers for Medicare and Medicaid Services ("CMS"), in their 2021 Medicare Physician Fee Schedule Final Rule on December 1, 2020, included a 10.2% cut in the conversion factor used to calculate provider payments.[245] The deep cut was made necessary after CMS approved payment increases for the revised office/outpatient evaluation and management services.[246] This cut directly affects psychologists and a wide array of other health care professionals.[247] The APA partnered with a coalition of healthcare providers asking Congress to work with CMS to find a solution that would allow for the higher values of outpatient evaluation and management services without cutting payments to other providers;[248] which did not succeed.[249] This cut makes getting behavioral health treatment even more difficult and may cause Medicare beneficiaries to go out of network, as many psychologists are not likely to take Medicare beneficiaries if their reimbursement has been so drastically reduced.[250] Additionally, a reduced access to psychologists caused by low reimbursement rates by Medicare has contributed towards a dangerous trend of use of psychotropic medications.[251] The link between the usage of psychotropic medications

243. *Id.*
244. *See* McGinty, *supra* note 117.
245. *CMS Adopts deep Medicare fee schedule cuts for 2021*, AM. PSYCH. ASS'N (Dec. 4, 2020), https://www.apaservices.org/practice/clinic/medicare-fee-schedule.
246. *Id.*
247. *Id.*
248. APA Office of Healthcare Financing, *Medicare Proposals for 2021: Psychologists' payments impacted*, AM. PSYCH. ASS'N (Aug. 14, 2020), https://www.apaservices.org/practice/reimbursement/government/medicare-proposals-2021.
249. *See* Holding Providers Harmless from Medicare Cuts during COVID-19 Act of 2020, H.R. 8702, 116 Cong., (2020), available at: https://www.govtrack.us/congress/bills/116/hr8702.
250. *See generally id.*
251. *Medicare's Shrinking Psychologist Reimbursement Rates*, AM. PSYCH. ASS'N (Mar. 2015) [hereinafter *Medicare's Shrinking Psychologist Reimbursement Rates*],

and inadequate access to psychologists (furthered by low Medicare reimbursement) is demonstrated by the statistic that four out of five antidepressant prescriptions are written by physicians who are not psychiatrists.[252] These drugs are dangerous and can have significant health risks, including death.[253] By slashing payments to psychologists, an uptick in the dangerous use of psychotropic medications will likely follow.[254] This clearly will continue to have a detrimental effect on Medicare beneficiaries.[255] The best solution is to lobby Congress to suspend budget neutrality in Medicare.[256] Because Medicare is budget neutral, that means that when much-needed support is provided in some other parts of the federal healthcare system, it must be offset by cuts to other vital services.[257] This budget neutrality law is imposing a crisis when there does not need to be one.[258] This is detrimental to those needing psychological services because it will continue to drive psychologists out of the Medicare program, leaving Medicare beneficiaries with more out of pocket costs and the possibility of going out of network for mental health care.[259] This Note has shown that access to mental health care is an issue in elderly POC communities and cutting payments to psychologists drives another wedge into access to care. The APA should continue lobbying Congress to suspend budget neutrality around Medicare so no more payment cuts have to be made, especially to psychologists.

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https://www.apaservices.org/practice/advocacy/state/leadership/medicare-payment.

252. *Id.*

253. *Id.; see also* Duff Wilson, *Side Effects May Include Lawsuits*, N.Y. TIMES (Oct. 2, 2010), https://www.nytimes.com/2010/10/03/business/03psych.html (explaining the harmfulness of antipsychotic drugs and how their usage has been the center of much litigation across the United States).

254. *See generally Medicare's Shrinking Psychologist Reimbursement Rates*, *supra* note 250.

255. *See generally id.*

256. Eva Chalas, *To Protect America's health infrastructure, eliminate budget neutrality*, THE HILL (Sept. 25, 2020), https://thehill.com/opinion/healthcare/518171-to-protect-americas-health-infrastructure-eliminate-budget-neutrality.

257. *Id.*

258. *Id.*

259. *Safeguard Psychologists' Services from Harmful Medicare Reimbursement Cuts*, AM. PSYCH. ASSOC., https://www.nvpsychology.org/assets/docs/Safeguard%20Psychologists%E2%80%99%20Services%20From%20Harmful%20Medicare%20Reimbursement%20Cuts.pdf (last visited Oct. 28, 2021).

3. REFORMS TO SECTION 8 HOUSING VOUCHERS

While Section 8 seems like it would be a good avenue for helping low-income elderly people of color, reforms are necessary to make this program work for this demographic and to help lessen the load of housing stressors.[260] According to a 2020 article, housing vouchers are supposedly better than government housing projects, but federal regulations have limited their effectiveness.[261] The article states that Section 8 is supposed to give people consumer choice, remove the government as a middleman, incentivize landlords to provide good housing to voucher recipients, and prevent the ghettoization of the poor.[262] Section 8 vouchers, however, have failed to achieve those goals.[263] An Urban Institute study actually found that landlords in a U.S. city were rejecting those with Section 8 vouchers at a seventy-eight percent rate.[264] Many landlords are not accepting the vouchers and pushing the applicants back to poor housing or no housing at all.[265] The administration of Section 8 vouchers also proves to be a barrier to the success of this program.[266] That administration requires excessive paperwork, longer leases, and oversight from PHAs.[267] Essentially, landlords spend time and money navigating the Section 8 housing voucher system with little success and tenants do not know who will and will not accept vouchers, so they give up on searching.[268]

These issues clearly need to be fixed for this program to have a positive effect on the mental health of elderly POC. One solution is to allow PHAs to experiment with the money they are given for the vouchers and to craft tenant-landlord protocols.[269] Alternatively, it could help to eliminate the PHAs from the equation all together and give vouchers straight to tenants.[270] The vouchers would be calculated on recipient income level and local cost of living.[271] Thus, this would allow tenants to shop the market, without added regulations put on the

260. Scott Beyer, *It's Time to Reform Section 8*, CATALYST (Mar. 19, 2020), https://catalyst.independent.org/2020/03/19/its-time-to-reform-section-8/.
261. *Id.*
262. *Id.*
263. *Id.*
264. *Id.*
265. *Id.*
266. *Id.*
267. *Id.*
268. *Id.*
269. *Id.*
270. *Id.*
271. *Id.*

landlords that they choose.[272] If they do not like the place they are living, when the lease is done, he or she can take the voucher money and move elsewhere.[273] Allowing people to select their own housing as opposed to doing it through a PHA could bring increased confidence and happiness to an elderly person, as they are able to make their own decisions and take matters into their own hands. It seems to be that the PHA's cause more trouble and push people to stop looking for housing because it is just too difficult; adding on yet another stressor to a stressful situation.

Eliminating PHAs as the middleman could be a viable option, but there are even bigger reform ideas out there.[274] The Poverty & Race Research Counsel's 2020 policy brief detailed various reforms that were introduced by the Obama Administration, but were never enacted.[275] Some of these include addressing the insufficient supply of vouchers to meet an overwhelming demand, addressing widespread discrimination against families with vouchers (and overcoming landlords reluctance to participate), expand voucher search times, reforming Section 8 administrative fees, reforming landlord listings and tenant information systems that steer families into poor, segregated neighborhoods, and improving the PHA accountability system.[276] Because elderly people of color are more likely to have less money going into retirement than their white counterparts,[277] making the housing search a possible struggle and stressor for them, allowing for more vouchers, expanding voucher search times, and reforming landlord listings[278] all could assist elderly people of color in finding safe and sufficient housing that not only assists in their physical health, but their mental health as well.

Another potential, albeit less likely, avenue for reform could be to encourage President Joe Biden to actually pursue the universal housing voucher program he called for as a presidential candidate in the wake of the COVID-19 crisis.[279] There have not been many political efforts focused on this, but a universal housing voucher program could

272. *Id.*
273. *Id.*
274. Philip Tegeler, *Housing Choice Voucher Reform: A Primer for 2021 and Beyond*, POVERTY & RACE RSCH. ACTION COUNCIL (Aug. 2020), https://www.prrac.org/pdf/housing-choice-voucher-reform-agenda.pdf.
275. *Id.*
276. *Id.*
277. *See* Terry, *supra* note 170.
278. Tegeler, *supra* note 274.
279. *Id.*

"change the face of poverty in this country. Evictions would plummet and become rare occurrences."[280] Section 8 has been shown to reduce overcrowding by fifty percent, homelessness by seventy-five percent, and repeated moves within five years by one-third.[281] The Center on Budget and Policy Priorities states that providing vouchers to all eligible households would lift over one million people aged sixty-two and over above the federal poverty level, cutting this age group's poverty rate by twelve percent.[282] "[V]ouchers may be particularly important for older people of color, who often face even more limited housing choices due to a long history of discriminatory policies that created and reinforce the racial segregation of people, particularly Black families, with low income."[283] It seems as though that the government is going to attempt smaller-scale Section 8 reforms before moving to larger reform options; as a universal housing voucher would be a significant undertaking. That being said, keep in mind that having a universal voucher program would likely fix many of the problems that Section 8 poses.[284]

In the context of elderly POC, reforms that would likely help these communities gain access to better housing and vouchers themselves would address the insufficient supply of vouchers, address widespread discrimination and landlords' reluctance to participate, reform landlord listings and tenant information systems, and improve the PHA accountability system.[285] Philip Tegeler's Policy Brief on Housing Choice Voucher Reform addresses the insufficient supply of vouchers in terms of families and the 2019 initiative to create 500,000 more and put families on the top of the priority list.[286] If there could be an initiative like this in the coming years for the elderly, that could be groundbreaking.

How can our legislatures reform the housing choice voucher program to accommodate the elderly? It seems that much of recent research has been focused on families.[287] According to the Center on

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280. *Id.*
281. Jacquelyn Simone, *It's Time to Make Housing Vouchers Universal*, COAL. FOR HOMELESS (June 28, 2021), https://www.coalitionforthehomeless.org/universal-housing-vouchers/.
282. *More Housing Vouchers Needed to Help Older Adults Afford Stable Homes in the Community*, CTR. ON BUDGET & POL'Y PRIORITIES (Aug. 5, 2021), https://www.cbpp.org/research/housing/more-housing-vouchers-needed-to-help-older-adults-afford-stable-homes-in-the.
283. *Id.*
284. Tegeler, *supra* note 274.
285. *Id.*
286. *Id.*
287. *See generally id.*

Budget and Policy Priorities, while adults with children are the largest group to use the vouchers at thirty-six percent, the second largest group is the elderly, at twenty-three percent.[288] Crafting policies that only look through the lens of a single group will exclude others and thus, lead the programs to require additional reforms.[289] Great work can be done in Section 8 housing vouchers by including elderly people in the conversation, as eliminating the stressor of finding affordable housing should be high on the priority list.[290]

4. REFORMS TO NURSING HOME BEHAVIORAL HEALTH SERVICES

Since elderly people of color make up a large amount of the nursing home population,[291] it is crucial that reforms are made to behavioral health care in nursing homes to get them the treatment they need. One solution is to have nursing homes employ or contract a part-time psychologist, who could provide staff training, be available to consult with staff members about problems with certain residents, work with family groups, help with team building, and increase nursing home efficacy utilizing industrial-organization techniques.[292] There is a clear connection in having behavioral health training and psychiatric training among nursing home staff and the provision of behavioral health services in nursing homes.[293] For example, nursing home facilities with registered nurses, who had previously received psychiatric training, were less likely to report problems meeting residents' behavioral health needs.[294]

As previously mentioned in Part III, a 2008 study found that a quality improvement initiative which focuses on training nursing assistants to identify and report targeted observations could be helpful in

288. *Policy Basics: The Housing Choice Voucher Program*, CTR. ON BUDGET & POL'Y PRIORITIES (Apr. 12, 2021), https://www.cbpp.org/research/housing/the-housing-choice-voucher-program.

289. Dianne Hall & Robert Davis, *Engaging multiple perspectives: A value-based decision-making model*, 43 DECISION SUPPORT SYS. 1588, 1600 (2007) (establishing that exposure to a large number of perspectives will allow policy makers to create stronger results).

290. *Id.*

291. *See* Howard, *supra* note 146.

292. Eleanor Feldman Barbera, *Improving the treatment of mental health issues in nursing homes*, MCKNIGHT'S LONG-TERM CARE NEWS (June 1, 2010), https://www.mcknights.com/blogs/guest-columns/improving-the-treatment-of-mental-health-issues-in-nursing-homes/.

293. *See* Spanko, *supra* note 156.

294. *Id.*

detecting depression or behavioral health issues in nursing home residents.[295] Additionally, if nurses used validated assessment measures, like the Hamilton Depression Scale ("HDS") or the Geriatric Depression Scale ("GDS"), they could make a critical difference in detection and treatment of this problem.[296] Currently, nursing home residents are often evaluated using the Minimum Data Set, as discussed in Part III, which does not seem to be as effective as other measures like HDS or GDS.[297] An alternative could be to have the MDS examination should be administered by a social worker, because they have the most training in mental health.[298] Essentially, there are many different ways that nursing home care can be reformed, starting with giving more training to nurses and nurse aides on how to recognize mental illnesses in nursing homes.[299] There has been research on the efficacy of mental health training for staff in nursing homes. A 2012 study found that internet mental health training can be an effective approach to help staff in long term care facilities work with residents with mental illness.[300] Both nurse's aides, who are direct care workers, and licensed health professionals had positive reactions to the training.[301] Mandating training for nurse's aides as well as the implementation of a contracted or employed on-site psychologist could be a helpful solution to the lack of mental health care in nursing homes, and in turn, assist elderly people of color who are a large population of these communities. This could be crucial to helping elderly people of color in these facilities.

B. Additional Initiatives

1. NATIONWIDE AWARENESS CAMPAIGN

While the Substance Abuse and Mental Health Services Administration ("SAMSHA") has declared a National Older Adults Mental Health Awareness Day on May 20th, there has not been enough national attention brought to the issue of the disparities in mental health

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295. Crogan, *supra* note 151.
296. *Id.*
297. *Id.*
298. Richard Juman & Robert Filgerski, *Vintage Voices: Depression in Nursing Homes*, 10 TODAY'S GERIATRIC MED. 34, 34 (2017).
299. Crogan, *supra* note 151.
300. Blair Irvine et al., *Mental Illness Training for Long Term Care Staff*, 13 J. AM. MED. DIR. ASSOC. 1 (2012).
301. *Id.*

services to elderly people of color.[302] A targeted media campaign could reach not only elderly people of color, but also, make their friends and family members aware of these issues as well.[303] National Older Adults Mental Health Awareness Day has only been around since 2019; and thus, it is likely that not many people are aware of it.[304] A great deal of work has to be done in terms of elderly minorities and helping stop the stigma towards asking for help with their mental health. The first step to doing that is heightening awareness and conversation.[305] Knowledge and an understanding of the issue is crucial to include with the calls for the reforms as mentioned above, especially Section 8 Housing reforms, as there could be a push for those legislatively.[306]

This campaign could consist of organizations like SAMSHA or the National Institute for Mental Health reaching out to nursing homes, coordinating with Public Housing Authorities, as well as coordinating with state and federal Medicare and Medicaid offices to disseminate information about the mental health of elderly people of color. This could also take the form of requesting SAMSHA to pick a day in the mental health space to dedicate specifically to elderly POC. By targeting these groups, the information would hopefully get to the people who need it the most.

Additionally, social media campaigns have proven to be successful in reaching older adults, especially in the age of COVID-19.[307] According to a 2015 study, nearly ninety percent of older adults have used social media to find and share health information.[308] A social media campaign would be a quick and effective way to inform viewers about the issue of the disparities in the usage of mental health services in elderly POC, especially if it came from a reputable source like the Mayo Clinic or SAMSHA. Extra help would be creating an eye-catching hashtag for people to follow. The goal of this campaign would be not

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302. Everett, *supra* note 8.
303. *See id.*
304. *Id*.
305. *See* Lorna Keane, *More Internet Users are concerned about COVID-19s effect on their mental health (31%) than access to a vaccine (29%)*, GWI (Nov. 4, 2020), https://blog.gwi.com/marketing/mental-health/.
306. *See* Everett, *supra* note 8.
307. *See* Christina Newberry, *How to Use Social Media in Healthcare: A Guide for Health Professionals*, HOOTSUITE (July 22, 2021), https://blog.hootsuite.com/social-media-health-care/.
308. *See* Bethany Tennant et al., *eHealth Literacy and Web 2.0 Health Information Seeking Behaviors Among Baby Boomers and Older Adults*, 17 J. MED. INTERNET RSCH. 1 (2015).

only to increase awareness, but also, to bring more education on the subject and have people know the facts: that a lack of mental health services for elderly people of color is prevalent in this country. Not only that, but additionally, a campaign could make more clear what resources are available for these people in their communities. Community outreach would be helpful, as well as organizing a walk to shed light or a public demonstration.

2. IMPROVE RESEARCH ON AND IMPLEMENTATION OF THE COLLABORATIVE CARE MODEL

As stated in Part III, there is limited research on the collaborative care model's impact within communities of color and how the model can help improve access to mental health services.[309] A December 2020 study, however, began to outline how helpful collaborative care can be for minority populations.[310] Results from the study show that using collaborative care in primary care settings can be effective in improving depression for people of color and even those coming from low socioeconomic backgrounds.[311] It also showed that minority veterans had higher rates of response to collaborative care than white veterans, showing that this model may be an intervention in helping to address untreated depression in male POC.[312] Positive outcomes can occur in as little as a month and up to about two years.[313] Future research is still needed in less-studied populations, such as South Asians, Native populations, and those of Middle Eastern descent.[314] While this 2020 study is just a start for the usage of the collaborative care model in minorities, it is definitely encouraging.[315] Thus, this Note calls for medical researchers to consider the useful benefits of the collaborative care model when it comes to mental health care and implement it into their practices.[316] It also calls for healthcare providers to examine the American Psychiatric Association website, which outlines an effective way to implement

309. *Collaborative Care Model*, *supra* note 202.
310. Jennifer Hu et al., *The Effectiveness of Collaborative Care on Depression Outcomes for Racial/Ethnic Minority Populations in Primary Care: A Systematic Review*, 61 PSYCHOSOMATICS J. 632, 642–43 (2020).
311. *Id.*
312. *Id.*
313. *Id.*
314. *Id.*
315. *See generally id.*
316. *Id.* at 642.

integrated care, specifically, the collaborative care model.[317] There are guides on learning about the collaborative care model, getting trained in the collaborative care model, implementation of the model, and getting paid using the model.[318] In the vein of getting paid, the APA states that primary care services that are providing collaborative care services can bill for those services using specific CPT codes.[319] Additionally, as stated in Part III, Medicare, some commercial players, and Medicaid are also providing coverage.[320]

There are many benefits to healthcare professionals in using collaborative care models that do no't just come from payment coverages. According to InSync Healthcare Solutions, collaborative care empowers team members because it allows various members of a care team, including EMTs, nurses, radiologists, social workers, and the like be able to offer recommendations when it comes to a joint patient's care.[321] It also helps lessen communication gaps, as all medical professionals are working together to provide care instead of working on their own.[322] Collaborative care also minimizes readmission rates, as the chance of misdiagnosis drops drastically when team members provide a more fleshed-out care plan.[323] The model additionally divvies up responsibility between care providers and promotes teamwork while helping a patient.[324] Finally, collaborative care results in patient-centered care.[325] The care is not just patient-centered in that the patient has a care team working with them together from the start, but also, support for patients from the financial front.[326] Studies of medical cost offset have shown that well-designed, combined behavioral and physical programs have saved twenty to forty percent of previous expenditures and that is just for providers.[327]

317. *Integrated Care: Improving access to mental health services and the overall health of patients.*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care (last visited Oct. 28, 2021).
318. *See id.*
319. *Id.*
320. *Id.*
321. *The Top 8 benefits of Collaborative Care for Providers and Patients*, INSYNC HEALTHCARE SOLUTIONS (Apr. 9, 2019, 10:36 AM), https://www.insynchcs.com/blog/the-top-8-benefits-of-collaborative-care-for-providers-and-patients.
322. *Id.*
323. *Id.*
324. *Id.*
325. *Id.*
326. *Id.*
327. *Id.*

Thus, if a healthcare provider is concerned with implementing collaborative care, they should be aware that there is a plethora of benefits not only to the patient, but also, to the provider as well.[328] This especially will help elderly minorities, as the stigma towards getting help from a mental health professional can be lessened when it is combined with primary care and other forms of healthcare. Normalization of mental health services in these communities is highly necessary to help mend this issue and collaborative care can be one of many possible solutions to this problem.

V. Conclusion

Mental health issues and a lack of access to mental health care are serious problems for elderly people of color in the United States.[329] This problem only is going to worsen as the elderly population grows and people start living longer while modern medicine develops.[330] Bringing awareness to and fixing this issue will require the banding together of many disciplines, like governmental/legislative groups, public housing authorities, lobbying and public policy groups, medical care staff, nursing home entities, and those in health care administration. Additionally, this Note only has explored certain facets of the racial disparity in usage and accessibility to mental health services. Ultimately, this problem is deeply rooted in a mistrust of the healthcare system by minority groups,[331] especially, elderly minorities who may have had bad health care experiences in their lifetime and are not looking to give new treatments or providers a chance.[332] We, as a society, need to continue looking into this problem, find workable solutions, and get elderly minorities, like Mrs. B, the mental health care they need and deserve.

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328. *See generally id.*
329. *See* Jimenez, *Disparities*, *supra* note 13.
330. *See* Dicks, *supra* note 9; *see also* Mather, *supra* note 10.
331. *See Mental Health Disparities*, *supra* note 20.
332. *See generally* Kyaien O'Connor et al., *Mental Health Treatment Seeking Among Older Adults with Depression: The Impact of Stigma and Race*, 18 AM. J. GERIATRIC PSYCHIATRY 531, 531–43 (2010).