Aging & Behavioral Health Partnerships - Strategies for SUCCESS!

Speakers:

- Marian Scheinholtz, Public Health Advisor, U.S. Substance Abuse and Mental Health Administration
- Sherri King, Pam Werner, John Fryer, Karen McCloskey, The Michigan Office of Services to the Aging and Michigan Department of Community Health
- Pam Capaci, Prevention Links, Inc.
Older Adult Behavioral Health: Issues and Background

Marian K. Scheinholtz, MS, OT/L
National Council on Aging Webinar
May 13, 2014
What We All Know Is Coming

- 13 percent of U.S. population age 65+; expected to increase up to 20 percent by 2030

- 78 million “Baby Boomers” (born from 1946-1964) in U.S. Census 2000
  
  - Second wave “Baby Boomers” (now aged 35-44) contains another 45 million people.
What You May Not Know: Projected Prevalence of Major Psychiatric Disorders by Age Group

![Graph showing projected prevalence of major psychiatric disorders by age group from 2000 to 2030. The graph indicates an increase in prevalence across all age groups, with the elderly (65+) experiencing the most significant rise.]
Older Adult Mental Health Problems

• 1 in 4 persons aged 55+ experience anxiety and mood disorders (Bartels)

• 1 in 5 older adults in the community experience symptoms of depression (AAGP)

• 1 in 3 older adults in primary care experience symptoms of depression (AAGP)

• Depression is costly, disabling and deadly
BUT

• Mental health and substance use disorders:
  – Are not a part of normal aging
  – Are treatable

• Numerous Evidence Based Practices and modalities exist for Recovery from Depression and Anxiety in Older Adults
Older Adults in Jeopardy

• By 2030 number of older adults in U.S. with major psychiatric illnesses is projected to reach 15 million

• Older adults comprise about 12% of current U.S. population, yet account for nearly 17% of all suicides
  – @ 40% higher than other adults in U.S.
Prevalence of Anxiety Disorders

• 3-12% prevalence in the community
  • Specific phobias (SP) & Generalized Anxiety Disorder (GAD) are most prevalent
  • Social phobia, OCD, panic disorder, and Post Traumatic Stress Disorder (PTSD) are less common
  • Prevalence is similar to incidence in younger adults
  • There may have been history of anxiety disorder in younger years
Anxiety Disorders Treatment

• Medication –
  – Issues – potential for abuse, mixing with other substances; physical changes in older adults

• Therapy
  – No particular type of psychotherapy is recommended for anxiety in older adults

• Alternatives and Complementary Therapy
  – Stress and Relaxation Techniques, Yoga, Acupuncture

• SAMHSA Older Adult – Targeted Capacity Expansion Program served older adults who had been in concentration camps
  – They experienced both depression and anxiety disorders
  – Peer support was very helpful
  – Trauma was passed on to children & grandchildren
Substance Use/Misuse in Older Adults

- 3 in 10 older adults use 5 or more prescription drugs (plus OTC, supplements, herbals)
- Many side effects, drug interactions
- An estimated 1 in 5 older adults may be affected by combined difficulties with alcohol and medication misuse
Substance Abuse Issues and Treatment

• Chronic health conditions
  – 80% have 1 CHC
  – 50% have at least 2 CHC
• 1997-2008 Hospital admissions +96%
• Traditional Substance Abuse Tx not “user friendly” to older adults
• Only 3 inpatient programs exist in the United States specifically for older adults with substance abuse problems.
Suicide Is a Preventable Tragedy

Suicide Rates for Ages 65 to 85+

- **Age Group**: 65-69, 70-74, 75-79, 80-84, 85+

- **Rates per 100,000**

- **Legend**:
  - Male
  - Female

- **Graph** shows the suicide rates for different age groups and gender.
Suicide in Older Adults

- Older adults = 12% of U.S. population
  16% of suicides
- Especially white males over age 64
- Attempts are more lethal
  - 1/4 vs. 1/100-200 in young adults
- Up to 75% visited MD in last month before suicide
- Suicide is strongly associated with depression and other mental illnesses
National Issues that Influence Behavioral Healthcare

- Health Seeking Behavior and Healthcare Services are changing in the United States
  - Aging Baby Boomers will impact health delivery system
- Evidence Based Programs and Practices must be part of the future to Address Physical and Mental Health of Older Adults
- Changes (in payment, service systems, services delivery) will be based on outcomes and performance (Data)
- Partnerships are at the core of health reform (ACO’s, Integration of physical and behavioral health, Social services for older adults meshing with changes in healthcare)
Behavioral health Service System?

Behavioral Health is a component of service systems that improve health status and contain health care and other costs to society.

- People with mental and substance use disorders, because of their illness (or age), have largely been excluded from the current health care system and rely on public "safety net" programs.
- Health and wellness of the individual is jeopardized.
- Unnecessary costs to society ripple across America's communities, schools, businesses, prisons & jails, and healthcare delivery systems.
• SAMHSA provides national direction and funding for Behavioral Health Promotion, Prevention and Treatment Programs

• SAMHSA activities/direction are based on
  – Theory of change
  – Parity legislation
  – Strategic Initiatives
  – System change based on outcomes and performance (data)
“Things do not change; we change.” – Henry David Thoreau
SAMHSA Working Definition of Recovery

• A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

• Feedback to SAMHSA is desired.

SAMHSA Supports Recovery for people of all ages through:

- Enhancing uptake and dissemination of EBPs
- Implementation of programs and services that emphasize Integrated Care (Health Care Reform)
- Parity legislation requires screening, evaluation, and treatment which are commensurate with physical health care
SAMHSA Older Adult Program Goals
2002-2014

Outcomes of Programs = Current Goals

• Improvements in local infrastructure serving older adults
• Decrease in symptoms of depression, anxiety, isolation, substance misuse, suicidal thinking and actions
• Increase in functioning: engagement in meaningful activity, social connectedness and community integration
• Support for families and caregivers
• Public education to reduce discrimination and identify older adults in need of services - Gatekeeper Training
• End of silos
  • Identifying and bolstering partnerships with
  • aging networks and other community organizations
Evidence-Based Practice Modalities Used by SAMHSA Grantees

• Problem Solving Therapy
• Behavioral Activation
• Telehelp/telecheck – Befriending
• Care management
• Gatekeeper
• Wraparound networks
• Depression Care Management (Healthy IDEAS, PEARLS)
• Development of social networks
• Primary Care Integration (IMPACT)
• Activity Based Intervention
  – Physical Exercise
  – Link to Habits and Routines
Success through Partnership: New York

- IMPACT model of mental health care integration with primary health care established in 6 local demonstrations
- GATEKEEPER outreach model engaging nontraditional workers to identify individuals in need of mental health assessment and linkage to services established in 3 local demonstrations
- Health Impact:
  - IMPACT model research has resulted in 50% or greater improvement in depression; improved physical functioning and fewer thoughts of suicide.
Lessons Learned for SAMHSA Grantees:
Partnerships for EBPs with Older Adults with Behavioral Health Conditions

• Delivering care in diverse settings, such as Senior Centers, clients’ homes, primary care offices, behavioral health or social service organizations
• Developing partnerships between aging and behavioral health, social service and primary care
• Developing strategies to engage and serve persons with a variety of cultural and ethnic diversity
• Receiving training and guidance from national experts on EBP implementation

• Having an evaluation strategy to monitor process and outcome data – This helps to inform CQI, secure funding, and justify inclusion in state and local planning efforts

• Seeking diverse funding to ensure program sustainability (billing strategies, volunteers, private donors, contracts with other providers)
Resources Available

• SAMHSA/AoA – ISSUE BRIEFS, WEBINARS, STATE PROFILES ISSUE BRIEFS (AOA BEHAVIORAL HEALTH WEBPAGE)
• LESSONS LEARNED ON SUSTAINABILITY OF OLDER ADULT COMMUNITY BEHAVIORAL HEALTH SERVICES (REPORT - 2011) (NCOA WEBPAGE)
• PROMOTING-EMOTIONAL-HEALTH-AND-PREVENTING-SUICIDE – A TOOLKIT FOR SENIOR LIVING COMMUNITIES COMMUNITY SUICIDE PREVENTION TOOLKIT
• SAMHSA - EBPS on TREATING OLDER ADULT DEPRESSION TOOL KIT
• AMERICAN FOUNDATION FOR SUICIDE PREVENTION-HTTPS://WWW.AFSP.ORG/ABOUT-AFSP
Chronic Disease Self-Management and Mental Health in Michigan

Sherri King
Pam Werner
John Fryer
Karen McCloskey

The Michigan Office of Services to the Aging and Michigan Department of Community Health
2012 Michigan Behavioral Risk Factor Survey Findings:

- On average, 8.7% of respondents aged 55 and older reported poor mental health for at least 14 days in the past month.

- On average, 17.6% of respondents aged 55 and older reported having been told by a provider that they had depression.
2013 Michigan Office of Services to the Aging
Statewide Needs Assessment: (aged 60 and better)

• 78% of respondents (3287) indicated they have access to mental health care
• 29% (960) of the above respondents indicated they have used mental health services
• 42% receive services in a private office
• 14.8% community mental health setting
• 6.8% in a large group practice
• 2.2% in a VA setting
• 2% in a community setting
Why Michigan is Partnering with Community Mental Health to provide CDSME

- Because of their **coexisting physical conditions**, older adults are significantly more **likely to seek and accept services in primary care versus specialty mental health care** settings (IOM, 2012).

- Mental health conditions, such as anxiety and depression, **adversely affect one’s physical health and ability to function**, especially in older adulthood. For example, untreated depression in an older person with heart disease can negatively affect the outcome of the heart disease (APA, 2005). Conversely, older adults with medical conditions such as heart disease have higher rates of depression than those who are medically well.
Why Michigan is Partnering with Community Mental Health to provide CDSME (cont.)

- 15-20 percent of older adults in the United States have experienced depression (Geriatric Mental Health Foundation, 2008). Approximately 11 percent of older adults have anxiety disorders (AOA, 2001). *Even mild depression lowers immunity and may compromise a person’s ability to fight infections and cancers* (APA, 2005).

- For some older adults, the development of a disabling illness, loss of a spouse or loved one, retirement, moving out of the family home or other stressful event may bring about the onset of a depressive episode (NAMI, 2009).
Integration with Behavioral Health 2009

- Joe’s Story
- Morbidity and mortality report that persons with mental illness are dying 25 years younger
- Funding from adult mental health block grant and Transformation Transfer Initiative grant
- Peer specialists leader training pilot project
Certified Peer Support Specialists

- Is a person with a lived journey of recovery from mental health and/or co-occurring conditions
- Has received public mental health services
- Works at least 10 hours per week
- Attends 56 hours of training and completes a final exam for certification
- Receives 3 Lansing Community College credit hours after all requirements are met
Certified Peer Support Specialists (cont.)

- Work in a variety of settings including consumer run drop in centers, vocational programs, access centers, housing outreach, jail diversion, psychosocial rehabilitation programs, hospitals and Federally Qualified Health Centers
- Focus on health and wellness and navigating complex service systems for both physical and behavioral health
National Recognition

- ASTHO award for creative and innovative approach to addressing public health challenges
- Stanford study with Kate Lorig
- Tobacco recovery award
- Transformation Transfer Initiative grant employing CPSS in FQHC
Individuals who participated in PATH workshops

- Have attended based on a flyer advertised at a program
- Received a referral and recommendation to attend by a physical health or behavioral health care provider
- Have heard from other peers who have benefited from the classes by informal networking
Participant Chronic Conditions

- Heart Disease: 11%
- Emphysema/Lung Disease: 13%
- Other: 23%
- Diabetes: 24%
- Asthma: 25%
- Obesity: 30%
- Chronic Pain: 40%
- Arthritis: 41%
- High Blood Pressure: 41%
- High Cholesterol: 41%
- Serious Mental Illness: 44%
- Depression/Anxiety: 73%
# of Chronic Conditions

- None, 7%
- 1 Chronic Cond, 18%
- 2 Chronic Conditions, 19%
- 3 Chronic Conditions, 19%
- 4 Chronic Conditions, 14%
- 5 + Chronic Conditions, 23%
Partnerships

CDSMP Workshops & Trainings

Michigan Office of Services to the Aging
Community Mental Health
Area Agencies on Aging
MDCH Substance Abuse and Mental Health
MDCH Disability Health Program
MDCH Arthritis Program
National Kidney Foundation of Michigan
Impact

- 268 Workshops
  - 260 CDSMP
  - 6 DSMP
  - 2 CPSMP
- 2,084 Enrolled
- 1,319 Completers (63% completion rate)
- 254 CPSSs trained
- 94 CPSS led a workshop
What did or didn’t go smoothly in the classes?

Strong Leadership: Self-Care Management

• Confidentiality
• Respect is righteous and mutual between partners.
• Guidelines create a comfortable and safe environment.
• Processing feelings builds self-efficacy with support from active participants.
Lessons Learned

- Fidelity
  - Have a Plan
  - Fidelity is a learned behavior
- Have a Project Coordinator
- Have Screening & Counsel Out Procedures
- Meet Participant where she/he is at
- Quality of Life vs. “Is this the Beginning of the End”
- Educate ourselves about the cause of stigma within public health systems
- Promote PATH services by being an example of one healthy self
Home and Community Based Waiver Clients and CDSME (MI-Choice)

- Each CDSME program has a separate code number so number of participants can be tracked by program.
- Programs include:
  - Chronic Disease Self-Management
  - Diabetes Self-Management
  - Chronic Pain Self-Management
  - Arthritis Self-Management
  - Better Choices Better Health
  - Matter of Balance
  - Healthy Moves
  - Physical Activity Programs
  - Creating Confident Caregivers
  - T-Care

- Waiver clients must complete 4 of 6 sessions for payment to be made. (Differs by program).
- Hosting agency must have a medicaid number.
- Currently we have a small workgroup of waiver agencies that are working on the logistics: i.e. how to verify leader certifications, attendance, etc.
Reimbursement

- CPSS are a Medicaid Covered Service in the Managed Care 1915 (b) Specialty Services Waiver
- Have a distinct provider description focusing on health and wellness including:
  - Developing health and wellness plans
  - Integration of physical and mental health care
  - Developing, implementing and providing health and wellness classes to address preventable risk factors for medical conditions
Reimbursement (cont.)

- CPSS have a distinct code of H0038 to capture Medicaid funding
- CDSMP/PATH is a covered service meeting the description for a CPSS in the Medicaid Provider Manual
- The individual plan of service must have a goal & objective with amount, scope and duration related to why the person is attending CDSMP
Questions?

Sherri King, Michigan Office of Services to the Aging
kings@michigan.gov

Pam Werner, Michigan Department of Community Health, Office of Recovery Oriented Systems of Care
Bureau of Community Based Services
wenerp@michigan.gov

John Fryer, Michigan Department of Community Health, Office of Recovery Oriented Systems of Care
Bureau of Community Based Services
fryerj@michigan.gov

Karen McCloskey, Michigan Department of Community Health Arthritis Program
mccloskeyk@michigan.gov
Union County
Strategies for Success!

Presented by:

Pam Capacci
Executive Director, CEO
Prevention Links, Inc.
Prevention Links has been delivering evidence-based substance abuse prevention services to Union County residents for over 35 years. The data collected by a comprehensive needs assessment was the driving force for Prevention Links to begin implementing the Chronic Disease Self-Management Program.
The Health and Wellness Coalition of Union County conducted a comprehensive countywide needs assessment.

The Coalition identified the 55 and older population as a priority group showing a need for substance abuse services in our area.

Prevention Links analyzed local data from this needs assessment and compared it to statewide and national data to gain a full understanding of the issues of Union County seniors.
Prevention Links looked at the following data sources to determine the needs of Union County seniors:

- The Blueprint for Healthy Aging in New Jersey:
  - 32.7% of Union County seniors reported “Fair or poor general health”, the second highest countywide percentage in the state.
  - 15% of Union County seniors reported “Poor mental health”, much higher than the state average of 7.6% according to the CDC Healthy Aging Data Portfolio.
  - 5.5% of Union County seniors reported binge drinking in the last 30 days.
    - The CDC states that the 65 and older population is the age group that binge drinks most often.
    - The 2012 NJ SPE Older Adult Survey reports that 9% of New Jersey seniors reported binge drinking in the last 30 days.
    - Since we know binge drinking is a problem in older adults, this raises the question: Are seniors not aware of their binge drinking habits? Are they not reporting their habits when asked? Raising awareness on this topic through the CDSMP program became an important part of our program.
How were attendees with behavioral health needs identified for the program?

• Prevention Links has a long history of working with the local state-funded Municipal Alliances. These groups focus on substance abuse prevention on the local level.
  – The New Jersey Governor’s Council on Alcoholism and Drug Abuse (GCADA) administers over $10 million each year to the Municipal Alliance to Prevent Alcoholism and Drug Abuse Program
  – The alliances are grassroots Coalitions in 19 of 21 municipalities in Union County

• The Municipal Alliances have a long standing relationship with the senior population in their communities.
  – Through this work, we identified a need for continued services for intensive early intervention programs for seniors.
Prevention Links has a long history of implementing the W.I.S.E. program, which strongly addresses substance abuse related issues among seniors

- The Wellness Initiative for Senior Education (W.I.S.E.) Program helped older adults celebrate healthy aging, make healthy life choices, and avoid substance abuse
- The Chronic Disease Self-Management Program was quickly identified as the next logical program to identify and address the needs of Union County seniors
- CDSMP serves as an enhancement program for seniors that previously participated in the W.I.S.E. Program
- Over time, Prevention Links has built long-lasting relationships with W.I.S.E. Program participants and they expressed a desire to have additional programming
- The W.I.S.E. Program was developed and maintained by the New Jersey Prevention Network (NJPN). For more information, contact Diane Liga at diane@njpn.org
What did or didn’t go smoothly in the classes?

• Our W.I.S.E. and CDSMP participants report high rates of feelings of isolation and loss. Additionally, many participants show a lack of awareness related to alcohol misuse, prescription drug abuse, and serving as an access/availability point for prescription drug abusers. Many participants are in pre-contemplation, with no intention of changing their behavior in the foreseeable future.

• Participants do not initially join the program because they have behavioral health needs. However, they quickly begin to identify they may be dealing with behavioral health issues during the implementation of the program.
How was the partnership initiated and what does it involve?

- As previously mentioned, Prevention Links has a long history of working with the local Municipal Alliances.
  - Prevention Links implemented the W.I.S.E. program in many of these communities
  - The Chronic Disease Self-Management Program was identified as an enhancement tool to work with the senior population
  - CDSMP also serves as an additional program that Prevention Links works very closely with the Municipal Alliances on
  - Prevention Links is able to provide the CDSMP program to many senior groups and local municipal alliances that express a desire for the program, yet may not have all the resources necessary for implementation.
The needs assessment identified multiple data sources indicating alcohol and prescription drug issues facing or potentially facing the senior population. Through our data analysis, we have found this happens on the local level. The Chronic Disease Self-Management Program directly addresses these issues.

The information and data we have collected reaffirms our commitment to implementing the CDSMP Program as well as developing and implementing several other enhanced initiatives, including:

- W.I.S.E.
- Brown Bag Campaign for Proper Medication Disposal
- Senior Presentations
The Chronic Disease Self-Management Program continues to grow in requests and participation.

To date, Prevention Links has implemented 18 rounds of CDSMP and served 250 seniors throughout Union County!

Also, our W.I.S.E. Program has completed 9 rounds and served 186 seniors throughout Union County!

In addition to our programs, Prevention Links has worked with local law enforcement to increase the number of prescription drug permanent collection sites. Currently, Union County has 6 permanent collection sites, accessible 24 hours a day, 7 days a week.
After participating in the Chronic Disease Self-Management Program, many seniors realize there are improvements they can make in their lives. This ranges from seeking help with drug and/or alcohol abuse to exercising more regularly and eating healthier foods.

A participant in a 2013 round of CDSMP shared with the group that he was recently widowed and was using alcohol to deal with his loss. Our peer leaders then explained to him that there were healthier ways for him to deal with this. Thanks to the program this participant was given information about a local support group that he joined to help better deal with his loss.

This is just one example of a long line of success stories associated with the program.
Questions and Answers

THANK YOU
121-125 Chestnut Street, 3rd Floor
Roselle, NJ 07203

pcapaci@preventionlinks.org

(732) 381-4100
www.preventionlinks.org