Thank you for joining today, please wait while others sign in.

- Due to the large number of participants, all lines will be muted during the call.
- If you want to ask a question, please type in your question into the box.
The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

NCOA Behavioral Health Webinar
October 25, 2012
3:00 pm – 4:30 pm Eastern
Overview

- About PEARLS
  - Background
  - Research Study

- Implementation
  - Infrastructure
  - Adaptations and Fidelity
  - Training and Technical Assistance
  - Funding and Sustainability
Background

- 1 in 5 older adults are depressed
- Impacts quality of life, function, chronic conditions, health care costs, mortality
- Often under-recognized and untreated or under-treated
- Effective treatments exist
  - Depression Care Management (Task Force)
WA State 2005 Prevalence Study
ADSA Older Adults (60+yrs)

N= 16,032

% depressed

38
35
27

% CES-D Scores

<6
6-10
>10
Older adults with social isolation, medical comorbidity, and physical impairment are more likely to be depressed but may be less able to seek appropriate care for depression.

The PEARLS RCT study aimed to collaborate with existing aging service agencies to determine the effectiveness of a home-based program of detecting and managing minor depression or dysthymia among older adults.
Depression Care Management

- Active screening for depression
- Trained depression care manager
  - Brief evidence-based interventions
  - Education / self-management support
- Proactive outcome measurement/tracking
- Team approach, stepped care
- Follow-up
PEARLS Sessions

- 8 home-based sessions, tapered weekly-monthly (19 wks)
- Problem-Solving Treatment
  - Theory:
    - Overwhelming, unsolved problems increase depression
    - Solving Problems decreases depression
  - Patient Centered and Directed
  - Skill building
  - 7-steps
- Physical and Social activities
- Pleasant Events scheduling
PEARLS RCT Study Results
6 month (N=138)

- ≥50% drop on HSCL-20
  - Usual Care: 8
  - Intervention: 54

- % achieving remission
  - Usual Care: 10
  - Intervention: 44

- % reporting any hospitalizations
  - Usual Care: 34
  - Intervention: 22
“I'm able to cope with things a whole lot better.”

“PEARLS gave me other avenues to not completely solve the problem but other ways of approaching and dealing with it, and weighing the facts out. Or, to get out going walking, and get some fresh air.”

“PEARLS was very helpful to me to understand what I should do. I now have some tools to know what I need to do.”
PEARLS Implementation
Active screening

- Late-life depression is under-recognized
- PEARLS targets frail, homebound elders
- Validated screening instrument
  - E.g., PHQ-9, PHQ-2, GDS-SF
- Partner with existing older adult programs
  - E.g., intake for AAA’s and/or MH/SA, Meals on Wheels
  - Gatekeepers
  - Staff training
Measurement-based outcomes

- PHQ-9 administered at each session
- Other client outcomes
  - e.g., physical activity, health services utilization
- Data management
  - Excel spreadsheet template in toolkit or Peer Place
  - Most sites use existing databases
- Testimonials
- Staff training
- Collect process outcomes as well!
Trained depression care manager

- “PEARLS Counselor”
- Trained from existing agency staff
- Pros/cons of working with master’s or bachelor’s level staff
- OK for case manager as long as ‘separate hats’
Clinical supervision

- Key program component (ongoing training and coaching)
- Psychiatrist or clinician + medical provider
- Conference calls/skype OK after initial meeting
- Partner with universities
- More frequent sessions initially to support staff training
- Group sessions ideal for peer learning
- New cases, problem cases, success stories
Stepped care

- In-person sessions tapered weekly to monthly
- Brief follow-up calls for 3-6 months
  - “Wrap up” activities built into treatment plan
- Referrals to more intensive services
Adaptations

- Epilepsy
- Younger older adults (age 50-59)
- Major depression
- Limited English-speaking
- Assess client’s current function when assessing eligibility re: cognition, and other MH/SA
- Home and center-based
- Community mental health
Fidelity

- PEARLS fidelity instrument
  - Brief: 20-items, 15 minutes
  - Developed and validated with key informants
  - Current study looking at outcomes and key components
- Clinical supervision
- Monthly technical assistance calls
Training and Technical Assistance

- **Trainings**
  - In-person (Seattle or site-based)
  - Online supplement (Nov 2012)
- **PEARLS Toolkit**
  - Free implementation manual
  - All forms and materials
- **PEARLS website**: [www.pearlsprogram.org](http://www.pearlsprogram.org)
- **PEARLS Technical Assistance (TA)**
  - Free monthly conference calls with other providers
  - Tailored TA is also available
Funding Sources

- In-house agency funding
- Federal, state, local aging services
- Medicaid waiver for ancillary services
- Voter-approved levy
- University research and education grants
- Non-profit organizations
- Endowments and foundations
Program Costs

- Average costs/participant: $630 (from RCT study)
  - Calculated based on per client costs

- Recent estimate: $1,350 (from PEARLS programs)
  - Calculated based on agency costs
  - Accounts for recruiting, screening, outreach and education and costs to support a full-time interventionist
  - Costs will vary based on staffing needs and # of clients

- WA Medicaid waiver reimburses at @$150/session for 9 sessions (1 screening and 8 active)
Sustainability

- Diverse, multiple funding sources
- Program champions
- Integrating PEARLS into service package
- Partnerships
- Recruitment / outreach
- Culturally appropriate language and media
- Recognition
Recognition

- SAMHSA’s National Registry of Evidence-Based Programs and Practices (NREPP)

- AHRQ Healthcare Innovations Exchange

- 2011 Archstone Award for Excellence in Program Innovation
Contact Us

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HEALTHY IDEAS

Identifying Depression
Empowering Activities for Seniors

www.careforelders.org/healthyideas
Addressing Depression in Older Adults

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)

An evidence-based community depression program designed to detect and reduce the severity of depressive symptoms in older adults through existing community based case management services or caregiver support programs.
Program Goals

- Detect and reduce the severity of depressive symptoms in older adults
- Reach underserved populations
- Train agency staff to deliver an evidence-based intervention for depression to older adults
- Improve linkage between community aging service providers and health/mental health professionals
- Embed into routine case management services
Target 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 community care management program
- Cognitive ability to participate
- Able to communicate verbally
Conducted in the client’s home on a one-to-one basis by case managers over a 3-6 month period.

Utilizes existing staff with established relationships with targeted participants.

A manual outlines the steps and includes written worksheets, client handouts, and forms to support and document the process and client outcomes.

Partner with health/mental health care providers to facilitate referral and uses community partnership approach for training, evaluation & fidelity.
Core Program Components

- Screening
- Education
- Referral & Linkage
- Behavioral Activation (BA)
  - Empowering older adults to manage their depressive symptoms by engaging in meaningful, positive activities.
- Follow-up Reassessment
New or Existing Agency Client

Depression Screening Administered Two Questions

Positive Screen

Geriatric Depression Scale (15 item) or Patient Health Questionnaire (PHQ-9) administered

Severe Depression

Mild/Moderate Depression

No Depression

Referral to MD or MH specialist

Behavioral Activation Offered

Negative Screen

Education Offered
Healthy IDEAS Steps & Client Contact

- **Initial Visit**
  - **Step 1**: Screen & Assess Your Client for Depression
  - **Step 2**: Educate Your Client About Depression and Treatment
  - **Step 3**: Refer and Link your Client to Treatment

- **Second Visit (in 2-3 weeks)**
  - **Step 4**: Empower Your Client Through Behavioral Activation

- **Follow up visits by phone or in person**

- **Reassessment Visit @ 3 months**
  - **Step 5**: Reassess Your Client’s Progress
What We Know

- Older adults vary in their “readiness” to address depression
- Most elders prefer treatment through primary care; others accept mental health services
- Medication use is common, yet not always effective
- Identification of depression is not sufficient
- Effective treatment is available
Benefits to Clients

- Reduction in severity of depressive symptoms
- Reduction of self-reported pain
- Increased knowledge of how to get help for depression
- Increased level of activity
- Increased knowledge of how to manage depressive symptoms
Healthy IDEAS in 21 States

- States
  - California
  - Delaware
  - Florida
  - Georgia
  - Hawaii
  - Illinois
  - Indiana
  - Iowa
  - Maryland
  - Maine
  - Massachusetts
  - Michigan
  - Minnesota
  - Missouri
  - New Jersey
  - North Carolina
  - Ohio
  - Oklahoma
  - Tennessee
  - Texas
  - Vermont

- Organizations
  - Area agency on aging programs
  - Local non-profit social service agencies
  - Behavioral health provider agencies
  - Caregiver support programs
  - Senior service centers
Technical Assistance & Training

- Care for Elders and Baylor work with agencies to replicate the program
- Plan includes phone conference technical assistance and tools for each core component
  - On-line Agency Readiness Survey
  - Implementation Materials
  - Intervention Manual
  - Tools and Resources
  - Skills Training DVD
- On site training of all case management staff
- Use Agreement and Fee for these resources
Implementing Healthy IDEAS

1. Healthy IDEAS Readiness Assessment
2. Leadership Team & Partnership Development
3. Staff Selection
4. Program Installation “Fit” into the Agency
5. Pre-Service and In-Service Training
6. Consultation and Coaching
7. Program Evaluation
Financing Healthy IDEAS

Implemented in over 80 agencies

- Older American's Act case-management programs through Area Agencies on Aging (AAA) and Family Caregiver Support Programs through state and local agencies -- Titles III & IV
- AAA discretionary funding
- SAMHSA Mental Health Funding to States
- SAMHSA Older Adult Targeted Capacity Expansion Grants
- Medicaid: -- Home and Community Based Services or State supported Case Management Programs
- Medicare Community Based Mental Health Programs
More Funding Sources

- State-funded case management
- State-funded mental health services
- United Way funded non-profit case-management programs
- State and Local Foundations
- Voter-approved funding (local/state levies/taxes) for aging services or mental health programs
- University research and education grants
- Non-profit organizations (discretionary funds)
- In-kind partnership resources
Keys to Successful Implementation

- Collaboration with community mental health experts to assist with:
  - Training of care managers and supervisors
  - Linkages to evaluation and treatment resources for clients
- Organizational & Staff Readiness for Change
  - Internal advocate/cheerleader
- Training and follow-up coaching or supervision
- Committed to the value of addressing depression

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In 1908 St. Barnabas Senior Services opened its doors in Los Angeles, California. Over 100 years later, St. Barnabas is thriving as a dynamic nonsectarian, nonprofit organization that is widely recognized for its innovative programs. By pioneering and array of programs that promote healthy aging, prolong independence, and enhance dignity for more than 8,000 seniors, SBSS has become a leader in the field of aging; especially among low-come, multi-ethnic urban older adults. The primary ethnic populations that SBSS serves are Hispanic, Korean and Phillippino older adults.
The opportunity was made possible by a grant from the Archstone Foundation. We did not know of HI before.

To build the professional capacity of SBSS social work staff to provide and deliver an evidence-based intervention for depression to older adults.

Embedded in the case management relationship: it enhanced the possibility to “enlarge the ‘safe space’” in which older adults could face threats to living independently and facing those threats collaboratively.

To insure systematic identification of depression and action through attention to depression screening embedded into routine case management services.

Why did SBSS choose Healthy IDEAS?
Retaining EB structure while making its introduction “conversational” in keeping with our “client centered vs. program-curriculum centered” philosophy.

Made the screening and the GDS when appropriate a part of our initial conversation during office or home visit.
Why we chose the GDS vs PHQ-9

- We determined the Geriatric Depression Scale (GDS) (15 questions with a depression assessment threshold of 6 or higher) to be more appropriate for our multi-lingual- cultural population: Korean, Hispanic, Philippine people groups…

- **GDS narrows the response options:** Y/N VS. 0-3: ‘Not at all’, ‘several days’, ‘more than ½ the days’, ‘nearly every day’.

- We have screened 545 clients in the last 11 months
SBSS’ Prep Challenges

- **Determining demand:** the possible number of older persons currently in case management at SBSS with depression

- **Program Management:** besides hiring a short-term Clinical Coach, Healthy IDEAS Assistant Program Coordinator position added

- **Outcome management:** the creation of data management system – Excel spreadsheet

- **Client follow up:** over 60 – 90 days with an already demanding multipurpose center case load
Addressing Barriers

- **Client Barriers**
  - **Stigma** – “I’m not crazy! I’m not a weak person”
    “I don’t want to lose my apartment if my landlord finds out I am depressed!”
    “I don’t want to shame my family or have God look down on me for admitting I am depressed.”
  - **Lack of knowledge** – “It’s just my diabetes or being old”

- **Provider Barriers**
  - Primary Care faces many competing demands
  - Scarcity of mental health professionals who accept Medicaid/Medi-Cal
Lessons Being Learned

- Education – verbal vs. written and finding appropriate print materials
- Behavioral Activation (BA): motivating and helping older persons to remain focused/follow through
- How to balance a demanding case load of non-HI clients with HI clients
- Not all our clients are “ready” to talk about or address their depression
- Increased participation in BA associated with better outcomes .... It is the ‘total package’ that seems to be the most effective.
Why we are expanding HI?

✓ Positive results for our agency
✓ New SBSS CM projects have come online
✓ Strengthen staff capacity by embedding HI
✓ Increase depression intervention for elders across our region of Los Angeles.
✓ Contact info: ggibb@sbssla.org