



Integrated Care of Older Adults with Mental Disorders RESOURCE DOCUMENT

Approved by the Joint Reference Committee, January 2009

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The documents was prepared by the Ad Hoc Subcommittee on Integrated Care of the Elderly¹, November 2008.

I. Introduction

Elderly persons often have complex medical and psychiatric needs for which the input of different medical specialties and clinical disciplines is required. The involvement of multiple specialists gives patients access to greater expertise than any single clinician could provide; however, it presents significant challenges of coordination and integration of health care. We endorse the ideal of providing well-coordinated interdisciplinary treatment to older Americans with psychiatric and medical problems but recognize that this ideal is not easily or often fully realized. In this document, we provide a brief review of the problem and describe a number of models that seek to provide exemplary care to elderly persons with psychiatric and medical problems by mobilizing and integrating the input of multiple specialties and clinical disciplines. We conclude with recommendations for policy, services design, and training.

II. Elderly persons with mental health problems and medical illnesses—the current state of affairs

A. *Epidemiology: How big is the problem?*

1. The prevalence of mental disorders among Medicare beneficiaries is high.
 - a. 26% of Medicare beneficiaries have mental disorders
 - b. 59% of Medicare beneficiaries with disabilities have mental disorders;
2. Persons with mental disorders have high rates of medical comorbidity.
 - a. Persons with mental illness die on average 25 years earlier than persons without mental illness due primarily to common medical conditions, such as cancer and cardiovascular disease.
3. The elderly will be the most rapidly growing segment of the population over the next several decades, so we will need to have the resources to treat rapidly growing numbers of elderly persons with mental illness and significant comorbid medical conditions.

B. *Treatment settings—Where is care provided?*

1. Homes (this would include patient's, family's, others)
2. Primary care ambulatory settings
3. Specialty mental health ambulatory settings
4. Hospitals
 - a. Medical-surgical units in general hospitals
 - b. Behavioral health units in general hospitals
 - c. Psychiatric specialty hospitals
 - d. Hospital-based outpatient clinics
 - e. Long-term acute care hospitals
5. Long-term care facilities (nursing homes and assisted living facilities)

C. *Workforce—Who provides the care?*

1. Primary care physicians and physician-extenders (e.g., nurse practitioners and physician assistants)
2. Mental health professionals
 - a. Psychiatric nurses
 - b. General psychiatrists
 - c. Geriatric psychiatrists
 - d. Psychologists
 - e. Social workers

D. *Funding—Who pays for care?*

1. Federal/State programs
 - a. Medicare
 - b. Medicaid
2. Commercial carriers, including HMOs

III. Integrating ambulatory care: The challenge of coordinating care across providers, time, and space

A. *Poorly coordinated care is at best less effective and less efficient; at worst it is dangerous to patient safety*

B. *Models of integration (Buchanan and Berg)²*

1. Enhanced referral
2. Training of primary care professionals
3. Consultation
4. Co-location of primary and behavioral healthcare providers
5. **Collaboration**
 - a. Definition: "Collaborative care involves providers from different specialties, disciplines or sectors working together to offer complementary services and mutual support, to ensure individuals receive the most appropriate service from the most appropriate provider in the most suitable location, as quickly as necessary, with a minimum of obstacles. Collaboration can involve better communication, closer personal contacts, sharing of clinical care, joint educational programs and/or joint program and system planning" (Canadian Collaborative Mental Health Initiative, page 3).³

C. *Experimental models of collaboration*

1. IMPACT (Improving Mood – Providing Access to Collaborative Care)⁴
 - a. Setting: 18 primary care clinics in 5 States
 - b. Mental health staffing: depression care specialist (nurse or psychologist) and supervising psychiatrist
 - c. Intervention: Depression care specialist (DCS) assessed elderly patients with major depression or dysthymia, provided them with educational materials, discussed treatment preferences (medications, problem-solving psychotherapy), reviewed results of assessment with supervising psychiatrist and liaison primary care expert, and worked with patients primary care physician to establish treatment plan. DCS then provided weekly monitoring (in-person or by phone), helped develop a relapse prevention plan, and contacted patient monthly thereafter to provide support.
 - d. Outcome: Compared to treatment-as-usual, the intervention resulted in higher rates of depression treatment, greater improvements in depressive symptomatology, and greater patient satisfaction with care.
2. PROSPECT (Prevention of Suicide in Primary Care Elderly)⁵
 - a. Setting: 20 primary care clinics in New York City, Pittsburgh, and Philadelphia
 - b. Mental health staffing: depression care managers (social worker, nurse, or psychologist) and supervising psychiatrist
 - c. Intervention: Primary care physicians were given a clinical algorithm for treating geriatric depression in a

- primary care setting. Practice-based, depression care managers collaborated with physicians to help them recognize depression, offering guideline-based treatment recommendations, monitoring clinical status, and providing appropriate follow-up. Patients were initially offered citalopram, but if they declined medication therapy, the physician could recommend interpersonal therapy from the care manager.
- d. Outcome: Compared to usual care, the intervention resulted in faster resolution of suicidal ideation. Intervention patients also had faster and more complete symptom reduction.
3. PRISM-E (Primary Care Research in Substance Abuse and Mental Health for the Elderly)⁶
- a. Setting: 10 sites consisting of primary care and specialty mental health/substance abuse clinics
- b. Mental health staffing: social workers, psychologists, psychiatric nurses, psychiatrists, and master's level counselors
- c. Intervention: Integrated models included (1) mental health and substance abuse services co-located in primary care; (2) mental health and substance abuse services provided by licensed mental health/substance abuse providers; (3) communication between mental health/substance abuse and primary care providers; (4) an appointment with mental health/substance abuse provider within 4 weeks following the primary care appointment.
- d. Outcome: Compared to enhanced referral care, older adults who received mental health services integrated into primary care were more likely to receive mental health care.
4. RESPECT-D (Re-Engineering System in Primary Care Treatment of Depression)⁷
- a. Setting: Five healthcare organizations and 60 affiliated practices
- b. Mental health staffing: Care managers with background in mental health or primary care supervised by a psychiatrist
- c. Intervention: Care provided by primary care clinicians with trained intervention staff (backgrounds in primary care and mental health nursing) providing telephone support under supervision from a psychiatrist. Intervention included a systematic approach to the assessment and management of depression by the clinician, with a centrally based care manager providing tele-phone support for patients. Care managers made monthly calls to assist patients in overcoming barriers to adherence to the protocol. They also supported self management practices such as exercise or engaging in social activities. Care managers also assessed symptoms of depression which were provided to the psychiatrist who recommended changes in treatment either to the care manager or to the primary care clinicians.
- d. Outcome: Compared to usual care, patients in the intervention group had higher rates of response and remission.
5. UPBEAT (Unified Psychogeriatric Biopsychosocial Evaluation and Treatment)⁸
- a. Setting: 9 VA medical centers in California, Florida and the northeastern US
- b. Mental health staffing: Care coordinator (nurse, social worker or psychologist) and mental health clinicians of various disciplines
- c. Intervention: In-depth structured diagnostic assessment, assignment to care coordinator, collaboration between primary care and mental health clinicians, inclusion of patient preferences in an individualized multidisciplinary care plan, proactive follow-up and outcomes monitoring by the care manager.
- d. Outcomes: Improvement at 12 month follow-up in various measures of physical and mental health; reduced inpatient utilization; increased outpatient costs but decreased total costs due to reduced inpatient utilization.
6. "Effectiveness of collaborative care for older adults with Alzheimer disease in primary care"⁹
- a. Setting: Primary care practices in 2 US university-affiliated health care systems
- b. Mental health staffing: Psychologist developed behavioral management protocols for clinicians and caregivers; psychologist and geriatric psychiatrist met weekly with the care manager (advanced practice nurse) and a medical geriatrician to review the care of new and active patients and monitor adherence to standard protocols
- c. Intervention: Intervention patients (as opposed to care-as-usual patients) received 1 year of care management by an interdisciplinary team led by an advanced practice nurse working with the patient's family caregiver and integrated within primary care. The team used standard protocols to initiate treatment and identify, monitor, and treat behavioral and psychological symptoms of dementia, stressing nonpharmacological management.
- d. Outcome: Intervention patients were more likely to receive cholinesterase inhibitors and antidepressants and had fewer behavioral and psychological symptoms of dementia at 12 and 18 months without significant increases in the use of antipsychotics or sedative-hypnotics. Caregivers showed improvement in measures of distress and depression.
- D. *Messages emerging from the empirical literature on collaboration (Canadian Collaborative Mental Health Initiative)*¹⁰
1. Collaborative relationships among providers and systems of care require preparation, time and supportive structures
 2. Co-location is valuable for both providers and patients (important)
 3. Degree of collaboration does not in itself predict outcome
 4. The pairing of collaboration with treatment guidelines appears to offer advantages over either intervention alone
 5. Collaboration paired with treatment guidelines may most clearly show superiority over routine care in patients with the most severe symptoms
 6. Systematic follow-up may be one of the most important predictors of good outcomes in depression
 7. Multidisciplinary efforts to increase medication adherence are a component of many successful studies
 8. Patient education about mental health provided by a mental health professional—rather than a primary care provider—was a component of many successful studies
 9. Patient choice about treatment (e.g., drugs, psychotherapy) may be an important factor in treatment engagement in collaborative care
 10. Collaboration alone does not have lasting impact on the knowledge of primary care providers regarding treatment of depression
 11. Collaborative interventions funded by research grants may be difficult to sustain once research funding is terminated.

E. "Real world" models of integration

1. Erickson model
 - a. Setting: Geriatric medical clinic located within a continuing care retirement community
 - b. Primary care staffing: Employed internists and nurse practitioners
 - c. Mental health staffing: Employed advance practice psychiatric nurse (full-time) and part-time geriatric psychiatrist (on-site 4 hours per week and on-call for emergencies).
 - d. Mode of mental health practice: Nurse is initial consultant, mental health "case manager," and psychotherapist. Psychiatrist provides advanced consultation and is actively involved in ongoing treatment of difficult cases. Primary care physician collaborates with and provides close oversight of the advanced practice nurses and reviews all their notes and treatment decisions.
2. VA model
 - a. Setting: Geriatric medical clinic in a community based outpatient clinic
 - b. Primary care staffing: Internists, nurse practitioners, and nurses
 - c. Mental health staffing: Part-time geriatric psychiatrist (on-site four hours per week and on-call for emergencies).
 - d. Mode of mental health practice: Psychiatrist provides consultation and is actively involved in ongoing treatment of complex patients.

IV. Recommendations for policy, services design, and training

- A. All forms of care integration, especially higher levels (e.g., collaboration), involve start-up costs and ongoing operational costs. Payers such as Medicare should provide financial incentives for integration of care, including reimbursement for case management services and telephone contact between clinicians.
- B. Health services for older adults should always be designed to include well-integrated mental health services as a matter of principle. This includes programs such as the Medical Home demonstration projects.
 1. Psychiatric practices and programs should be considered potential "medical homes" for appropriate patients, such as persons with serious mental illness for whom the mental health center may be the only connection to health care services of any kind.
 2. Services provided by multidisciplinary mental health teams should be integral elements of "medical homes" built around internists and other primary care providers.
- C. While collaboration may be the most desirable form of integration, other forms of integration (e.g., co-location) should also be encouraged because they offer advantages over poorly coordinated care and may be easier to implement than formal collaborative models (e.g., the RESPECT-D).
- D. Because of the enormous mismatch between the growth of the elderly population and availability of professionals trained in the care of older adults, programs and policies should be developed to increase the size of the geriatric mental health workforce in all disciplines.
- E. Because Medicare payment policy currently creates disincentives for practitioners to specialize in the care of the elderly, Medicare payment policy should consider such revisions as:
 1. Increasing Medicare Part B professional reimbursement annually to keep pace with inflation;
 2. Providing incentive payments to mental health care providers whose practice is primarily with the elderly.
- F. Because of the evidence that integrated care is more effective than standard care, particularly when integrated care includes use of practice guidelines in the care of individuals with more severe disorders (e.g., major depression as distinct from "minor depression"), Medicare payment policy should provide

reimbursement incentives for the use of practice guidelines in integrated care models for persons with major depression.

- G. Because of evidence that co-location can improve outcomes, co-location of primary care and mental health services should be encouraged. While this may usually mean having mental health services provided in primary care settings, it may be more effective to bring primary care providers into the mental healthcare setting for certain populations, such as elderly persons with schizophrenia who receive care in community mental health centers. Medicare payment policy should provide reimbursement incentives for co-location.
- H. Providers of mental health care services should receive specific training in how to collaborate with and provide consultation to primary health care clinicians.
- I. The APA should work with SAMHSA and with other professional organizations to develop "toolkits" to guide primary care and mental health clinicians in the implementation and maintenance of collaboration and other forms of integration in the care of older adults.

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¹⁰ Buchanan and Berg, op. cit.