Community Models of Care: Healthy IDEAS and PEARLS

A Time for Transition: Policy, Practice and Research in Aging & Mental Health
October, 2009

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NCOA’s Mission
To improve the lives of older Americans.

Who We Are
NCOA is a non-profit service and advocacy organization based in Washington, DC.

Visit www.ncoa.org

National Council on Aging

What We Do
• NCOA is a national voice for older adults - especially those who are vulnerable and disadvantaged -- and the community organizations that serve them.
• NCOA brings together non-profit organizations, businesses and government to develop creative solutions that improve the lives of all older adults.
• NCOA works with thousands of organizations across the country to help seniors live independently, find jobs and benefits, improve their health, live independently and remain active in their communities.
HEALTHY IDEAS

Identifying Depression
Empowering Activities for Seniors

Program to Encourage Active, Rewarding Lives for Seniors

Acknowledgement:
Our Contributors and Partners

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Area Agency on Aging for Seattle/King County
Pam Piering and Dick Sugiyama, MSW

University of Washington:
Health Promotion Research Center
A CDC-funded Prevention Research Center
Mark Snowden, MD, MPH; Sheryl Schwartz MPH
Session Outline

- Need for Community Depression Programs
- Key Components of Depression Care Management Model ....Delivered through Aging Services Linked to Mental Health Services
- Healthy IDEAS and PEARLS
- Implementation Steps and Lessons
- Q & A - Opportunities for Action

**Depression is Common, Costly, Disabling, and Deadly**

- Depression affects 15%-20% of older adults:
  - Depression is Costly:
    - Expensive (50-100% higher health care costs)
    - Increased Morbidity, Mortality, Non-adherence, recovery
  - Depression is Disabling:
    - #2 cause of disability (WHO)
    - Impact on Self-Care: ADLs and IADLs
  - Deadly and Reduced Quality of Life:
    - Suicide: Elderly at greatest risk
    - Co-morbid illnesses Affected: Diabetes, Heart Disease
  - Costly:
    - Expensive (50-100% higher health care costs)
    - Increased Morbidity, Mortality, Non-adherence, recovery

**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"
    - "What will this pill do?"
- Provider Barriers
  - Lack of knowledge and skills
  - 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

**PUBLIC HEALTH**

- Increase awareness / reduce stigma
- Eliminate health disparities
- Improve access to services

[http://www.cdc.gov/aging/]
Setting Priorities for Older Adults

**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

Why Address Depression Within Community Agencies?

- Reaching high-risk populations
- Established rapport-cultural and linguistic competence
- Often already asking information on medication, health-co-occurring issues
- Existing focus on well-being and linkages with medical and community resources

Community Agencies Reach High-Risk, Underserved Older Adults

**Risk Factors:**
- Female
- Prior History
- Illness/Disability
- Family History
- Loss
- Financial Strain
- Immigrants
- Social Isolation

What We Know

- Health Disparities are significant
- Proactive Identification of depression is critical but not sufficient.
- Effective methods to identify, evaluate, & treat depression and improve quality of life are available.
- Strong evidence: depression care management and cognitive behavioral therapy approaches.
### Depression Care Management

**Core Components**

1. Screening / case finding
2. Patient education / self-management support
3. Support medication treatment
   - Monitor adherence, side effects, effectiveness
4. Proactive outcome measurement / tracking
   - e.g., PHQ-9, GDS, CES-D
5. Brief counseling (PST, CBT)
6. Psychiatric consultation / caseload supervision
7. Stepped care
   - Increased intensity, specialty mh referral as necessary

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### PEARLS Intervention

- Client’s screened in current setting of service:
  - Screened with PHQ-2 initially, now use CES-D-11
  - Community agency, veteran’s outreach, senior center
- Linked to a trained PEARLS depression care manager
  (not their current case manager)
- Receive service at home or place of client’s choosing
- Eight in-person, one-hour sessions
- Six monthly follow-up phone calls

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### Home-Based Depression Care Management

**PEARLS**

For Toolkit and Training Details:
http://depts.washington.edu/pearspr/

For more information about the PEARLS program, please e-mail Sheryl Schwartz at sheryls@u.washington.edu or call 206-685-7258.

### PEARLS Intervention

- Measurement-based outcomes: PHQ-9 done at each visit
- Trained depression care manager: part or full-time conducting PEARLS
  - Recruited from agency case managers
  - Training over 2 days in Seattle, Washington
  - Training and manual include skills/tools:
    - Problem Solving Treatment
    - Physical Activation (30 mins, 5D/wk)
    - Social Activation
    - Pleasant Events
Clinical Supervision: Washington Model

- Two times/month: PEARLS providers and clinical supervisor
- Team approach, learn from peers and supervisor
- Discuss depression level, medical complications, and difficult situations
- Ideally, with a psychiatrist; other experienced mental health professional OK, with access to psychiatrist as needed.
- Potential communication with PCP

PEARLS Participant Criteria: Study and Beyond

Inclusion:
- Age 60+ (original research-expanded to ages 50-59)
- Diagnosis of minor depression or dysthymic disorder
- Recipient of services from Senior Services or Aging & Disability Services, or resident of public housing
- Added Filipino Veteran’s, respite care clients, Chinese

Exclusion:
- Major depression and other psychiatric disorders (e.g., bipolar disorder and psychotic disorder)
- Substance abuse
- Cognitive disorder

Study Participant Demographics

<table>
<thead>
<tr>
<th></th>
<th>Usual Care (n=66)</th>
<th>Intervention (n=77)</th>
<th>Total (n=138)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>50 (76%)</td>
<td>59 (82%)</td>
<td>109 (79%)</td>
</tr>
<tr>
<td>Average age</td>
<td>73.5</td>
<td>72.6</td>
<td>73.0</td>
</tr>
<tr>
<td>Living Alone</td>
<td>43 (65%)</td>
<td>56 (78%)</td>
<td>99 (72%)</td>
</tr>
<tr>
<td>Ethnic Minority</td>
<td>28 (43%)</td>
<td>30 (42%)</td>
<td>58 (42%)</td>
</tr>
<tr>
<td>No. of Chronic Conditions</td>
<td>4.6</td>
<td>4.5</td>
<td>4.6</td>
</tr>
<tr>
<td>Annual Household income</td>
<td>33 (51%)</td>
<td>45 (64%)</td>
<td>78 (58%)</td>
</tr>
</tbody>
</table>

PEARLS Study Results
6 month (N=138)

JAMA 2004; 291:1569-1577

Usual Care
- Usual Care
- Usual Care
- Usual Care
- Usual Care

Intervention
- Interventation
- Intervention
- Intervention
- Intervention

Total
- Total
- Total
- Total
- Total

P<.01  P<.01  P=.07
PEAKS Study Results and Lessons

- Quality of Life Results
  - Improved Emotional Well-being
  - Improved Functional Well-being

- Lessons learned
  - Ongoing promotion/education required: to engage referrals and clients
  - AAA can be a valuable referral source
  - Flexibility in the model

Dissemination and Training Continues:
Washington State and Beyond

- Area Agencies on Aging and Medicaid service providers
- Senior Services of Seattle: Senior Centers
- Current or anticipated PEARLS implementation in:
  - Washington state: Seattle area, Spokane (AAA), others
  - SE Vermont
  - Ohio
  - California
  - New York
  - Iowa
  - Wisconsin

Future Directions

- PEARLS for Mandarin-speaking Chinese clients
- PEARLS for Russian- and Somali-speaking participants (Pilot testing of interpreter usage)
- PEARLS for seniors with major depression
- Potential funding under Washington’s COPES Medicaid Waiver Program

PEARLS Resources

- Refer to the Action Brief on PEARLS (handout)
- Web: www.depts.washington.edu/pearlsp
- Implementation Toolkit
- Trainings (check website for dates)
- Phone and e-mail consultation
- Contact Sheryl Schwartz sheryls@u.washington.edu
  206-685-7258
Healthy IDEAS: Following the Depression Care Management Road Map

- Science to Service
- Used an approach translated from specific scientific random controlled positive research.
- Combines evidence-based components from other depression interventions including these major depression studies:
  - PEARLS AND IMPACT
- Retains the key elements of the programs to ensure known evidence-based ingredients remain (Fidelity).

Evidence for Healthy IDEAS Components

- IMPACT AND PEARLS offered the "care management road map" and evidence for in-home approach
- Screening and Assessment: Early recognition of depression facilitates treatment and can be done by non-professionals using valid tools. (Whooley et al., 1997, Sheikh & Yesavage, 1986, Williams et al. 2002.)
- Education, Linkage, and Self-management Support: (Unützer et al., 2002 and Hunkeler et al., 2000.)
- Behavioral Activation: Helping clients “activate” to increase behaviors that fit with life goals and produce rewards will help decrease depressive symptoms. (Hopko et al., 2003, Jacobson et al., 2000.)

Core Program Components

- **Screening** for symptoms of depression & assessing severity
  - Two-question screen & standardized assessment
  - 15 item Geriatric Depression Scale (GDS) or PHQ-9
- **Educating** older adults & family caregivers about depression & effective treatment: including self-care & medication.
- **Referral, linkage & follow-up** for older adults with untreated depression to health or mental health providers.
- **Behavioral Activation (BA)** empowering older adults to manage their depressive symptoms by engaging in meaningful, positive activities.

Target Population

**Underserved Populations**

- Ethnically diverse and socio-economically diverse populations of older adults who are at high risk for depressive symptoms and living in the community.

**Inclusion Criteria:**

- 60+
- Currently enrolled in a care or case management program
- Cognitive ability to participate
- Able to communicate verbally
Program Design

- Embedded in case management programs
- Case managers visit clients in their home and do telephone follow-up with individuals in the community over a 3-6 month period—not a separate case manager
- A manual outlines the steps and includes written worksheets, client handouts, and forms to support and document the steps and client outcomes. (SEE Guide Handout)
- Community partnership approach for training, evaluation & fidelity.
- Partner with health & mental health care providers to facilitate referral.

Delivery Experience and Outcomes

- Older adults vary in their “readiness” to address depression
- Most elders prefer treatment through primary care; others accept mental health services
- Increased participation in BA associated with better outcomes
- Medication Use is common, yet not always effective

Client Demographic Profile

<table>
<thead>
<tr>
<th></th>
<th>Clients Screened (n=327)</th>
<th>GDS Positive Clients (n=94)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age</td>
<td>75.9 years old (SD=9.5)</td>
<td>72.5 years old (SD=9.4)</td>
</tr>
<tr>
<td>Gender</td>
<td>76% female</td>
<td>80% female</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>¾ Hispanic: 28%</td>
<td>&gt; Hispanic: 44%</td>
</tr>
<tr>
<td></td>
<td>¾ African American: 43%</td>
<td>&gt; African American: 20%</td>
</tr>
<tr>
<td></td>
<td>¾ Caucasian: 27%</td>
<td>&gt; Caucasian: 34%</td>
</tr>
<tr>
<td></td>
<td>¾ Other: 2%</td>
<td>&gt; Other: 2%</td>
</tr>
<tr>
<td>Cognitive Errors</td>
<td>1.4 (SD = 1.4)</td>
<td>1.6 (SD = 1.5)</td>
</tr>
<tr>
<td>Living Alone</td>
<td>67% (SD = 1.4)</td>
<td>90% (SD = 1.4)</td>
</tr>
<tr>
<td>Mean Income**</td>
<td>$788/month</td>
<td>$846/month</td>
</tr>
<tr>
<td>Education</td>
<td>¾ 6 years or less: 24%</td>
<td>&gt; 6 years or less: 23%</td>
</tr>
<tr>
<td></td>
<td>¾ 7–12 years: 55%</td>
<td>&gt; 7–12 years: 50%</td>
</tr>
<tr>
<td></td>
<td>¾ 13+ years: 21%</td>
<td>&gt; 13+ years: 27%</td>
</tr>
<tr>
<td>Comorbidities***</td>
<td>3.1 (SD = 1.7)</td>
<td>3.6 (SD = 1.8)</td>
</tr>
<tr>
<td>3+ IADL Limitations***</td>
<td>59%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Client Impact

- Reduction in depression severity
- Reduction of self-reported pain
- Increased knowledge of how to get help for depression.
- Increased level of activity
- Knowledge of how to manage depressive symptoms.
GDS Outcomes
(15 item scale)

Scores at 3 and 6 months differ from baseline at \( p < .0001 \)

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Clients Reporting Pain

Scores comparing Baseline to 6 months differ at \( p < .005 \)

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Agency Impact

- Staff are trained to deliver an evidence-based intervention
- Adds credibility to the work
- Case management services are expanded to include mental health
- OK to talk about & take action on Depression
  - “I was surprised that my clients were not only willing to talk about their mood but chose to do something.”
  - “What seemed like a small step to me helped my client feel successful”

Community Impact

- Reached under-served populations
  - low-income, physically frail, ethnic and racial minorities
- Improved linkage between community aging service providers and health/mental health professionals
- Fostered community academic partnerships
- Helped prevent recurrence of depression
45 Healthy IDEAS Programs
active/starting in 13 states

Current Adopters in:
- Arizona
- Delaware
- Florida
- Georgia
- Hawaii
- Illinois
- Maine
- Maryland
- Michigan
- New Jersey
- Ohio
- Texas
- Vermont

Organizations considering adoption in additional states:
- California
- District of Columbia
- Minnesota
- Nebraska
- New Hampshire
- New York
- North Carolina
- Virginia
- Wisconsin
- Inquiries from many more

Maine Experience
- Lead: Elder Independence of Maine
  - an Area Agency on Aging and home care coordination agency
- Statewide: rural and urban
- Funding: OAA & Medicaid HCBS Waiver
- Case Managers: BAs, LSWs, RNs
- Clients: Caucasian, education high school or less, low-income

Fort Worth, Texas Experience
- Lead: Area Agency on Aging of Tarrant County and United Way
- Urban County
- Collaborative Model with agencies linked - Catholic Charities, Meals on Wheels, Senior Service, Mental Health Association and Authority
- Funding: OAA built into agency financing
- Case Managers: BAs, LSWs
- Clients: African Amer., Hispanic, Caucasian

Ohio Experience
- Lead: State Mental Health with Aging and Substance Abuse
- Statewide: urban and rural
- Model: Older Ohioans Behavioral Health Network leadership; local AAAs and county MH partners
- Funding: SAMHSA MH Transformation Funds/mini grants to local AAA agencies (Integrated CM for Medicaid and OAA funded services)
- Case Managers: BAs, LSWs, RNs
- Clients: African Amer., Hispanic, Caucasian
**Other Experience**

- Florida
  - Local health foundation
  - 3 lead agencies, 80% minority populations
- New Jersey
  - State Aging OAA grants to Jewish Family Services, Medicaid HCBS waiver, MSWs
- Hawaii
  - Lifespan community family service provider to Asian and minority populations, BAs,

**Lessons Learned**

- Various lead and provider agencies
- Success in urban and rural areas
- Success with racially and ethnically diverse groups; many low-income
- Variety in start-up funding
- Embed practice for sustainability

**Challenges**

- **Stigma** - among clients and providers
- **Reluctance to change** - Clients and staff both have to learn new behaviors
- **Resources** - Affordable mental health diagnostic or treatment services
- **Time** required for the intervention - in the face of competing demands
- **Commitment** - at the agency level to addressing depression and supporting a change process.

**Healthy IDEAS Readiness Assessment**

- Online survey from NCOA and Healthy IDEAS
- Assesses agency capacity and willingness to implement Healthy IDEAS by measuring key program elements:
  - Staffing
  - Partnerships
  - Case Management Practice
  - Record Keeping and Reporting Systems
  - Organizational Culture and Support
  - Program Leadership
  - Innovativeness
  - Evidence-based Experience
Readiness Report Grid

Graphic representation of a potential adopter organization’s readiness status in terms of each critical element of an innovative program.

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

Implementation Process: Activities and Resources

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

Healthy IDEAS Replication

- Tools for assessing organizational readiness
- Plan includes approach and tools for each core component

- Healthy IDEAS National Trainers in Community
- Technical Assistance via telephone consultation as your team develops local plans
For More Information

- Replication report: NCOA-Center for Healthy Aging website [http://www.healthyagingprograms.org](http://www.healthyagingprograms.org)
- Care for Elders: [www.careforelders.org/healthyideas](http://www.careforelders.org/healthyideas)

Resources

- NCOA Center for Healthy Aging website [www.healthyagingprograms.org](http://www.healthyagingprograms.org) mental health materials / Depression Webinar Series
- 2 new CDC Issue Briefs: Addressing Depression in Older Adults