Exploring Evidence-Based Programs to Address Depression in Community-Based Settings

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• Melissa Donegan, Assistant Director, Healthy Living Center of Excellence, Elder Services of the Merrimack Valley, Inc.
• Claribette Del Rosario, Mental Health Services Program Manager, Ethos
• Lesley Steinman, Research Scientist, Health Promotion Research Center, University of Washington
• Amelia Zepeda, Supervisor, El Sol Neighborhood Educational Center
Exploring Evidence-Based Programs to Address Depression in Community-Based Settings

NCOA webinar
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Lesley Steinman
UW Health Promotion Research Center

Amelia Zepeda
El Sol Neighborhood Educational Center
Acknowledgements

Family

Older adults

Community partners

Policymakers and funders

UW community
Overview

Depression in older adults

PEARLS: Program to Encourage Active, Rewarding Lives

PEARLS case study
Depression in older adults
1 in 5 older adults have experienced depression

- Higher % for vulnerable older persons
- Half have late-life onset

BRFSS, 2016
Late-life depression is a key public health issue

Impacts...

• Quality of life
• Function
• Chronic conditions
• Health care costs
• Mortality

Increased risk for suicide

CDC, 2011; Wall Street Journal, 2011
Occurrence of falls and depressive symptoms on the basis of the set of risk factors (poor self-rated health, poor cognitive status, impaired ADL, two or more clinic visits in the past month, slow walking speed).
Five myths and misconceptions about late-life depression (LLD)

Compared to younger adults:

1. LLD is not symptomatically different (consistently or clinically), though somatic symptoms may be more prevalent.

2. More research is needed to separate impact of medical comorbidity on LLD.

3. LLD is less common in late-life, but has a more chronic course. Older adults with subclinical depression report functional impairment similar to MDD.

4. Older adults respond to treatment as well as younger adults; antidepressants may be less efficacious in late-life, while older age is a favorable predictor of ECT response.

5. While older adults may benefit from enhanced ability to regulate emotions, research suggests that several age-related biological processes contribute to MDD in late-life.

MDD = Major depressive disorder

Haight, 2018
Depression is treatable for many older adults

• Often under-recognized and un-/under-treated
  • 1:2 undertreated in primary care settings
  • More than half of patients/providers feel depression is a “normal part of aging.” Stigma!

• Over 80% of older adults respond to treatment
  • Therapy, antidepressants, activation

• In 2008, the Community Guide recommended home-based depression care management as an effective treatment option

Task Force Finding (February 2008)
The Community Preventive Services Task Force recommends depression care management at home for older adults with depression on the basis of strong evidence of effectiveness in improving short-term depression outcomes.
The Program to Encourage Active, Rewarding Lives
PEARLS Birth Story

Older adults who are isolated, live with multiple chronic conditions, have low incomes, and have functional or mobility limitations are more likely to be depressed...

...and less able to access appropriate care for depression.

In the late 1990’s, HPRC was contacted by our local AAA to try and address this. The PEARLS RCT study aimed to:

- Collaborate with aging service agencies to develop and test a home-based program of both detecting and managing minor depression or dysthymia among older adults.
Coordinated care models

The Collaborative Care Model

- PCP
- Patient
- BH Care Manager
- Consulting Psychiatrist
- Other Behavioral Health Clinicians
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

New Roles
- Core Program
- Optional Additional Clinic Resources
- Outside Resources

Developed by The MacColl Institute © ACP-AMIA Journals and Books
Core components of PEARLS

- Active depression screening and referral
  - e.g. Meals on Wheels, Home and Community-Based Services, Evidence-Based programs, primary care

- Measurement-based outcomes
  - PHQ-9

- Trained care manager at social service CBO
  - Care coordination, psychoeducation, support, and skill building using brief, person-centered interventions

- Coordination - psychiatrist and PCP role re-defined
  - Task shifting / task sharing through regular case consultation

- Delivered at home or in the community
  - 6–8 one hour sessions over 4–5 months

Measurement-based outcomes

Trained care manager at social service CBO

Coordination - psychiatrist and PCP role re-defined

Delivered at home or in the community
Problem Solving Treatment (PST)

Rationale
- Depressive symptoms are caused by everyday problems
- If problems are resolved, their symptoms will improve
- Problems can be resolved using problem-solving techniques

7 steps
1. Clarify and define the **problem**
2. Set a realistic **goal**
3. Generate multiple **solutions** (*brainstorming*)
4. **Evaluate** and **compare** solutions (*pros and cons*)
5. **Select** a feasible solution
6. **Implement** the solution
7. Evaluate the **outcome** (at the next session)
Behavioral activation (BA)

• Depression results in people feeling bad and then doing less
  • People become lethargic, less active, socially withdrawn

• Behavioral focus: do more → feel better

• Focus on activities that are:
  • Social (engaging with others)
  • Physical (moving the body)
  • Pleasant (brings us joy / enhance quality of life)

• Do it even if don’t “feel” like it

• “Outside-in” approach, not “inside-out”
PEARLS Randomized Control Trial #1 Study Results

Depression improvements continued at 12-mo. (6-mo. post-PEARLS).

Ciechanowski, 2004
PEARLS Randomized Control Trial #2 Study Results

**Study Results**

**Significant reductions in suicidal ideation as well**

Chaytor, 2011
Outcomes

Depression

• ~50% response: >/=50% drop pre/post PHQ-9
• ~50% remission: PHQ-9<5

Improvements in:

• Self-rated health
• Recommended physical activity
• Social activities
• Pleasant activities
Client story

Jennifer and Jack

• Stroke support group
• Respite care
• Rebuilding Together
• Minivan
• Swimming
• “PEARLS helped me to sort out all of my stuff.”
• “I liked how Paul came to our house to help me figure out how to do the things I used to do, just do them differently.”
Training and technical assistance

2-day in-person training
April 11-12, 2019 in Seattle
**Register by March 31**

Online Master Training & Booster Training
MT: March 29 – May 3 (Fridays)
**Register by March 22**

Learn more at www.pearlsprogram.org

PEARLS Toolkit
Free implementation manual online

Monthly TA calls
1st Thursdays 10:30am PT
Sustainability

**Funding**
- WA Medicaid waiver
- ACL CDSME (self-management support)
- Research and Foundation grants
- Local levies
  - King County property tax
  - CA Millionaire’s Tax
- Healthcare reform*
  - Quality Improvement measures (HEDIS)
  - Medicare Access & CHIP Reauthorization Act 2015 (MACRA)
  - 1115 Transformation Waiver

**Lessons Learned**
- Diverse, multiple funding sources
- Engage program champions (participants, providers, policymakers)
- Integrate PEARLS into service package
- Partnerships and opportunities
- Culturally appropriate
- Balance adaptations and fidelity
- Plan for RE-AIM
Looking ahead

PEARLS Connect Study – social isolation (AARP Foundation, WA, TX, MY, MD, FL partners)

Economic evaluation (AARP Foundation, WA DSHS)

Improving Equity in Depression Care via PEARLS Translation (CDC)

Integrating with other EBPs and with health care to address SDOH (Evidence-Based Leadership Collaborative, Archstone Foundation)

Tele/hybrid models (MN, TX)
PEARLS case study
El Sol Neighborhood Education Center

Mission
To empower our communities to lead healthy lives & access to health care; safe, affordable housing; opportunities for education; and the leadership skills to eliminate disparities.

Vision
Our community members will reach personal empowerment to move towards self-sufficiency and contribute to their community’s well being.
El Sol’s PEARLS Program

- Implementing PEARLS since 2017
- Archstone Foundation-funded
- *Care Partners Initiative for Late-Life Depression*
- PEARLS staffing
  - CHWs trained to deliver PEARLS
  - Program manager former CHW
  - Additional mental health support from psychotherapist
  - Clinical supervision by psychiatrist assistant
### CHWs and social determinants of health

#### Figure 1: Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
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<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Stress</td>
<td>Community engagement</td>
<td>Provider availability</td>
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<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Discrimination</td>
<td></td>
<td>Provider linguistic and cultural competency</td>
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<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td></td>
<td></td>
<td>Quality of care</td>
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<tr>
<td>Support</td>
<td>Walkability</td>
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<td></td>
<td>Zip code / geography</td>
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**Health Outcomes**
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
PEARLS client story – Maria

When she enrolled in PEARLS:
• PHQ-9 = 20 (severe depression)
• No income
• Had to live with neglectful daughter
• Stress and high blood pressure
• Isolated

During / after PEARLS:
• PHQ-9 = 2
• Now receiving SSI monthly benefit
• Applied for senior housing
• Obtained machine for regular home BP self-monitoring
• Got cell phone to stay in touch with family and friends
Implementation successes

• CHW with long history of trust to reach underserved community

• Recruitment via low income senior housing

• Significant improvements in depression

• Connection to other supports and services (SDOH!)
Implementation challenges & opportunities

Even though structured, evidence-based program, no one size fits all

“problems” → What is something you want to do and have not been able to do? What is stressing you out this week?

Not all poor quality and access to care issues can be solved

Partnering with CHWs, health plans (IEHP), clinics (La Salle, SACS)

Can be stressful for PEARLS providers

Self-care for CHWs

Sustainability of program post grant funding

Working with AIMS and Care Partners
Where to find EBPs

The Community Guide
- https://www.thecommunityguide.org/topic/mental-health

ACL Title III D list
- OAA Health Promotion and Disease Prevention Programs
- NCOA: https://www.ncoa.org/resources/ebpchart/

SAMHSA’s NREPP*
- https://www.samhsa.gov/nrepp

AHRQ Innovations Exchange
- https://innovations.ahrq.gov/

EBLC Locator
- www.eblcprograms.org/
References


• Unutzer, J., “Depressive symptoms and the cost of health services in HMO patients aged 65 years and older,” *JAMA* 277;20 (1997).
Thank you!

Lesley Steinman  
UW Health Promotion Research Center  
Evidence-Based Leadership Collaborative  
E: lesles@uw.edu  
O: 206-543-9837  
C: 206-850-4066

Amelia Zepeda  
El Sol Neighborhood Education Center  
E: ameliazepeda@elsolnec.org  
C: 951-544-2456
Healthy IDEAS
(Identifying Depression, Empowering Activities for Seniors)
History:

- Developed and managed by Baylor College of Medicine and Care for Elders
- First implemented in 2002, now in 32 states
- Designated as an Evidence-based program
- January 1, 2018 National Dissemination and Technical Assistance transferred to Elder Services of the Merrimack Valley
What is Healthy IDEAS?

- Community depression program to detect and reduce depressive symptoms
- Embedded into ongoing case management services
- Improves linkages between community providers and healthcare professionals
- Reaches frail, high-risk, diverse, community dwelling older adults
Healthy IDEAS Program Components:

• **Screening** for symptoms of depression
• **Education** to older adults and caregivers about depression, effective treatment and self-care
• **Referring and linking** clients to treatment and follow-up with PCP and mental/behavioral health providers
• Empowering clients through **Behavioral Activation**
• Assessing client progress
Healthy IDEAS Implementation:

• Core intervention program delivered over 3-6 months
• Implemented by a case manager- extension of case management services
• Face to face visits in clients home and follow up calls
• Healthy IDEAS Training provides the tools/forms/education handouts to implement
• Ongoing supervision of staff implementing provided by their agency
Is Healthy IDEAS a good fit for your agency?

Agency sees a need to address depression in older adults

- **Creating** a program leadership team
- **Developing** effective partnerships and community providers
- **Installing** the core Healthy IDEAS components into current service delivery
- **Establishing** a system for collecting and monitoring client outcomes and ensuring program fidelity
- **Training** staff to deliver Healthy IDEAS and providing ongoing supervision
Training Models

Traditional: 2 day on site training model
Hybrid: online and one day on site training model
Cost: $4,000 for up to 22 trainees. (Additional trainer, travel and hybrid online access additional)

Agency Preparedness

• Key organizational readiness tasks
• Review agency policies
• Pre-training
• Program start up activities take 2-3 months
Healthy IDEAS and 1:1 EBP’s: opportunities to pair programs

• Reaching underserved populations
• Address highest need first
• 1:1 tailored program
• Improve efficiency and sustainability
• Pair with community based programs
Healthy IDEAS and Housing

- Eliminates barriers
  - Homebound
  - Transportation
  - Mobility Issues
  - Stigma
- Freedom of choice
- Social isolation and loneliness
Melissa Donegan, LSW
Assistant Director, Healthy Living Center of Excellence
National Healthy IDEAS Contact
Elder Services of the Merrimack Valley, Inc.
280 Merrimack Street, Suite 400
Lawrence, MA 01843
978-946-1338
mdonegan@esmv.org
www.healthyliving4me.org
www.healthyideasprograms.org
Questions?