Advancing Community Collaboration in Aging and Mental Health

AN ODYSSEY OF TEAMWORK

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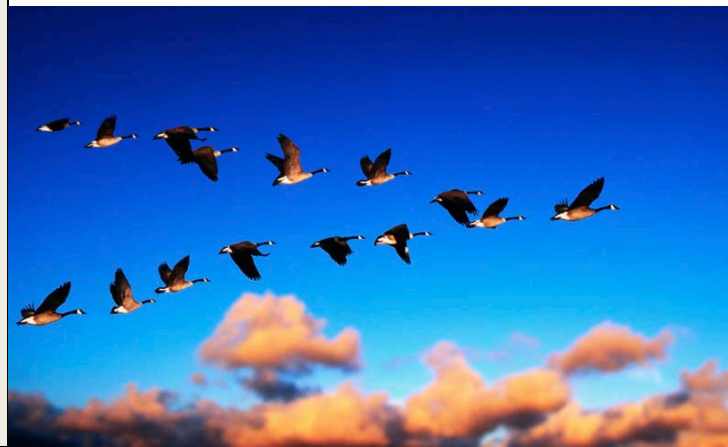
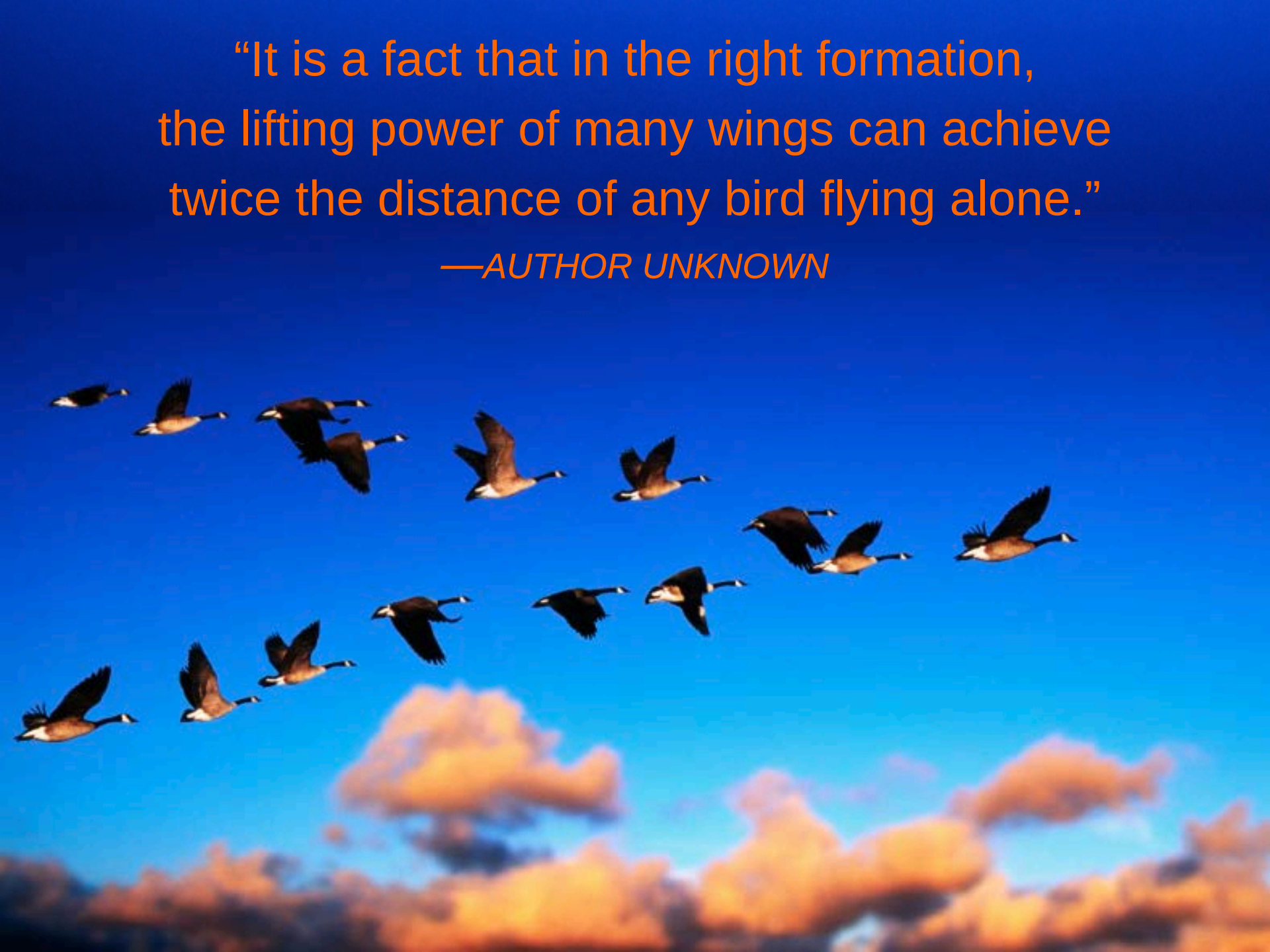



“It is a fact that in the right formation,
the lifting power of many wings can achieve
twice the distance of any bird flying alone.”
—AUTHOR UNKNOWN

Four Ways to Advance Community Collaboration in Aging and Mental Health

- Create and Disseminate Evidence-based Models in Diverse Communities
- Champion Successful Implementation in Communities and Organizations
- Mobilize Policy Support and Funding Aligned with Evidence
- Prepare a Community-based Interdisciplinary Workforce

Perhaps More like Ms. Frizzle

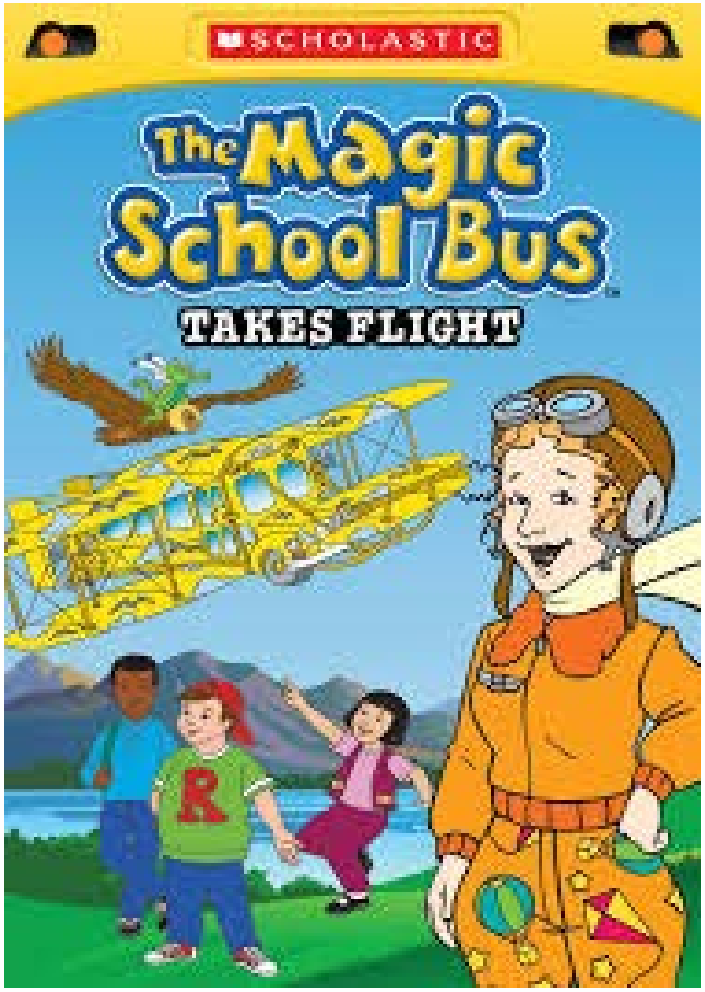
"Take chances! Make Mistakes! Get Messy!"

"Never say never!“

"WAHOO!"

"If you keep an open mind, you never know who might walk in!"

"Let’s get out there and explore!"



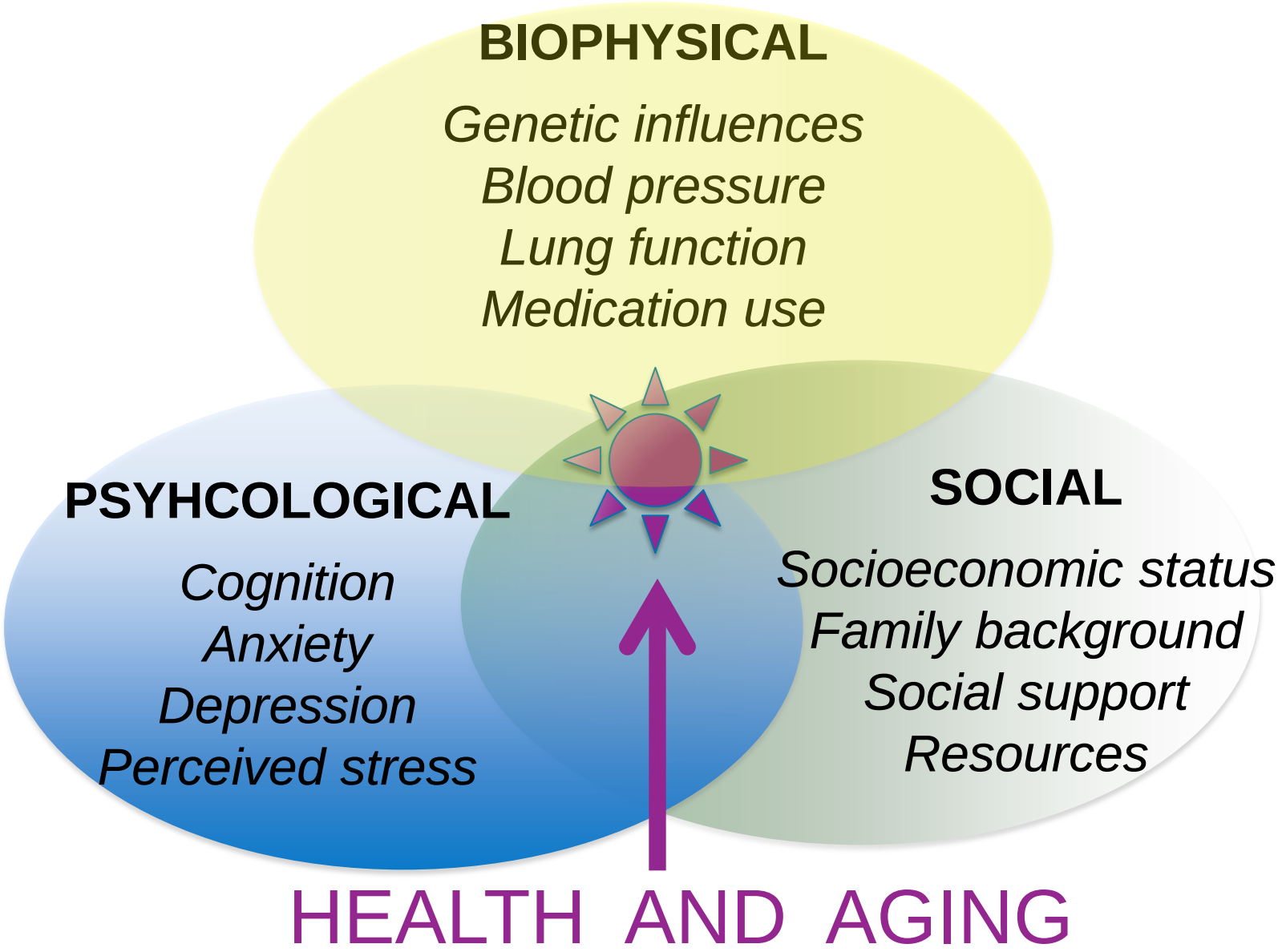
Mental Health in Late Life

"Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."

—WORLD HEALTH ORGANIZATION, 2014

World Health Organization

Biopsychosocial Aging



Adaptation of models by WHO and Engel

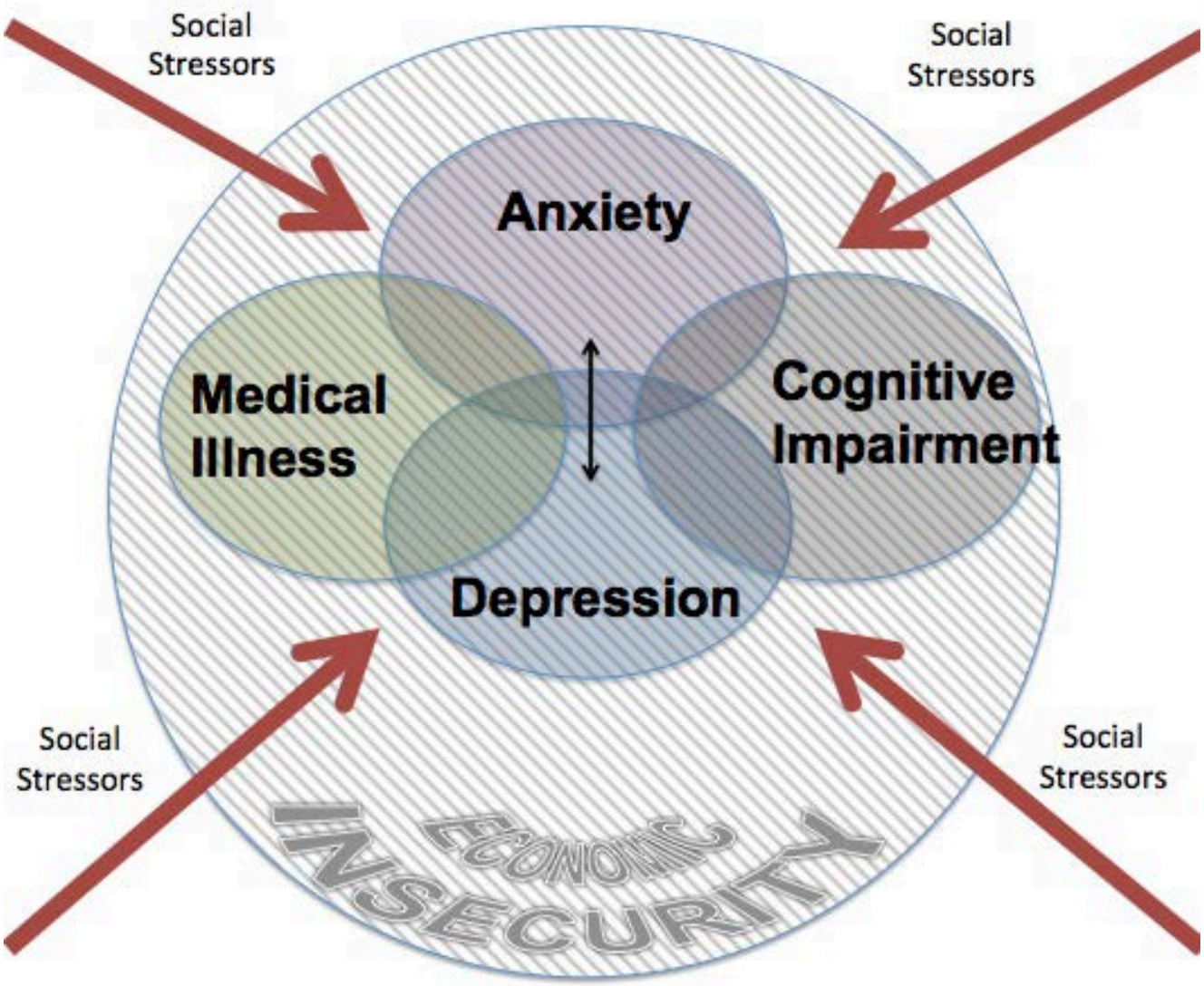
JOHN A HARTFORD FOUNDATION 2012 SURVEY

Seniors Struggle with Anxiety and Depression and Lack Awareness of Related Health Risks

- One in four reported symptoms of depression; 29% reported symptoms of anxiety
- More than 50% had not learned of nonpharmacologic strategies-
- Almost two thirds did not know that depression doubled risk of heart disease and dementia

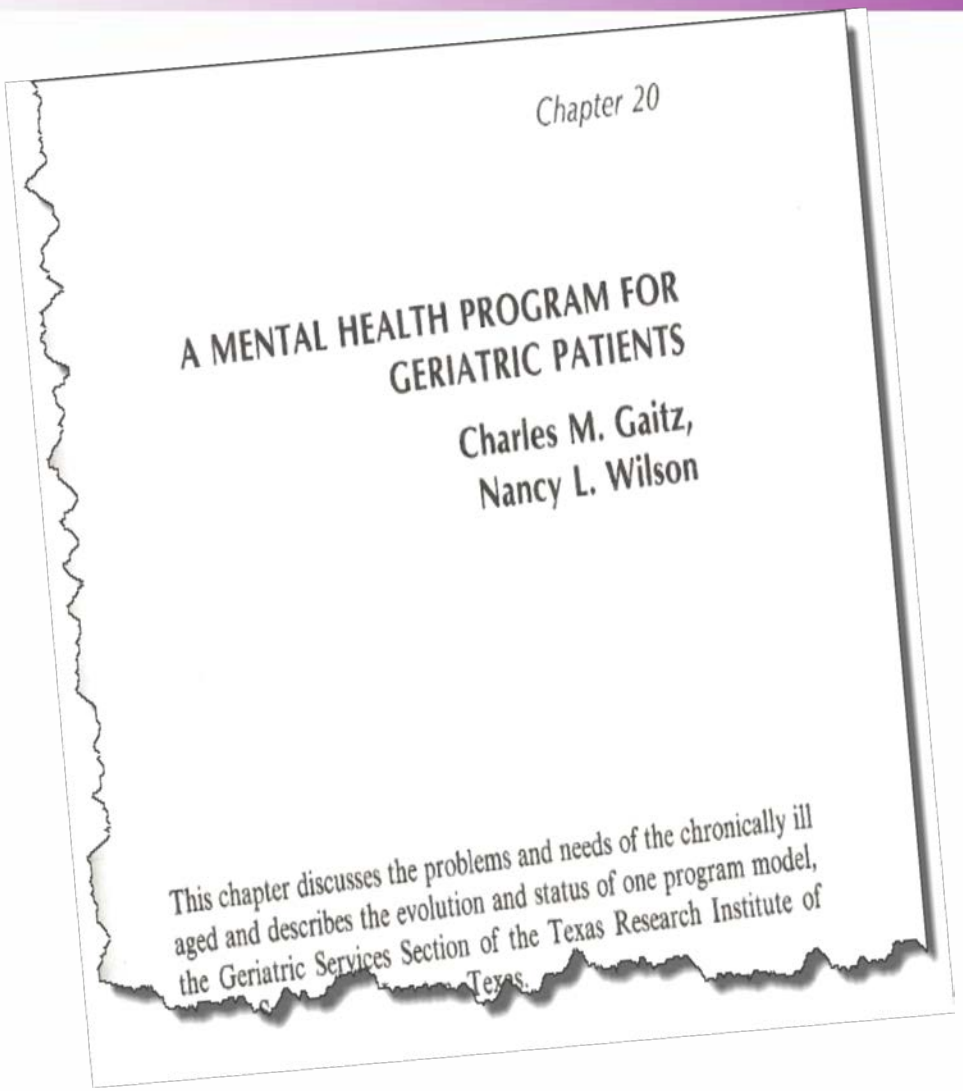
Silver and Blue Survey, 2012
John A. Hartford Foundation
New York,NY

Rarely Are the Only Problems Depression and Anxiety



Create and Disseminate Evidence-based Models in Diverse Communities

Once Upon a Time at TRIMS

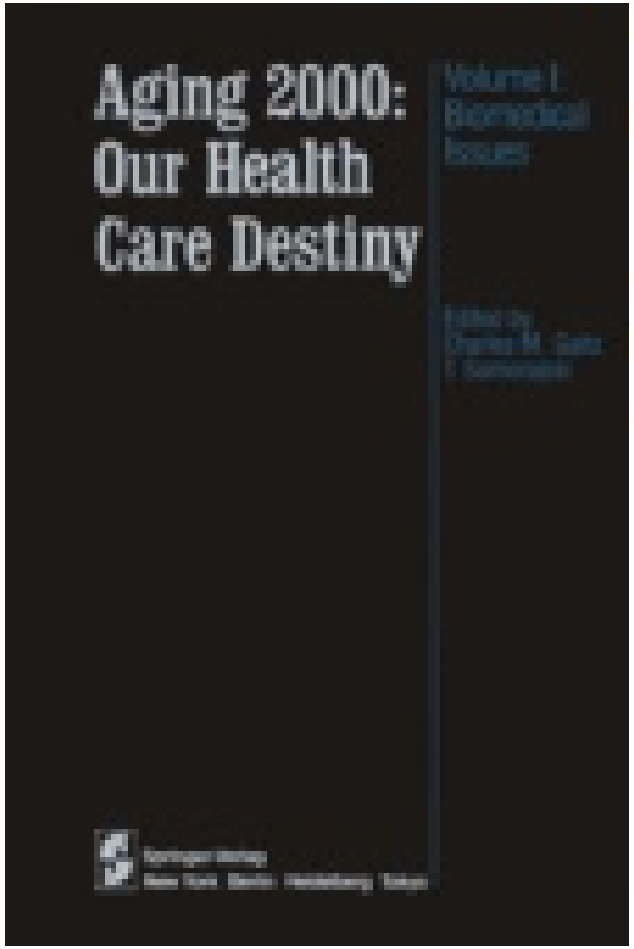


Chapter 20

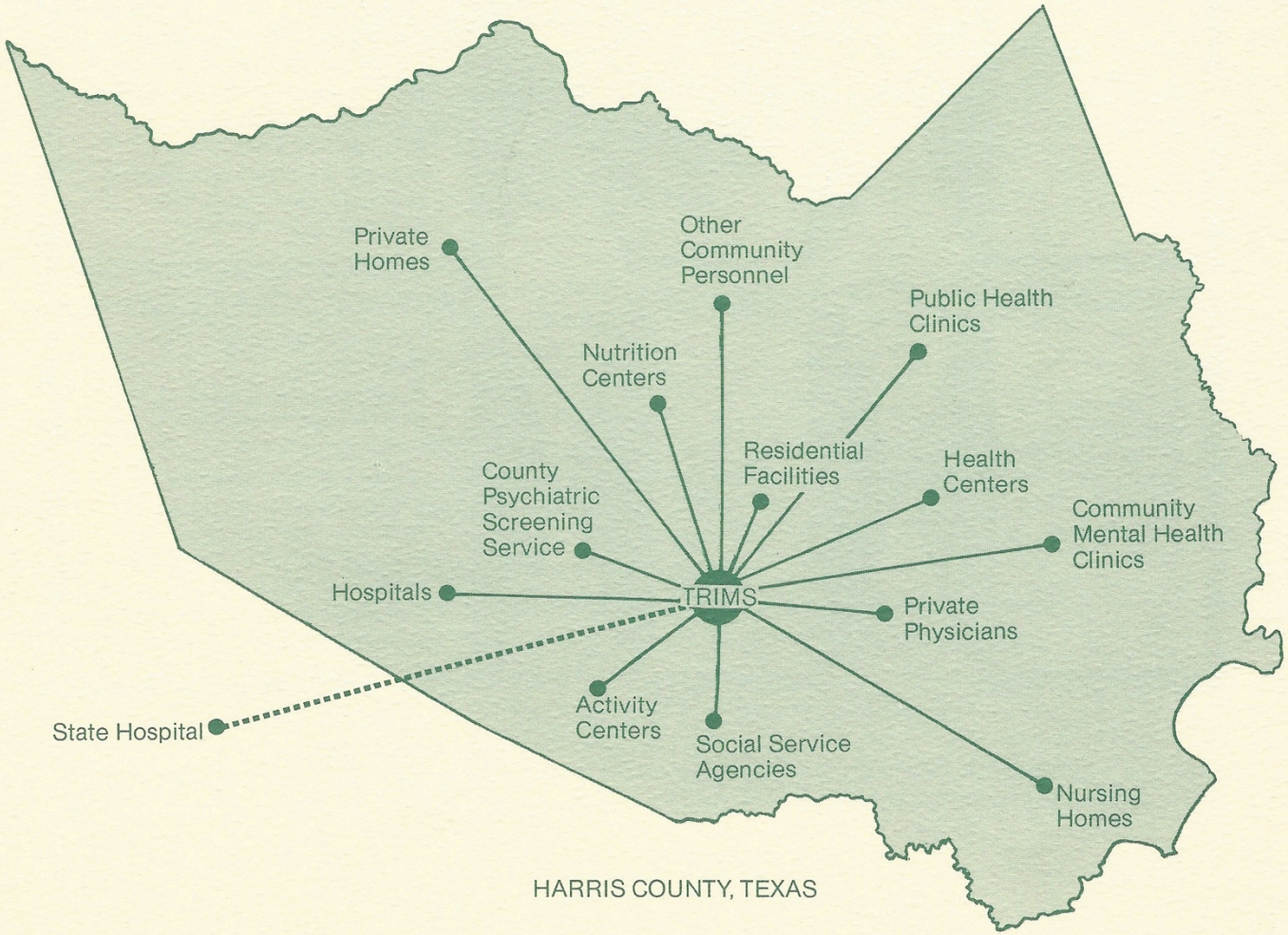
A MENTAL HEALTH PROGRAM FOR GERIATRIC PATIENTS

Charles M. Gaitz,
Nancy L. Wilson

This chapter discusses the problems and needs of the chronically ill aged and describes the evolution and status of one program model, the Geriatric Services Section of the Texas Research Institute of Texas.



Community-based, Comprehensive Geriatric Services

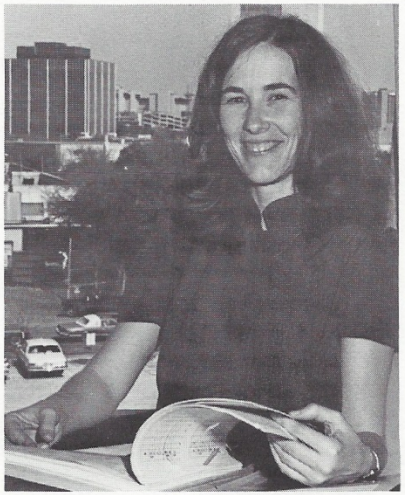


A Multidisciplinary Mental Health Model
1975

Texas Project for Elders

Something new for someone old

In 1981 TRIMS was selected as the sponsoring agency in Texas for a federal research and demonstration project to help chronically ill elderly people live in their homes despite their disabilities. This is the story of the Texas Project for Elders, its staff, and the people they serve.



Project director NANCY WILSON says her staff must be resourceful and flexible to deal with a social service network that is forever changing.

Case managers

Linking people to the help they need

No day is typical for case managers of the Texas Project for Elders.

They must be ready to change and rearrange timetables and plans at any moment. The things they do regularly, though, are telephone social service agencies, work on an endless stream of paperwork, and visit or call clients.

Emissary editor Kathleen Kimball-Baker and photographer Marc Meyers recently joined case manager Hasu Patel when she spent an afternoon visiting two of her clients.

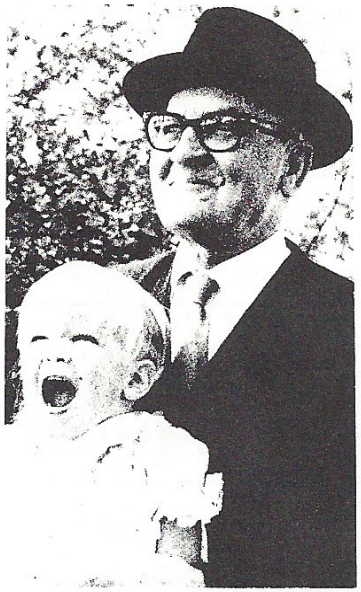
Joe John Girash was stricken by polio as a child.

Now, at 78, he is almost completely paralyzed.

Asthma has withered his voice to little more than a whisper, but if you ask him if the Texas Project for Elders has been helpful, his eyebrows rise, his eyes widen, and through a grin he says: "Oh, yeah."

Ask his wife, Theresa, the same

Texas Project for Elders



Case managers helped 692 frail elders, they want to keep doing it

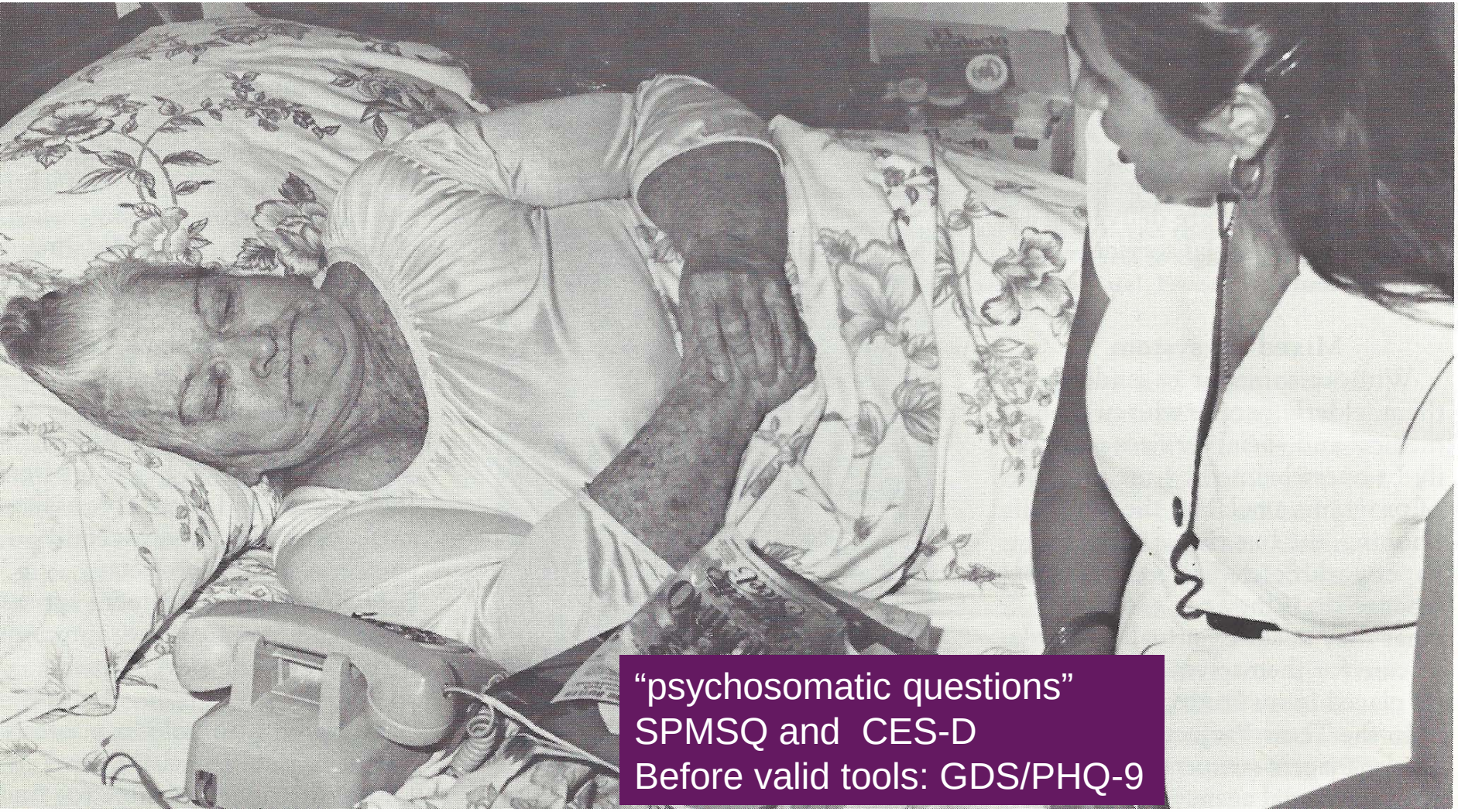
Four years ago the TRIMS Gerontology Center's Texas Project for Elders won a national "beauty contest" and became one of the country's pathfinding case management programs to connect frail, elderly people with the services they need to live at home.

Houston's "long-term care channeling," as the case management demonstration is called, is funded through April by the U.S. Department of Health and Human Services.

By 1985, 692 clients living at home and their caregivers received services

- Age: 25%, ≥85 years; 42%, 75–84 years
- Income: 61%, <$400/month; 20%, $400–$600/month
- Clients requiring feeding: 20%

Texas Project for Elders: Channeling



Evidence –Based Practices Were Developed

- Outreach Models
- Psychological Treatments
  - CBT, PST, IPT, Counseling
- Integrated Service Delivery in Primary Care (Collaborative Care)
- Family/Caregiver Support Interventions
- Mental health consultation and treatment teams in long-term care

Barriers to Addressing Depression in Older Adults

- Client Barriers
  - Stigma – “I’m not crazy! I’m not a weak person”
  - Lack of knowledge- “ It’s just my diabetes or being old”
- Provider Barriers
  - Primary Care faces many competing demands
  - Scarcity of mental health professionals
- System Barriers
  - How can we get care to the person or the person to care?”
  - Financing of services is limited and in silos

Setting Priorities for Older Adults

PRESIDENT'S NEW FREEDOM
COMMISSION ON MENTAL HEALTH

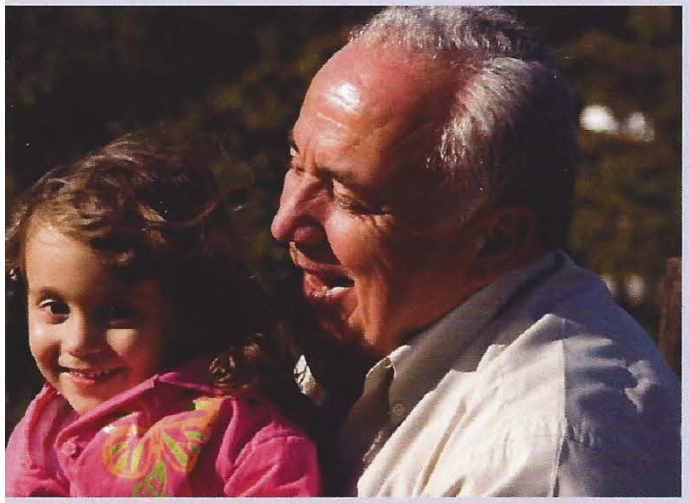
Improving Access:

- Integration of Mental Health and General Health Care
- Home and Community-based Services

Improving Quality:

- Evidence-based Practice Implementation
- Trained Healthcare Workforce with Expertise in Geriatrics

Create and Disseminate Evidence-based Models in Diverse Communities



IMPACT

Improving Mood-Promoting Access to Collaborative Treatment

IMPACT is a program for older adults who have major depression or dysthymic disorder. The intervention is a stepped, collaborative care approach in which a nurse, social worker, or psychologist works with the participants' regular primary care provider to develop a course of treatment.

Target population: Older adults.

Setting: Primary care settings. (The program has also been implemented in other settings, including home health care and chronic disease management.)

Description of activity: Potential participants are either referred by the primary care provider or identified via routine screening of all clients. During the initial visit, the depression care manager (DCM) completes an assessment, provides education about depression and available treatments, and asks the participant about his or her depression treatment preferences. All participants are encouraged to engage in some form of behavioral activation, such as engaging in physical activity or scheduling pleasant events. For participants already taking antidepressant medications who are still depressed, the recommendation typically is to increase the dose, augment the antidepressant with a trial of problem-solving treatment (PST) or switch to a different medication or PST.

IMPACT Model Implementation Resources

Evidence-based depression care

http://www.impact-uw.org/

AIMS CENTER

Advancing Integrated Mental Health Solutions

University of Washington

Seattle, WA

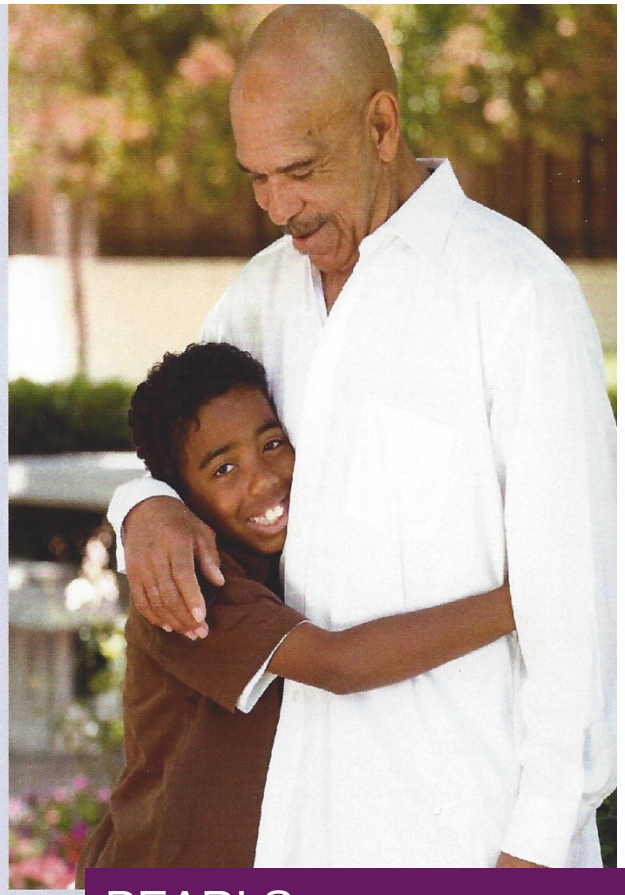
Create and Disseminate Evidence-based Models in Diverse Communities

PEARLS is a brief, time-limited, and participant-driven program that teaches depression management techniques to older adults with depression. It is offered to people who are receiving home-based services from community services agencies. The program consists of in-home counseling sessions followed by a series of maintenance session contacts conducted over the telephone.

Target population: Community-dwelling older adults (60+ years).

Setting: Participant's place of residence in the community.

Description of activity: PEARLS is an intervention for older adults who have minor depression or dysthymia and are receiving home-based social services from community services agencies. The program is designed to reduce symptoms of depression and improve health-related quality of life. PEARLS requires its depression care managers (DCM) to use three depression management techniques: (1) problem-solving treatment, in which participants are taught to recognize depressive symptoms, define problems that may contribute to depression, and devise steps to solve these problems; (2) social and physical activity planning; and (3) pleasant event planning and scheduling.



PEARLS
Program to Encourage Active Rewarding Lives for Seniors

Vision, Teamwork, Models, Public-Private Partnerships, Movements

center for Healthy Aging
model health programs for communities

JAHF and NCOA begin Model Programs (2000–2002)

- Baylor academic-community team develops and pilots model

AoA and NCOA launch Healthy Aging Movement

- Shows essential role of diverse community organizations and self-management
- Demonstrates importance of partnerships: consumers, agencies, providers, academics
- Translates and applies evidence to achieve better outcomes in health and functioning

HEALTHY IDEAS

Identifying
Depression
Empowering
Activities for
Seniors

Care for Elders

Leading ideas. Enhancing life.

What is Healthy IDEAS?

IDEAS = **I**dentifying **D**epression, **E**mpowering **A**ctivities for **S**eniors

Healthy IDEAS is a community-based depression program designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations through existing community-based case management or caregiver support services.

It follows the road map for home-based depression care management.

Core Program Components

- **Screening** for symptoms of depression and assessing severity

  ☑ Two-question screen and standardized assessment—Geriatric Depression Scale (GDS) or PHQ-9

  ☑ Suicide risk protocol for all significant symptom scores

- **Educating** older adults and family caregivers about depression and effective treatment, including self-care and medication.
- **Referral, linkage,** and **follow-up** for older adults with untreated depression to health or mental health providers.
- **Behavioral activation** empowering older adults to manage their depressive symptoms by engaging in meaningful, positive activities.
- **Outcomes tracking** of depressive symptoms and self-care skills and behaviors

Program Design

The design

- Embeds the tools in **case management** programs.
- Promotes interaction **in the client's home** on a **one-to-one** basis by **case managers** over 3 to 6 months
- Uses **existing staff** with established relationships with targeted participants
- Provides a **manual** outlining steps and supplies written worksheets, client handouts, and forms to support and document the process and outcomes
- **Promotes partnering** with health/mental health care providers to facilitate referral and uses community **partnerships** for training, evaluation, and fidelity

Impact on Clients

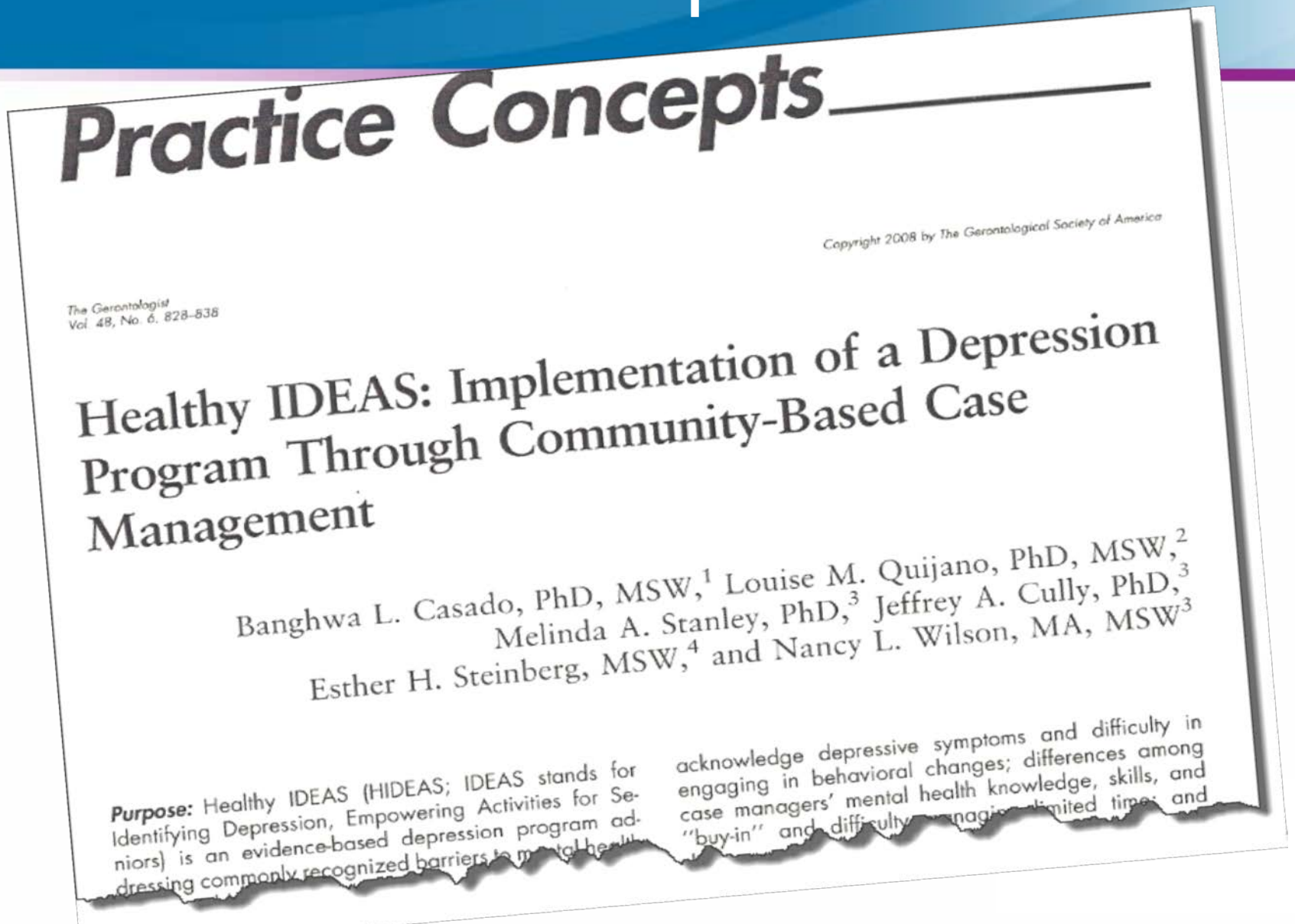
Evaluation indicated that Healthy IDEAS:

- Reduces depression severity
- Reduces self-reported pain
- Increases knowledge of how to get help for depression
- Increases level of activity
- Improves knowledge of how to manage depressive symptoms

NOTE: No cost-effectiveness data collected or analyzed.

Quijano, L.M., Stanley, M.A., Petersen, N.J., Casado, B.L., Steinberg, E.H., Cully, J.A., Wilson, N.L. Healthy IDEAS: A depression intervention delivered by community-based case managers serving older adults. (2007) *Journal of Applied Gerontology* 26:139-156.

Lessons from Implementation



Practice Concepts

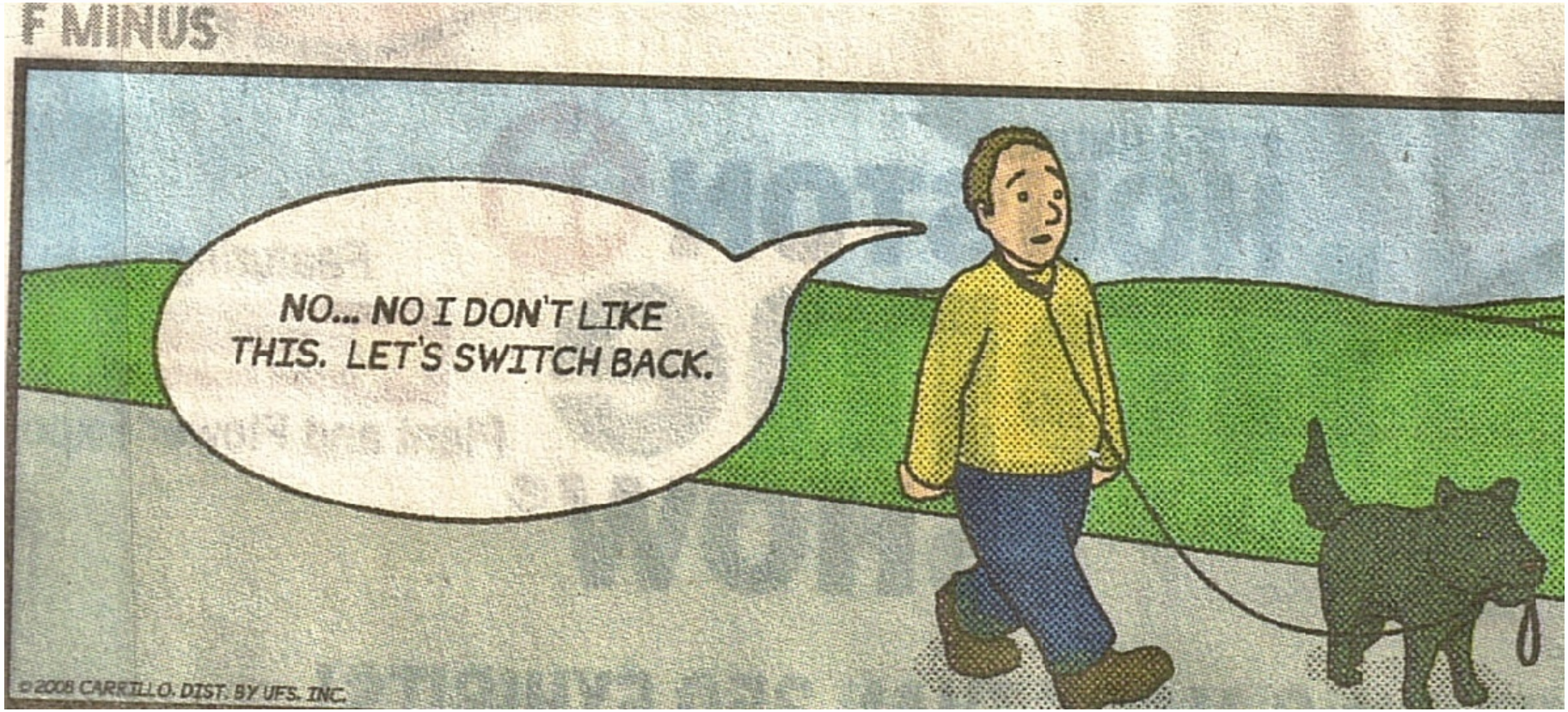
The Gerontologist
Vol. 48, No. 6, 828–838

Healthy IDEAS: Implementation of a Depression Program Through Community-Based Case Management

Banghwa L. Casado, PhD, MSW,[1] Louise M. Quijano, PhD, MSW,[2] Melinda A. Stanley, PhD,[3] Jeffrey A. Cully, PhD,[3] Esther H. Steinberg, MSW,[4] and Nancy L. Wilson, MA, MSW[3]

Purpose: Healthy IDEAS (HIDEAS; IDEAS stands for Identifying Depression, Empowering Activities for Seniors) is an evidence-based depression program addressing commonly recognized barriers to [illegible] acknowledge depressive symptoms and difficulty in engaging in behavioral changes; differences among case managers' mental health knowledge, skills, and "buy-in" and difficulty [illegible] limited time; and

Change Is Hard . . .



Implementation Process : Activities and Resources

Healthy IDEAS

Agencies or Community Partnerships need:

- Dedicated program leadership: Champion, Supervisors
- Mental/Behavioral Health Expertise for Training/Coaching
- Effective Linkage & Communication systems with Treatment Providers
- Practitioners with capacity/ability to incorporate components into their existing case management routine with older adults/caregivers
- System for collecting and monitoring depression and other relevant outcome data

Applying Lessons to Role of Program Purveyor

STAGES

- Exploration and Adoption
- Program Installation
- Initial Implementation
- Full Implementation
- Innovation
- Sustainability

- **Healthy IDEAS Readiness Assessment**
- **Leadership team and partnership development**
- **Staff selection**
- **Program installation**
- **Pre-service and in-service training**
- **Consultation and coaching**
- **Program evaluation**

Fixen, D.L., Naoom, S.F., Friedman, R.M., Wallace, F., (2005) Implementation Research: A Synthesis of the Literature, Tampa, FL: University of South Florida, Louis de la Parte Mental Health Institute. The National Implementation Research Network (FMHI Publication #231).

Healthy IDEAS

Program Components, Tools, and Resources

Healthy IDEAS Guide to Program Components and Tools and Resources

- Tool case manager and client use together
- Tool given to client
- Agency-specific material
- Tool for case manager

TIMING	IMPLEMENTATION	TOOLS AND RESOURCES
STEP 1: Screen and Assess Your Client for Symptoms of Depression		
• Incorporate as part of an initial client assessment or a client reassessment.	*In person* • Ask two questions to determine if a new or continuing client may be experiencing depressive symptoms. • When clients respond positively, ask additional questions to determine severity of client's depressive symptoms.	Two-Question Depression Screen (T-1) Snow's Guide to Administering a Standardized Depression Scale (T-2) Geriatric Depression Scale (GDS) (T-3) Tips for Administering PHQ-9 (T-2Alt) Patient Health Questionnaire (PHQ-9) (T-3Alt) Suicide Screen (T-4) Agency Suicide Protocol (T-5) Agency Outcome Measures (T-6)
STEP 2: Educate Your Client About Depression and Treatment		
• Combine education with screening, or make it a separate activity.	*In person* • Review depressive symptoms with older adult and with family members or caregiver (with permission). • Explore client's attitude about depression and depression treatment. • Explain what good depression care is. • Help older adults understand what they can do to improve depressive symptoms (self-care) and how family can help. • Assess client's readiness to change.	Depression (T-7) Information about Depression for Family and Friends (T-8) Other depression educational materials agency chooses (printed material or videotape) (T-9) Ten Facts About Depression (T-10) Depression in Older Persons (T-11) Depression is not a Normal Part of Aging (T-12) Resources: Organizations (T-13) Antidepressant Medications: How They Work and Common Questions About Them (T-14) Quick Reference List of Antidepressants (T-15) Motivational Interviewing: Principles, Strategies, and Skills (T-16) Readiness Ruler (T-17)
STEP 3: Refer and Link Your Client to Treatment		
• Refer and link clients who have a GDS score of 6 or higher.	*In person or by telephone* • Help clients obtain appropriate medical treatment through interaction with primary care provider and/or mental health professional. • Address and overcome barriers where possible. • Ensure effective linkage through follow-up communication with care provider and client.	Steps for Effective Referral and Linkage (T-18) Talking With the Doctor About Depression (T-19) Agency Form Authorizing Release of Medical Information (T-20) Letter to Primary Care Provider (T-21) Inventory of Local Mental Health Resources to Facilitate Referrals (T-22) *(Continued on page 6)*

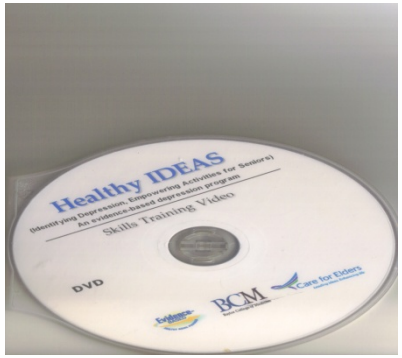
Healthy IDEAS Guide to Program Components and Tools and Resources, *continued*

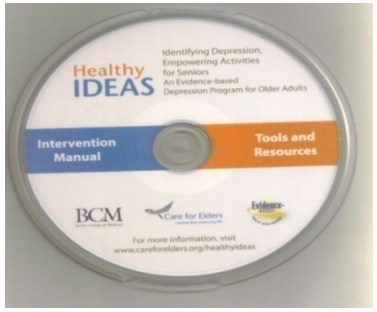
- Tool given to client
- Agency-specific material
- Tool for case manager

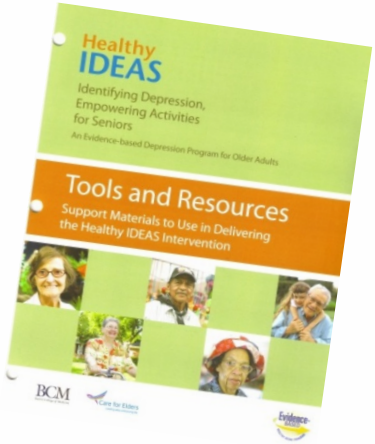
TIMING	IMPLEMENTATION	TOOLS AND RESOURCES
STEP 4: Empower Your Client Through Behavioral Activation		
UNDERSTANDING THE CONCEPT		
• Begin as soon as client with GDS score of 6 or higher is ready to talk about his or her mood.	*In person* • Help clients understand the connection between behavior and mood.	Behavioral Activation Tips (T-23) Depressed Mood and Symptoms (T-24) Better Mood and Fewer Depressive Symptoms (T-25) Healthy Idea #1—Recording Daily Activities and Rating Mood (T-26)
SETTING GOALS AND REVIEWING ACTIVITIES		
• Assess client's current level of activity. • After assessing client's readiness to follow through on chosen activity plan, set goals.	*In person* • Assess client's readiness for behavioral activation. • Identify pleasant events and meaningful activities; identify activities and steps to promote well-being. • Coach client and family through changing behaviors, taking action to improve symptoms, achieving goals.	Healthy Idea #2—Identifying Pleasant Events and Meaningful Activities (T-27) Checklist of Life Activities or Events (T-28) Choosing Goals for Behavioral Activation (T-29) Healthy Idea #3—Identifying Activities With Steps to Take to Feel Better (T-30)
SUPPORTING YOUR CLIENT		
• One week after helping client choose activity or set a problem-solving goal, contact the client. • Maintain contact every two weeks or as needed to support client's efforts until three-month reevaluation of depressive symptoms.	*In person or by telephone* • Review depressive symptoms and condition. • Review progress on all goals. • Review accomplishments. • Support client for progress made. • Continue to coach client and family through changing behaviors and taking action to improve symptoms and achieve goals.	Healthy Idea #3—Identifying Activities With Steps to Take to Feel Better (T-30) Positive Events Planning and Tracking Chart (T-31) *Yes I Can!* Calendar (T-32)
STEP 5: Assess Your Client's Progress		
• Three months following the initial assessment, reassess client progress and outcomes according to agency documentation plan.	*In person* • Readminister the GDS or PHQ-9. • Review accomplishment of goals. • Encourage client to maintain gains and seek to attain new goals. • Review with supervisor and pursue additional professional input for untreated clients with GDS score higher than 6.	Geriatric Depression Scale (GDS) (T-3) or Patient Health Questionnaire (PHQ-9) (T-3Alt) Suicide Screen (T-4) Agency Outcome Measures (T-6) Healthy Idea #3—Identifying Activities With Steps to Take to Feel Better (T-30)

Support Replication and Spread

- Tools assess organizational readiness.
- Plan includes approach and tools for each core component and multimedia training curriculum.







- Technical assistance via telephone/Webinar supports teams as they develop local plans.

Readiness Report Summarizes Willingness and Capacity as Low, Medium, or High

Leadership

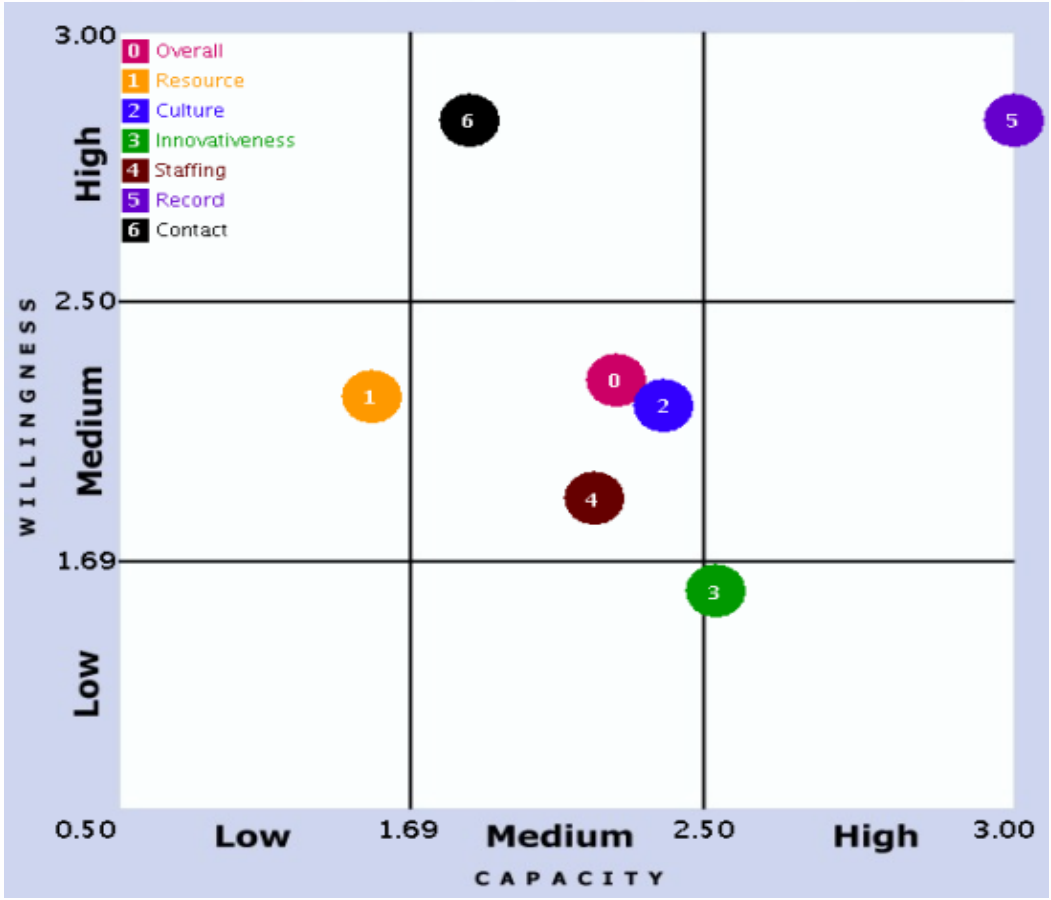
Staffing

Culture

Resources

Recordkeeping

Innovativeness



The Retirement Research Foundation

Hasche L, Wilson NL. NCOA, Predictive validity of an online assessment to measure agency readiness to implement Healthy IDEAS. Forthcoming.

Key Steps in Program Implementation

- Identifying Resources
- Building the Right Team:
- Installing the Program
- Training and Coaching
- Evaluation for Continuous Quality Improvement and Monitoring Fidelity

Mobilize Policy Support and Funding Aligned with Evidence

Advocacy Advancing Action

Illinois Coalition on Mental Health & Aging

NCMHA

North Carolina

Recovery has no age limit.

OMHAC

OKLAHOMA MENTAL HEALTH & AGING COALITION

2005 White House Conference on Aging

Collaborating to Advance Broader Diffusion of Community Models: 2008

- NCOA with SAMHSA and AoA support convenes program leaders, funders, and staff of federal agencies.
- Public-private diffusion goals are set with plans.
  - In 2013, one or more sustainable depression care management programs in 10–15 states are implemented.
  - Plans call for a “distribution system” for fostering broad diffusion of evidence-based programs and practices nationwide.
  - The goal is to embed depression screening, tracking, and treatment in practice nationwide.

FEDERAL SUPPORT
CDC in 2008

CDC Sponsors Healthy Aging Program at Carter Center

- ☑Prepare professionals in public health, aging services, and mental health
- ☑Offer effective strategies for depression screening
- ☑Offer effective treatment for older adults

Issue Brief #1:
What Do the Data Tell Us?

In recognition of the essential role mental health plays in overall health, the Healthy Aging Program at the Centers for Disease Control and Prevention (CDC) and the National Association of Chronic Disease Directors (NACDD) are releasing two issue briefs focused on the mental health of older adults in the United States.

This first issue brief reviews existing data and lays the foundation for understanding key issues related to mental health in adults over 50. The second brief will focus on depression, an important and emerging public health issue. Recent public health efforts to develop, test, and disseminate programs that address depression in older adults have led to practical information on this topic; the second issue brief will examine interventions to address depression that communities can use to improve the mental health and quality of life of older Americans.

The State of Mental Health and Aging in America

Why is Mental Health a Public Health Issue?

The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (1). Because mental health is essential to overall health and well-being, it must be recognized and treated in all Americans, including older adults, with the same urgency as physical health. For this reason, mental health is becoming an increasingly important part of the public health mission. In fact, the mental health of older Americans has been identified as a priority by the Healthy People 2010 objectives (2), the 2005 White House Conference on Aging (3), and the 1999 Surgeon General's report on mental health (4).

The goals and traditions of public health and health promotion can be applied just as usefully in the field of mental health as they have been in the prevention of both infectious and chronic diseases. Public health agencies can incorporate mental health promotion into chronic disease prevention efforts, conduct surveillance and research to improve the mental health evidence base, and collaborate with partners to develop comprehensive mental health plans and to enhance coordination of care. The challenges for public health are to identify risk factors, increase awareness about mental disorders and the effectiveness of treatment, remove the stigma associated with mental disorders and receiving treatment for them, eliminate health disparities, and improve access to mental health services, particularly among populations that are disproportionately affected (5).

Federal Policy Attention

- Changes in Older Americans Act
  - (2006): Designate a staff member to be responsible for aging-related mental health projects
  - Authorized NOT REQUIRED to advance many goals for service delivery
  - FY-2012 Appropriation requires OAA Title IIID funding be for programs and activities which have been demonstrated to be evidence-based.
- SAMHSA Transformation Funding: 10%
- CMS Payment Policy: Problematic

STATES ACT To Support Implementation and Pursue Sustainability

- **Starting at the top by influencing statewide plans and structures**
- **Playing an active role in exposing key stakeholders to EBP approaches**
  - Hearing information from peers
  - Using existing forums to present models with thoughts about how to advance
- **Organizing cross-agency intrastate calls and Webinars to allow technical assistance for implementation activities**

STATES ACT To Support Implementation and Pursue Sustainability

- **Cultivating partnerships that flow downstream: Ohio, Missouri, Oklahoma, North Carolina**
  - Training workforce in mental health and aging; providing regional training for staff
  - Creating connections with mutual benefits for aging and behavioral health networks
- **Modifying assessment tools and reporting systems to ensure screening and outcome tools are valid**
  - Tools for Depression/Suicide Risk
  - Tools for Alcohol/Substance Use

STATES ACT To Support Implementation and Pursue Sustainability

- **Determining how to reimburse program functions within existing funding mechanisms**
  - Billable units for Medicaid, state programs
  - Title III-D funds—Administration on Aging
  - Mental health funding of training, coaching
- **Mobilizing linkages to evaluation expertise within state or within academic centers of affiliated partners**
  - Track outcomes for funders, to support delivery
  - Track processes to measure fidelity
  - Summarize data efficiently and effectively

Key Findings

- Embedding services into ongoing systems useful
  - Example: depression care embedded to enhance case management
- No one funding source was sufficient for sustaining services
  - Braided funding important
  - Sources varied: medical, mental health, aging
- Services sustained were often billable including:
  - care management, depression care management, psychotherapy and psychiatry

Financing PEARLS and Healthy IDEAS

Currently implemented in over 100 sites in 30 states through various sources, including:

- Older American's Act case-management programs through Area Agencies on Aging (AAA) and Family Caregiver Support Programs through state and local agencies
- AAA discretionary funding
- SAMHSA Mental Health Funding to States
- SAMHSA Older Adult Targeted Capacity Expansion Grants (not active)
- Medicaid Home and Community Based Services Case Management Programs and Client Training Services
- Medicare (limited to clinical counseling)

Financing PEARLS and Healthy IDEAS

Additional Funding of Implementation Includes:

- State-funded case management
- State-funded mental health services
- United Way- funded non-profit case-management programs
- Regional Foundations
- Voter-approved funding (special levies)
- University research and education grants
- Non-profit organizations (discretionary funds)

Champion Successful Implementation in Communities

Different Types of Organizations Deliver Healthy IDEAS in Multiple States: 26

ORGANIZATIONS: 106

- Area Agency on Aging case management programs
- Local nonprofit social service agencies
- Behavioral health provider agencies
- Caregiver support programs

Healthy IDEAS for Asian Immigrant Seniors in Los Angeles—Asian American Coalition

ARCHSTONE FOUNDATION

Training Funder

Coalition Collaborators

華埠服務中心
Chinatown Service Center

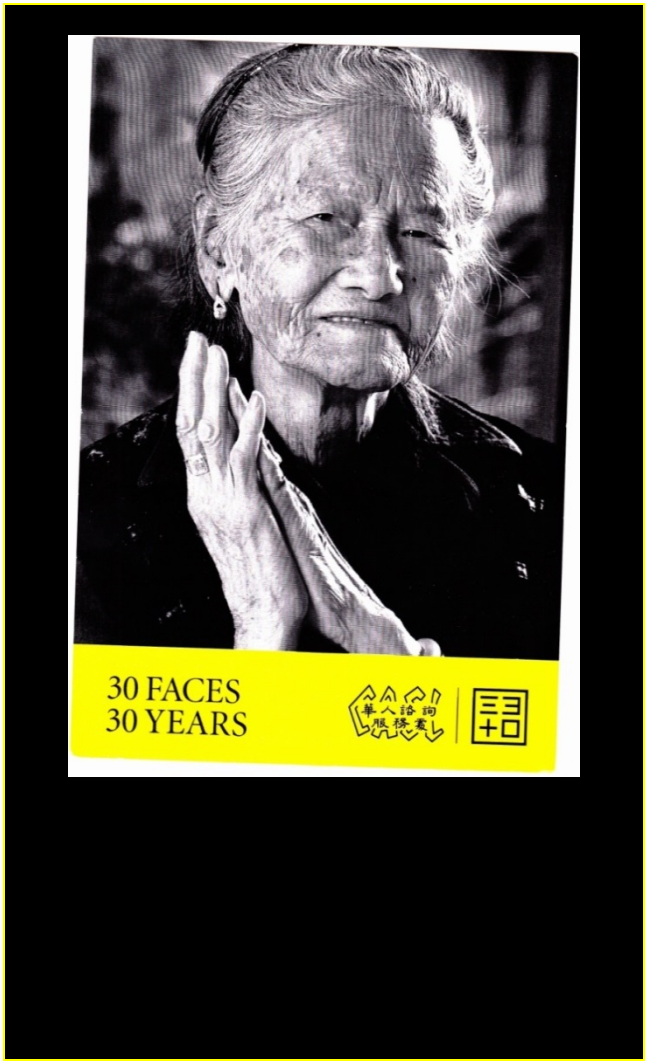
YNOT Foundation
Young Nak Outreach & Transformation Foundation

កម្មវិធីអ្នកអាហារខ្មែរសំរាប់វ័យចំណាស់
CAMBODIAN SENIOR NUTRITION PROGRAM

Korean American Family Service Center
한 인 가 정 상 담 소

Little Tokyo Service Center
a Community Development Corporation

Adapting Healthy IDEAS in Chicago—The Chinese American Services League

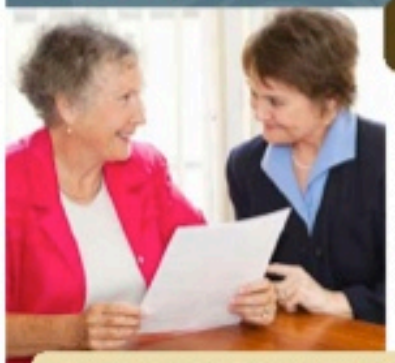


ADAPTATIONS

- Exercise flexibility in the timing of steps and focus on client only
- Emphasize education and use language with less stigma. Stress wellness.
- Provide more active guidance. Worker is authority.
- Make physical symptoms more prominent
- Use graphics liberally.

FEDERAL SUPPORT
AOA and SAMHSA Issue Briefs

OLDER AMERICANS BEHAVIORAL HEALTH
Issue Brief 1: Aging and Behavioral Health Partnerships in the Changing Health Care Environment



Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) and Administration on Aging (AoA) recognize the value of strong partnerships for addressing behavioral health issues among older adults. This Issue Brief is part of a larger collaboration between SAMHSA and AoA to support the planning and coordination of aging and behavioral health services for older adults in states and communities. Through this collaboration, SAMHSA is providing technical expertise and tools, particularly in the areas of suicide, anxiety, depression, alcohol and prescription drug use and misuse among older adults, and partnering with AoA to get these resources into the hands of aging and behavioral health professionals.

State Aging and Behavioral Health Partnerships

States are advancing older adult behavioral health services through partnerships between State Aging, Mental Health, and Single State Authorities. These partnerships have increased access to health interventions for suicide prevention, depression, at-risk alcohol and medication misuse, and chronic disease management such as the evidence-based practices and programs identified in this Brief. Access has improved for adults with mental health and substance use disorders and for those who are at-risk for developing these disorders. Successful partnerships can link aging and behavioral health providers in the community.

Behavioral health agencies and aging service providers that partner can offer health interventions as well as link older adults to specialists who address high-risk medication and alcohol use, depression, anxiety, and suicide prevention. Primary care providers can benefit by participating in these partnerships and referring older adults to appropriate evidence-based prevention, screening, and brief intervention practices.

- Many aging service providers offer care management, chronic disease self-management, and other evidence-based health promotion and prevention programs. Aging service providers also link older adults with benefits information and long-term services and supports. Health systems that choose to partner with aging service providers and behavioral health providers can better reach dual eligible and home-bound populations and link to community-delivered evidence-based services, to ultimately improve care coordination and reduce cost.

Key components of effective aging and behavioral health partnerships that result in positive health impacts for older adults and improved service delivery systems include:

- **Leadership** of at least one state government champion who has a goal of increasing or improving access to health services, building systems of delivery, mobilizing partners, taking advantage of opportunities, and proactively developing strategies to capitalize on new opportunities.
- **Advocacy** resulting in financing, policy, or program change that increases or improves access to health services.
- **Financial Sustainability** that increases or improves access to health services.
- **Development of statewide delivery systems** that link aging and behavioral health services and that leverage both systems to increase reach and effectiveness of overall health services.

AoA Administration on Aging

SAMHSA

OLDER AMERICANS BEHAVIORAL HEALTH
Issue Brief 2: Alcohol Misuse and Abuse Prevention

Introduction

The Substance Abuse and Mental Health Administration (SAMHSA) and Administration on Aging (AoA) recognize the value of strong partnerships for addressing behavioral health issues among older adults. This Issue Brief is part of a larger collaboration between SAMHSA and AoA to support the planning and coordination of aging and behavioral health services for older adults in states and communities. Through this collaboration, SAMHSA is providing technical expertise and tools, particularly in the areas of suicide, anxiety, depression, alcohol and prescription drug use and misuse among older adults, and partnering with AoA to get these resources into the hands of Aging Network professionals.

Importance of the Problem

The misuse and abuse of alcohol in older adults present unique challenges to recognizing the problem and determining the most appropriate treatment interventions. Alcohol use problems in this age group often go unrecognized and, if they are recognized, are generally undertreated. Standard diagnostic criteria for abuse or dependence are difficult to apply to older adults, leading to under-identification of the problem. Older adults who are experiencing substance misuse and abuse are aging and vulnerable population.

Over a number of years, community surveys have estimated the prevalence of problem drinking among older adults from 1 percent to 15 percent. The rates of problems found in community surveys vary widely depending on the definitions of older adults, at-risk and problem drinking, and alcohol abuse/dependence. Estimates of alcohol problems are the highest among people seeking health care because individuals with drinking problems are more likely to seek medical care. Fourteen percent of men and 3 percent of women older than age 65 engage in binge drinking.

Guidelines for Alcohol Use

The National Institute of Alcohol Abuse and Alcoholism and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol (TIP) 26 on older adults have recommended levels of alcohol consumption to minimize risky or problem drinking and to prevent alcohol-related problems.

For adults aged 65 and older the recommended limit is:

Overall consumption:

- Men: No more than 7 drinks/week, or 1 standard drink/day;
- Women: No more than 7 drinks/week, or 1 standard drink/day;

Binge drinking:

- Men: No more than 3 standard drinks on a drinking occasion;
- Women: No more than 2 standard drinks on a drinking occasion.

Older individuals should not drink any alcohol if they:

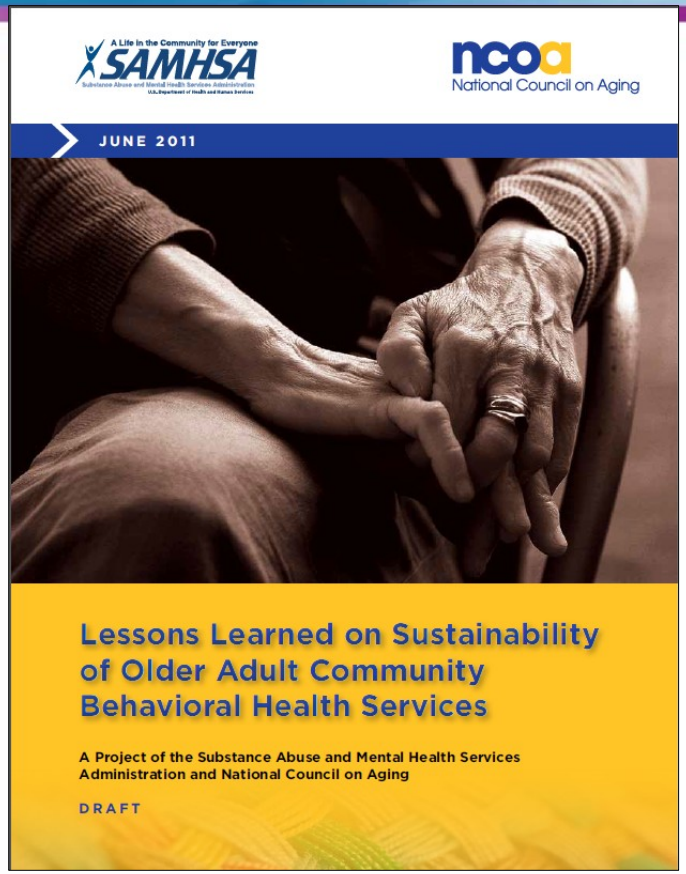
- Are taking certain prescription medications, especially psychoactive prescription medications (e.g., opioid analgesics and benzodiazepines),
- Have medical conditions that can be made worse by alcohol (e.g., diabetes, heart disease),
- Are planning to drive a car or engage in other activities requiring alertness and skill
- Are recovering from alcohol dependence, should not drink alcohol.

AoA Administration on Aging

SAMHSA

SAMHSA and NCOA Project

Lessons Learned on Sustainability of Older Adult Community Behavioral Health Services



Alixe P. McNeill, MPA and Emily A. Watson, MPH

Implementation Process: Activities and Resources—What Is Needed?

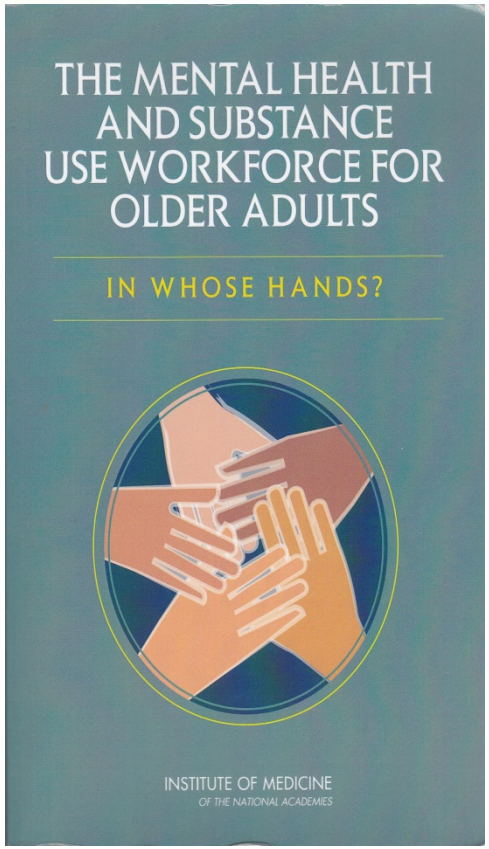
Agencies and Community Partnerships need:

- Dedicated program leadership: Champions, supervisors
- Mental/behavioral health expertise for training and coaching
- Effective linkage and communication systems with treatment providers
- Practitioners with capacity/ability to incorporate components into their existing case management routine with older adults, caregivers, or both
- System for collecting and monitoring depression and other relevant outcome data

Prepare a Community-based Interdisciplinary Workforce

In Whose Hands?
The Workforce Serving Older Adults

- Supply of trained professionals, especially for work with older adults, is inadequate.
- Service to growing under-served populations has gaps:
  - Older adults lack physical access.
  - Older adults face barriers because of culture/language.



2012

Advancing Evidence for New Workforce Roles and Models

Depression AND Anxiety
The official journal of ADAA

Research Article

LAY PROVIDERS CAN DELIVER EFFECTIVE COGNITIVE BEHAVIOR THERAPY FOR OLDER ADULTS WITH GENERALIZED ANXIETY DISORDER: A RANDOMIZED TRIAL

Melinda A. Stanley Ph.D.[1,2,3,*], Nancy L. Wilson M.S.W.[1,2], Amber B. Amspoker Ph.D.[1,2], Cynthia Kraus-Schuman Ph.D.[3,4], Paula D. Wagener B.A.[1,2], Jessica S. Calleo Ph.D.[1,2,3,4], Jeffrey A. Cully Ph.D.[1,2,3,4], Ellen Teng Ph.D.[1,2,3,4], Howard M. Rhoades Ph.D.[5], Susan Williams M.D.[2], Nicholas Masozera M.D.[3,4], Matthew Horsfield M.D.[2] and Mark E. Kunik M.D., M.P.H.[1,2,3,4]

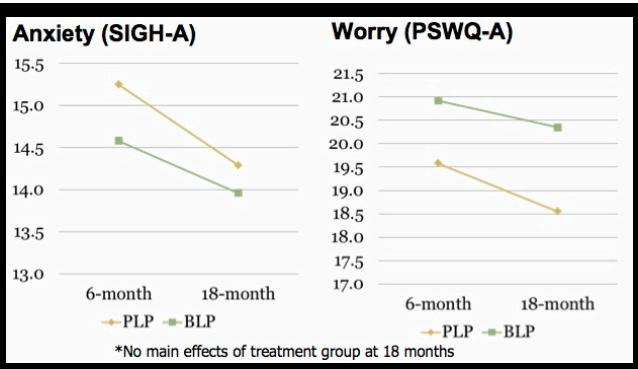
Article first published online: 27 FEB 2014

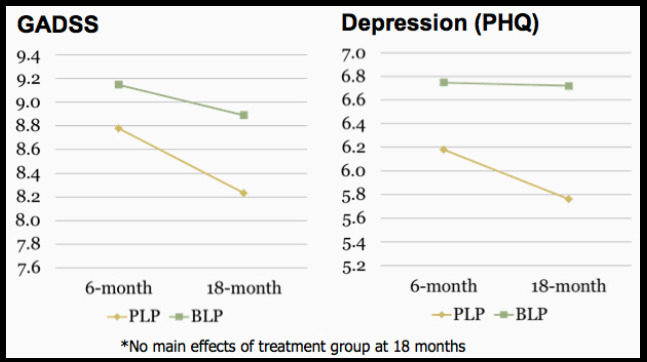
DOI: 10.1002/da.22239

Issue

Depression and Anxiety
Volume 31, Issue 5, pages 391–401, May 2014

Peaceful Living Data





Conclusions and Implications

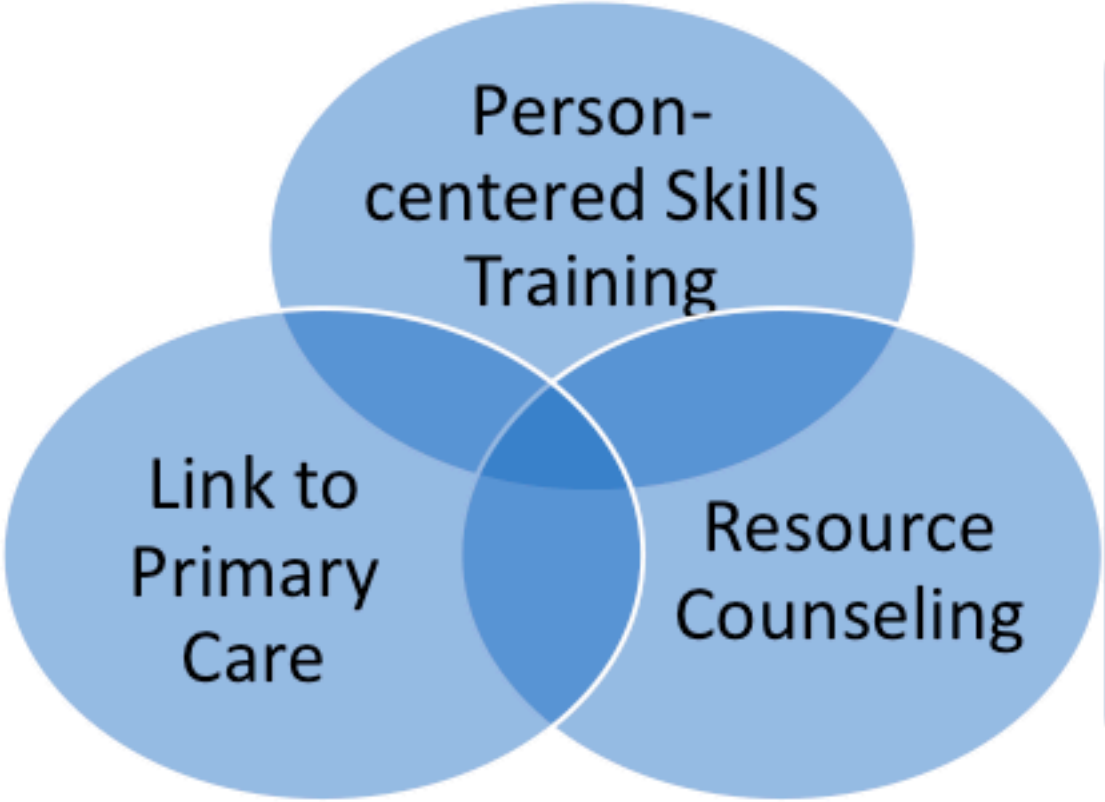
Treatment gains are maintained 12-months following the CBT intervention for both the lay and PhD level providers.

The use of supervised lay providers could help us bridge gap between evidence and meeting mental health needs of older adults.

Define requirements or guidelines for training of providers is needed.

Provide guidelines and costs for specialty supervision and consultation.

CALMER LIFE: PCORI Funding 2014-17
An Integrated Community Treatment for Worry



Training for Nontraditional Provider

(Community Health Worker; Case Manager)

CALMER LIFE Program

TREATMENT CONTENT

- Modular Treatment
  - ☑ Core and elective modules ☑ Integration of religion/spirituality
- Resource Counseling
  - ☑ Address basic unmet needs (medical, financial, meals, etc.)
- Facilitate communication with primary care provider
  - ☑ Urgent medical/psychiatric needs
  - ☑ Communication about anxiety symptoms and treatment

DELIVERY OPTIONS

- In-person delivery: Community (church, center) or home
- Telephone delivery
- Number of sessions/contacts
- Training for community providers in partner agencies (case managers, community health workers)

Academic Preparation Plays a Vital Role : Teamwork includes Self-Care & Family Care

Hartford Centers of Excellence in Geriatric Psychiatry

Interdisciplinary Practice Leadership Advancing Outcomes

PRACTICE CHANGE FELLOWS
LEADERS IN GERIATRIC CARE

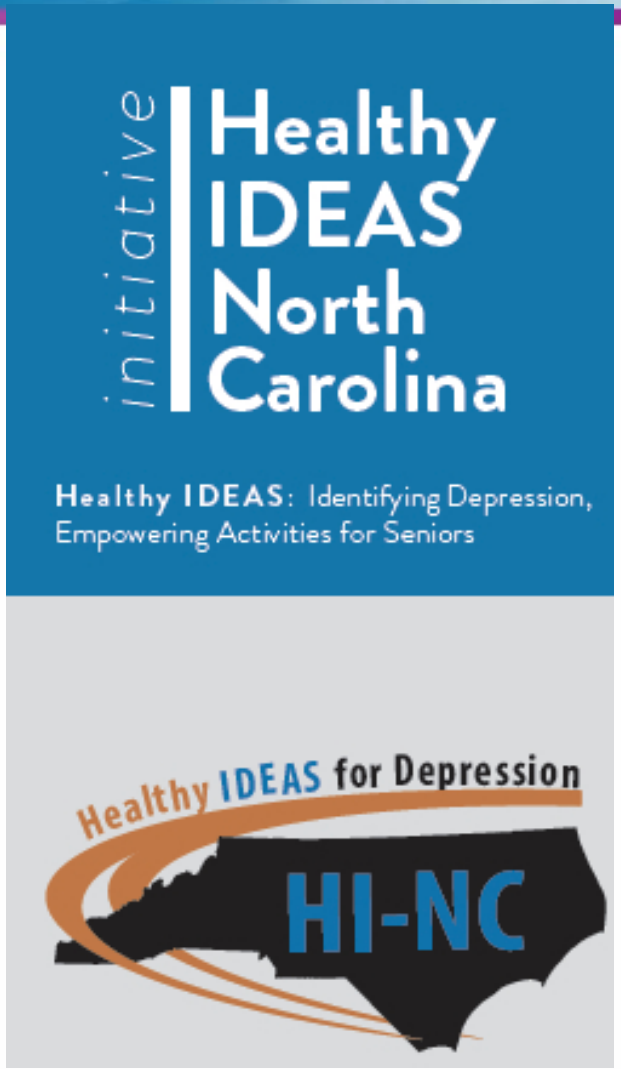
HARTFORD Change AGEnts

Practice Change Leaders for Aging and Health

REGIONAL ACADEMIC-PRACTICE CHAMPIONS
University of North Carolina School of Nursing

The University of North Carolina School of Nursing

- Acquired HRSA funding to develop clinical sites and accompanying curriculum in psychiatric nursing
- Established regional dissemination plan and procured foundation funding



REGIONAL ACADEMIC –PRACTICE CHAMPIONS
California State University, Bakersfield

CSUB leads many gerontological social work efforts in California:

- Leveraged support from the John A. Hartford Foundation ,Archstone and the California Social Work Education Center—Integrated Behavioral Healthcare Field Placement Project
- Created Project Esperanza, a Healthy IDEAS initiative, at four agencies
- Trains field instructors and student interns
- Links project with ongoing work in primary care

We Have Effective Interventions to Deliver . . . What Is Needed

Integrating Self-Management Support

EBLC
Evidence-Based Leadership Council

Healthy IDEAS

ENHANCE

HOMEMEDS

Scaling and Sustaining Is Hard Work

A MATTER OF BALANCE

FIT & STRONG!

STANFORD PATIENT EDUCATION RESEARCH CENTER

PEARLS

Core Work of EBLC

Evidence-Based Leadership Council

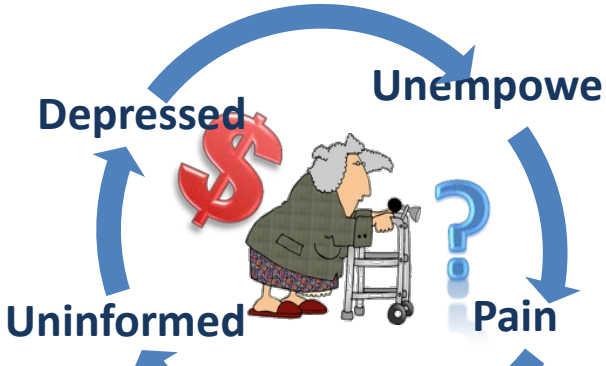
- Create opportunities to improve coordination and efficiency in the following:
  - Marketing
  - Technical assistance, including readiness assessment, fidelity, and implementation planning and evaluation
  - Training and trainers in evidence-based programs
  - Licensing and fee structures
- Develop a business model

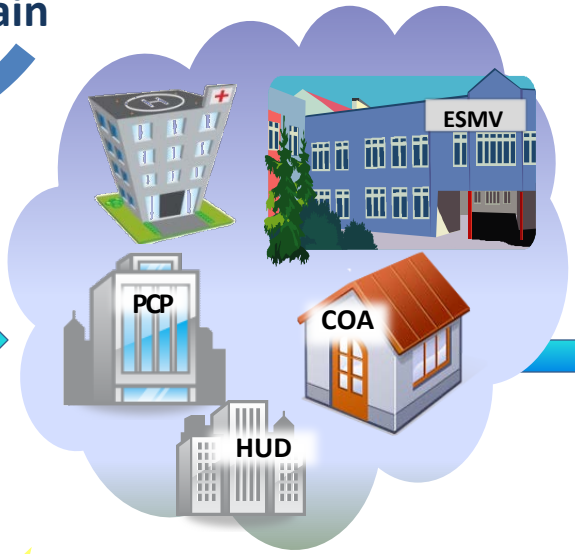
Priorities for EBLC

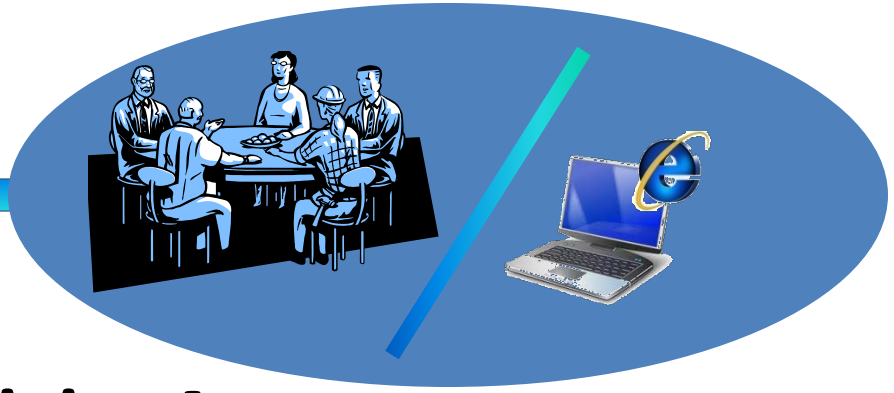
Evidence-Based Leadership Council

- National, coordinated outcome database
- Relationships with large regional and national health care systems for scaling
- Additional research—return-on-investment studies, dissemination models, and special population adaptations
- Models for implementation and sustainability
- Best practices and creative partnerships

Building an Integrated Healthcare and Social Services Delivery System: Way Forward







www.healthyliving4me.org

Reflections from an Old Bird

- Live and learn in interdisciplinary “nests” Build them —and invest in them …..
- Harvest nationally and invest in local community relationships
- Leave the home nest to connect with other “flocks “ of different species
  - National Opinion leaders
  - Policy leaders
  - Like minded birds advancing mental health and aging

Mentors, Collaborators, Colleagues

- **Charles M. Gaitz**
- **Robert J. Luchi**
- **Mark E. Kunik**
- **Melinda A. Stanley**
- **Nancy Whitelaw**
- **George Niederehe**
- Bob Applebaum
- Barbara Schneider
- Rosemary McCaslin
- Tom Teasdale
- Peter Kemper
- **Anita Woods**
- Paula Wagener
- Esther Steinberg
- **Alixe McNeil**
- **Jane Bavineau**
- Banghwa Casado
- **George Taffet**
- Nancy Hooyman
- Robert E. Roush
- Namkee Choi
- Lynn Snow
- Carl Fasser
- Laurence McCullough
- Practice Change Fellows/Leaders
- NCOA-Center for Healthy Aging
- Centers for Disease Control/HAN
- Evidence-Based Leadership Council Members

Acknowledgement of Funders & Support

- John A. Hartford Foundation
- Retirement Research Foundation
- Archstone Foundation
- NIMH
- Administration on Aging/ACL
- HRSA-Bureau of Health Professions
- Veterans Health Administration HSR&D
- Care For Elders-Houston
- Practice Change Fellows/Leaders Program
- NCOA-Center for Healthy Aging
- Centers for Disease Control and Healthy Aging Network
- SAMHSA

Thank You to The New York Community Trust
My Nominators who ALL inspire Me : Mark, Eric, the Nancys
Gerontological Society of America
My GSA Family: (You know who you are)
MY FAMILY