Tips for using Zoom

• You have joined the webinar in **listen-only mode**.
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• Please make sure your speakers are on and the **volume is turned up**!
• Click the microphone at the bottom of your screen for instructions **if you prefer to join by phone**.
• Type all questions into the **Q&A box** at the bottom of your screen.
• The **slides and recording** of this webinar will be shared by email within a few days.
Mission:
To provide opportunities for professional, consumer and government organizations to work together towards **improving the availability and quality of mental health preventive and treatment strategies** to older Americans and their families through education, research and increased public awareness.

Visit: www.ncmha.org
History, Membership and Activities:

• Formed in 1991 by a group of organizations from the aging and mental health fields
• Comprised of 100 national and state associations, state coalitions, and governmental agencies, e.g., SAMHSA and ACL.
• Co-sponsor events to highlight challenges of mental health and aging
• Identify new approaches to addressing problems.
Webinar Series on “Addressing Disparities in Behavioral Health Care for Older Adults”

• Following the May 20th **National Older Adult Mental Health Awareness Day (OAMHD)** events, NCMHA developed a plan to collaborate with interested government agencies, private sector groups, and experts to maintain the momentum and recommendations generated from OAMHD.

• A series of webinars during 2019/2020 that **target specific topics with a practical focus and accompanying tools/resources** to address the needs of older adults with mental health conditions, as well as state/local efforts/best practices.

• A special feature of the webinars will be that the sessions will coincide with **monthly, weekly and daily national mental health or aging observances**.
Key Objectives of the Webinar Series

• Identify specific approaches that address disparities in behavioral health care for older adults

• Ensure that older adults with mental health and addiction-related conditions are integrated within all MH awareness raising, policy, programmatic and research efforts going forward.

• Raise awareness among primary care, mental health, other health service providers and the aging network about the impact of suicide, opioid use, and interrelated problems, and impact provider practice patterns for older adults.

• Identify specific tools such as geriatric assessment, questions – suicide ideation, firearm presence, opioid use and other screening tools – and detailed guidance.
Webinar Series Roll Out – 2020

March 26 (3:00 PM EDT) – National Brain Injury Awareness Month
“Traumatic Brain Injury and Mental Illness Among Older Adults: The Problem and New Management Approaches”

April 10, 2020 (12:00 PM EST) – National Public Health Week
“Social Determinants of Mental Health for Older Adults: A New Perspective”
Today’s Webinar

“Bridging the Science-Practice Gap: Potential Opportunities in Geriatric Mental Health through Implementation Science”

Stephen Bartels, MD, MS
Director, The Mongan Institute
James J. and Jean H. Mongan Chair of Health Policy and Community Health
Professor of Medicine
Massachusetts General Hospital
Bridging the Science-Practice Gap Through Implementation Science: Opportunities for Geriatric Mental Health

Stephen J. Bartels MD, MS
James J. and Jean H. Professor of Health Policy and Community Health
Professor Medicine
Harvard Medical School
Director, The Mongan Institute
Massachusetts General Hospital
Overview

• We Know Prevention and Treatment works: Evidence-base Interventions
• The Implementation Gap
• Introduction to Implementation Science
• Future Opportunities
• Resources
Changing Demographic in the Population Identified with Mental Illness

![Graph showing the changing demographic in the population identified with mental illness from 2000 to 2030. The graph depicts the number of individuals in millions for different age groups: 18-29, 30-44, 45-64, and 65+. The data shows an increase in the number of individuals identified with mental illness across all age groups by 2030.]
For a Long Time we have known that: “Prevention and Treatment Works” for Older Adults with Behavioral Health and Substance Use Disorders

EVIDENCE BASED PRACTICES:

• Integrated service delivery in primary care
• Community-based mental health outreach services for older adults
• Mental health consultation and treatment teams in long-term care
• Family/caregiver support interventions
• Brief Interventions for Substance Use Disorders
• Psychological and pharmacological treatments

Bartels et al., 2002, 2003, 2005
EXAMPLE: Geriatric Mental Health Community Outreach Models

% Recovered from Depression*

* Greater than 50% reduction in symptoms or meeting syndromal criteria
Depression Care Management
Core Components

1. Active Screening to identify depressed patients
2. Patient education / self-management support
3. Outcome measurement (e.g., PHQ-9, GDS)
4. Evidence Based Treatment
   – Brief psychotherapy (e.g., PST, IPT)
   – Medication Treatment
5. Psychiatric consultation / caseload supervision
6. Stepped care
   – Increased intensity as needed
   – Specialty mental health referral when necessary
Preventing Late-life Depression in Age-Related Macular Degeneration

Barry W. Rohrer, M.D., Robina J. Casten, Ph.D.

Objectives: To determine whether problem-solving treatment (PST) can prevent depressive disorders in patients with age-related macular degeneration (AMD). Design: Two hundred sixty patients with AMD were randomly assigned to PST (n = 193) or usual care (n = 70). PST therapists delivered six PST sessions over 8 weeks in subjects' homes. Measurements: Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition Diagnosis of Depressive Disorders. Hamilton Depression Rating Scale scores, and rates of relapsing, relapsing episodes were assessed at 2 months for short-term effects and 6 months for maintenance effects. Results: The second-trimester incidence of depressive disorders in PST-treated subjects was significantly lower than controls (11.0% versus 22.9%, respectively; OR = 0.43, 95% CI 0.19-0.89). PST also reduced the odds of relapsing a relapse episode (OR = 0.40, 95% CI 0.25-0.89); this effect mediated the relationship between treatment group and depression. By 6 months most earlier observed benefits had diminished. Secondary analyses showed that a minimal level of depressive symptoms was doubled and predicted incident depressive disorders. Conclusion: PST prevented depressive disorders and loss of visual activities as a shorter-term treatment but these benefits were not maintained over time. To sustain PST's effect, an intervention that used a treatment model in combination with a structured problem-solving framework to enhance rehabilitation skills may be necessary. (Am J Geriatr Psychiatry 2008; 16:454-460)

Key Words: Problem-solving treatment, vision loss, age-related macular degeneration, depression

Preventing Depression in Old Age: It’s Time

Charles F. Reynolds III, M.D.

Although depression in old age can be successfully treated, often to the point of remission of symptoms, persisting impairment in functional status and in health-related quality of life is all too common. Long-term treatments also work to reduce rates of recurrence of major depressive episodes by about 50%, but there are maintenance of quality of life is far from satisfactory. Thus, the Illness-related burden of depressive illness, particularly in old age, continues to be an important public health challenge and seems larger still because of the increasing numbers of elderly people in developed economies.

Moreover, elderly who are members of minority groups are even less likely to access and engage in effective treatment of depression. Thus, it is not surprising that African Americans, for example, are overrepresented among those with severe depression. If you are old, depressed, and African American or Latino, you have three strikes against you.

We know now that evidence-based practices for treatment of older patients and can do work in primary care settings, however, the diffusion of models of depression care management to the general medical sector has to date been limited often for financial reasons. Twenty-minute mental health visits are the rule. Limiting the access of patients to adequate treatment and guaranteeing suboptimal outcomes.

This state of affairs underscores the need to prevent older depression. That is, the efficacy of treatment, while good, is still limited with respect to reversing illness-related burden and if diffusibility of evidence-based practices to general medicine is limited, particularly in minority populations, then the need to prevent older age depression in the first place is of great public health moment. I suggest that our field needs to make a commitment to depression prevention research, and that scientifically the time has come.

Rohrer et al. have done the basic epidemiology to identify characteristics that put elderly people at high risk, both for incident and persistent depression. In their work, having symptoms of anxiety, functional impairments, two or more chronic illnesses and either low education or below average levels of mastery identify elderly persons at high risk for persistent depression. The authors have taught us that profiles of high risk characteristic relatively small segments of the elderly population; and that one could contain the adverse effects associated with such risk factors, then the incidence of persistent depression could be substantially reduced (i.e., high attributable fraction). Also, reasonable efficiency is possible, assuming acceptable and effective interventions (as indexed by a number needed to treat of approximately 3).

We provide a preventice intervention could make the most sense scientifically and be acceptable to patients at high risk. The review by Cole's reminds us that brief psychotherapeutic interventions, especially those that are learning-based, are acceptable and feasible, and shown to be effective in well-controlled studies. Furthermore, based upon the available studies, reductions in absolute and relative risk for incident depression appear to be promising and thus justify the efforts of mounting further prevention research in high-risk older people. What is really high risk? Rohrer et al. have done ground-breaking research into selective prevention of depression in older adults, that is, taking a group of people at high risk, by virtue of known risk factors (e.g., bereavement, insomnia, limited social support) but not yet...
Example: Suicide Prevention

- Supportive interventions
  - Screening for depression, psychoeducation, and group-based activities

- Telephone-based supportive interventions

- PROSPECT: Protocol-driven treatment of depression delivered by a care manager
  - Outcomes:
    - Associated with a reduced suicidal ideation
# Overview of Promising Practices and EBPs in Geriatric Depression and Suicide Prevention

<table>
<thead>
<tr>
<th>Mental health</th>
<th>Universal Prevention</th>
<th>Selective/Indicated Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promising Practices</td>
<td>Outreach Gatekeeper PATCH IPT Exercise Care provider interventions</td>
<td>PST PEARLS Integrated care of mental health problems in a medical care setting (e.g., IMPACT)</td>
</tr>
<tr>
<td>Exercise Education programs Life review Reflections for Seniors</td>
<td>Telephone-based support (TeleHelp TeleCheck)</td>
<td>Treatment of depression (PROSPECT) Placing limits on analgesic packaging</td>
</tr>
<tr>
<td>Suicide</td>
<td>Screening for depression, psychoeducation, and group activities</td>
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</tbody>
</table>
Alcohol and Medication Misuse

An estimated one in five older adults may be affected by combined difficulties with alcohol and medication misuse.

Alcohol-medication interactions may be a factor in at least 25% of ED admissions (NIAAA, 1995).
Opioid Misuse/Abuse

Radio personality Rush Limbaugh for OxyContin

“OxyContin” helped me deal with the pain of living in a world that just didn’t resemble my perceptions or my claims.”
Example: Interventions for Alcohol Use Disorders in Older Adults

- Prevention/Education
- Brief Advice
- Brief Interventions
- Pre-Treatment Intervention
- Formal Specialized Treatments
“We Know Treatment Works”
Evidence-based Practices

- Integrated service delivery in primary care
- Community-based mental health outreach services for older adults
- Mental health consultation and treatment teams in long-term care
- Family/caregiver support interventions
- Psychological and pharmacological treatments

Bartels et al., 2002, 2003, 2005
YET, there is a huge GAP Between what we know and what we do

- Adults with a Mental Health or Substance Use disorder receiving ANY treatment:
  - 25% Age 18-65
  - 10% Age 65+

- Older adults (age 65+) in need less likely to receive specialty mental health services:
  - 17% age 18-64
  - 1% age 65+

IOM Report: In Whose Hands 2013
Why is implementation science important?

“The Research Translation Problem”
Too often, we have assumed, "If you build it..."
The Challenge of Getting Research into Practice

Main street

Bookshelf
Why Implementation Science?

Pace, Relevance, and Pipeline of Translating Research into Practice

- **PACE**: 17 years to implement 14% of research in practice

- **RELEVANCE**: Health care systems and communities often view academic research as too incremental, cumbersome, and siloed to be helpful

- **PIPELINE**: Inadequate and endangered pipeline of applied population and health care delivery scientists and applied real-time projects
Some Remedies and Key Terms

- **Implementation science** is the study of methods to promote the integration of research findings and evidence into healthcare policy and practice.

- **Dissemination research** is the scientific study of targeted distribution of information and intervention materials to a specific public health or clinical practice audience. The intent is to understand how best to spread and sustain knowledge and the associated evidence-based interventions.

- **Implementation research** is the scientific study of the use of strategies to adopt and integrate evidence-based health interventions into clinical and community settings to improve patient outcomes and benefit population health.

- **Pragmatic research** is the use of real-world tests in real-world populations and situations.

*Brownson, Colditz & Proctor. Dissemination and Implementation Research in Health. 2018*
What is Implementation Science?

- “...the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practice into routine practice, and, hence, to improve the quality and effectiveness of health services.”

Eccles & Mittman, Implementation Science, 2006
Why Implementation Science?
Implementation impacts key outcomes

- Uptake
- Morbidity
- Mortality
- Sustainability
- Quality of life
- Cost
- Quality of Care
- Safety

Interventions and Models of Care
Implementation Science: A Transdisciplinary Field

Applied health care delivery science informed by interdisciplinary methods including anthropology, data science, digital health, economics, engineering, epidemiology, health behavior psychology, informatics, intervention and improvement science, operations research, management, prevention science, and sociology.
Examples of Older Adult Mental Health Implementation Strategies

- Education & training
- Senior service providers, home delivered meals
- Family caregiver and peer support
- Task-shifting & community health workers
- Integration in primary health care
- Electronic clinical reminders, templates
- Telehealth, mHealth and technology
- Incentives
- Toolkits
- Technical assistance
Examples of Implementation Outcomes

- Acceptability
- Adoption
- Appropriateness
- Cost
- Feasibility
- Fidelity
- Scalability/Spread
- Adaptation
- Sustainability
RE-AIM Framework

Implementation Outcomes

- **Reach**
  - How do I reach the targeted population?
- **Effectiveness**
  - How do I know my intervention is effective?
- **Adoption**
  - How do I develop organizational support to deliver my intervention?
- **Implementation**
  - How do I ensure the intervention is delivered properly?
- **Maintenance**
  - How do I incorporate the intervention so it is delivered over the long-term?
Framework Example: Consolidated Framework for Implementation Science (CFIR)


[https://impsciuw.org/implementation-science/research/frameworks/](https://impsciuw.org/implementation-science/research/frameworks/)
SAMHSA Older Adult MH/SA Targeted Capacity Expansion Program

• Goal of Funded Projects:
  – **Expand capacity** to serve older adults using evidence-based practices
  – **Implementation** of evidence based mental health models of care
  – **Sustainability**

Grantees in three EBP models of care:
  – Integrated mental health and physical health care
  – Case identification and outreach services
  – Systems linkages and interdisciplinary care
Comparative Effectiveness of Older Adult TCE Programs on Depression Severity

50% Reduction in Depression Severity

How To Reduce the “Voltage Drop” for System’s Linkage Interventions?

<table>
<thead>
<tr>
<th>% of Participants with 50%+ Reduction in Depression Severity (GDS or PHQ-9)</th>
<th>Integrated PH and MH (n=155)</th>
<th>Outreach and Care (n=179)</th>
<th>Systems Linkage (n=93)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50%</td>
<td>43%</td>
<td>25%</td>
</tr>
</tbody>
</table>
Implementation “Lessons Learned” from Community Sites

• Achieving a balance between adapting the EBP to “real world” settings while maintaining fidelity to the selected EBP
  – Identify core essential features of the EBP
  – Understand the unique strengths, needs, and limits of the organization and population
  – Support local innovation while emphasizing the importance of fidelity

• Outcome Data Collection in Diverse Settings
  *Paperwork burden on older adults & clinical staff*
  – Make data clinically relevant and useful on the ground
  – Identify practical methods for data collection
  – Promote health information literacy and integrated use of outcome data
Examples of Future Directions in Older Adult Mental Health Implementation Science:

Telehealth and Illness Self-Management
We Know Integrated Self-management Training and Support Works in Older Adults

Integrated IMR for Psychiatric and General Medical Illness for Adults Aged 50 or Older With Serious Mental Illness

Stephen J. Bartels, M.D., M.S.
Sarah I. Pratt, Ph.D.
Kim T. Mueser, Ph.D.
John A. Naslund, M.P.H.
Rosemarie S. Wolfe, M.S.
Meghan Santos, M.S.W.
Haiyi Xie, Ph.D.
Erik G. Riera, Ed.M., M.B.A.

Illness Self-Management Health Coaching for n=71 older adults (mean age 60) with mental disorders and chronic illness (diabetes, COPD, CHF, CVD, hypertension, arthritis)

Self-management support, cognitive behavioral, and motivational skills training
Self-Management Training and Support Outcomes

Improved Self-management

- Patient and provider ratings of self-management
  - Knowledge of Symptoms, Meds, Coping
  - Symptom Distress
  - Symptoms Affecting Functioning

- Improved participation in the health care encounter

Decreased hospitalizations

Hospitalizations

- I-IMR
- UC

<table>
<thead>
<tr>
<th></th>
<th>I-IMR</th>
<th>UC</th>
</tr>
</thead>
<tbody>
<tr>
<td>BL</td>
<td>12.10%</td>
<td>0%</td>
</tr>
<tr>
<td>10mo</td>
<td>31%</td>
<td>25%</td>
</tr>
<tr>
<td>14mo</td>
<td>25%</td>
<td>17.40%</td>
</tr>
</tbody>
</table>
Example of an Implementation Science Research Study:

Which Works Best for Implementing Self-Management for People with Mental Illness and Chronic Health Conditions?

- Automated Telehealth?

  Or

- Health Coaching and Self-management Training

NIMH Randomized Trial (n=300) Bartels, PI
Example of Future Directions in Older Adult Mental Health Implementation Science:

What About Peers, Mobile Technology And Illness Self-management?
PeerTech
Integrated Medical and Psychiatric Self-Management
mHealth for Adults with Serious Mental Illness

- Psychoeducation
- Coping skills training
- Relapse prevention training
- Behavioral tailoring

Implementation Opportunities for Delivering Evidence-based Older Adult Mental Health Services

- Task shifting
- Telehealth and mHealth technology
- Peer and family support or behavioral health delivery
- Integrating behavioral health services into aging social services, assisted living, home based outreach services (e.g., home delivered meals, paramedics)
- Integrating mental health services into home health care, hospice care, and “hospital at home” delivery models
- Medicare and Medicaid ACOs
- Adaptation of evidence-based practices for older adults in racial/ethnic, LGBT and rural health disparity populations
The Underside of the Silver Tsunami — Older Adults and Mental Health Care

Stephen J. Bartels, M.D., and John A. Naslund, M.P.H.

Approximately 5.6 million to 8 million Americans 65 years of age or older have mental health or substance-use disorders, and the Institute of Medicine (IOM) estimates that their numbers will reach 10.1 million to 14.4 million by 2030. Yet the American Geriatrics Society estimates that there are fewer than 1,800 geriatric psychiatrists in the United States today and that by 2030 there will be only about 3,600 — less than 1 per 6,000 older adults with mental health and substance-use disorders. The IOM’s 2012 workforce report on this topic, aptly subtitled In Whose Hands, confirms that we will never be able to train enough specialists in geriatric medicine and geriatric psychiatry to care for this rapidly growing and highly vulnerable population. Indeed, more than half the fellowship positions in geriatric medicine or geriatric psychiatry go unfilled each year (see graph), and according to the American Psychological Association, only 4.2% of psychologists focus on geriatrics in clinical practice.

Older adults with mental health disorders have greater disability than those with physical illness alone, as well as poorer health outcomes and higher rates of hospitalization and emergency department visits, resulting in person costs that are 49% to more than 200% higher. Yet mental health services account for only 7% of Medicare expenditures. Formulating and implementing policies to build the geriatric mental health workforce to address these needs has been notoriously difficult, especially since different federal agencies hold responsibility for mental health services and aging services.

Fortunately, the IOM report reiterates needing yet another “crisis” — requiring the training of more geriatric specialty physicians — as an alarm and recommendation that has been repeated in vain for more than 90 years. Instead, the unprecedented aging of the population requires an unprecedented shift in the delivery paradigm for geriatric mental health care.

The new Medicare Annual Wellness Visit highlights for primary care physicians this challenge of meeting the health care needs of older adults; it requires screening for depression as well as the detection of cognitive impairment, thus adding newly identified disorders but without additional resources, trained personnel, or additional reimbursed time to provide follow-up services. The IOM report begins to address the shortfall of geriatric mental health services.
OLDER ADULTS

Adults age 65 and older represent an ever-growing portion of the United States population. This page contains a variety of resources to help integrate primary and behavioral health care providers prepare their services to align with the unique needs of older adults.

- Behavioral Health Identification and Treatment
- Screening and Assessment Tools
- Evidence-based Practices
- Workforce
- Financing
- Resources for Individuals and Families
- Federal and National Entities for Older Adults’ Health

FEATURED RESOURCE

Growing Older: Providing Integrated Care for an Aging Population is a new publication from the SAMHSA-HRSA Center for Integrated Health Solutions that offers tips for safety-net primary care providers to be prepared to meet the behavioral health needs of older adults.

BEHAVIORAL HEALTH IDENTIFICATION AND TREATMENT

In older adults, behavioral and cognitive conditions often present differently than younger adults. These resources provide information to help understand these differences.

General Resources
Resources: SAMHSA-HRSA Center for Integrated Health Solutions: Older Adults

Depression and Suicide

- SAMHSA's The Treatment of Depression in Older Adults Evidence-Based Practices Kit provides information on evidence-based programs to treat and improve outcomes for depression and dysthymia.

- Preventing Suicide in Older Adults, an issue brief from SAMHSA and the Administration for Community Living, assists health care and social service organizations in developing strategies to prevent suicide in older adults.

- The American Medical Association's Differentiating among Depression, Delirium, and Dementia in Elderly Patients, published in the Journal of Ethics, details the distinguishing characteristics of depression, delirium, and dementia and practical advice for differentiating among them.

- The National Council on Aging's Suicide Prevention Among Older Adults webinar described the prevalence of and risk factors for suicide among older adults, discussed how suicide is being addressed at the federal level and shared a list of resources.

- SAMHSA's Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities provides guidelines, hands-on tools and training manuals for senior living staff to integrate suicide prevention into ongoing programs.

Major Neurocognitive Disorder and Geriatric Depression: What's New in 2016? is a presentation from Brent Forester, MD, MSCe, that reviews the general principles of geriatric psychopharmacology, the identification, treatment, and prevention of major neurocognitive disorders and geriatric depression, and the risks associated with pharmacological interventions.

Substance Use

- Screening and Brief Intervention for Substance Misuse Among Older Adults: The Florida BRITE Project is a review of the effectiveness of the Florida Brief Intervention and Treatment for Elders (BRITE) project, a three-year, state-funded pilot program of screening and brief intervention for older adults. The study found those who received the brief intervention had improvement in alcohol, medication misuse, and depression measures.

- Substance Abuse by “Mature” Adults: Is Your Patient Using or Abusing? is a video with Louis A. Tovian, MD that describes how to identify and address substance abuse in older adults.

Implementation Science Resources

PCORI Dissemination & Implementation Toolkit

Dissemination and Implementation at Washington University in St. Louis - Educational, print toolkits, beginner/intermediate
https://sites.wustl.edu/wudandi/
Developed by the Dissemination and Implementation Research Core (DIRC), this website houses numerous Dissemination and Implementation toolkits. Toolkit topics include Aims, Barriers and Facilitators, Implementation Outcomes, and Implementation Organizational Materials.

Dissemination & Implementation Models in Health Research and Practice
http://www.dissemination-implementation.org/
This website was designed to help researchers and practitioners to select the D&I model that best fits their research question through a searchable database

The Community Tool Box – Niche/Community
https://ctb.ku.edu/en
The Community Tool Box, developed by the University of Kansas, is a comprehensive guide to working with community based organizations and participants. Content on the website includes chapters and toolkits on topics including community assessment, communications to promote interest and participation, and building leadership.
Any questions?

Type any questions into the Q&A box at the bottom of your screen.