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Supporting Older Adults with Co-occurring Health Conditions

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This webinar was developed [in part] under contract number HHSS283201200021I/HHS28342003T from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.
Agenda

- Who is MHA?
- Specific Challenges for Older Adult Mental Health
- Findings from the Better Care Survey for Older Adults
  - Barriers to Care
  - Recent Care Experiences
  - What Individuals Want from Care
- Additional Resources
A Century of Advocacy
“I must fight in the open.”

• To move mental health care from poor houses and prisons to health care facilities;
• To screen children for mental health conditions;
• To move dollars from custodial institutions to community-based programs;
• To make mental health a part of overall health.

-- 1913 Policy Agenda, National Committee for Mental Hygiene
Specific Challenges for Older Adult Mental Health

• For many, increased loneliness and experiences of loss
• Changing roles and identity
• More likely to have chronic physical health conditions
For older adults, often focus is on addressing chronic physical health conditions, but less attention to managing emerging or existing mental health conditions.

Which came first, problems with your mental health, or problems with your physical health?

- Mental health: 57%
- Physical health: 19%
- Happened at the same time: 10%
- I don't know: 14%
• March-August 2020
• Surveyed 1,353 adults ages 35-65+ with co-occurring physical and mental health conditions
  • Barriers to initiating care
  • Current care experiences
  • What they want to receive in care from their providers.

MHA Screening reflects the experiences of a help-seeking population that accesses mental health screening through www.mhascreening.org. We do not reach the entire population; therefore our numbers are likely to underreport the actual experiences of the population.
Starting the Conversation

- 44% of adults with co-occurring conditions wouldn’t bring up a problem if their provider didn’t ask.
- More likely to feel comfortable bringing up physical than mental health concerns.
- 65% percent of adults ages 35-64 and nearly half of adults over 65 didn’t know if it was enough of a problem to mention.
IT’S TOTALLY DIFFERENT. WHEN IT COMES TO MY PHYSICAL HEALTH, I RIGHT AWAY TELL THE DOCTOR AS MUCH DETAILS AS I CAN OF HOW I AM FEELING. I COULD NEVER HAVE THE GUTS TO BRING UP MENTAL HEALTH UNLESS THEY ASK ME. IT IS A VULNERABILITY ISSUE.

IT’S JUST MORE DIFFICULT TO FIND THE ENERGY TO REACH OUT. I FEEL LIKE A BURDEN AMIDST BIGGER CRISES.

IT WAS A WHILE AGO, BUT I RECALL WONDERING MOST WHETHER MY CONCERNS WERE SIGNIFICANT ENOUGH TO WARRANT TREATMENT. I FELT LIKE MENTAL ILLNESS WAS SOMETHING MUCH MORE SEVERE AND WHAT I FELT WAS MORE ABOUT MY INADEQUACY.
Difficulty Knowing Where To Go For Help

I Didn't Know Who to Bring It Up To

<table>
<thead>
<tr>
<th></th>
<th>Adults Ages 35-64</th>
<th>Adults Ages 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>57%</td>
<td>54%</td>
</tr>
<tr>
<td>Disagree</td>
<td>43%</td>
<td>46%</td>
</tr>
</tbody>
</table>

Agree  Disagree
Fear of Initiating Mental Health Care

I Was Nervous About What Would Happen If I Was Diagnosed With a Condition

Ages 35-64
- Disagree: 31%
- Agree: 69%

Ages 65+
- Disagree: 51%
- Agree: 49%
Compounding Costs of Care for Multiple Conditions

I Didn’t Think I Would Be Able To Afford the Care If I Did Have Something

- Ages 65+:
  - Agree: 53%
  - Disagree: 47%

- Ages 35-64:
  - Agree: 67%
  - Disagree: 33%

“I ultimately decided not to take the medication she prescribed because I was afraid I wouldn't be able to afford it, or any necessary follow up appointments with her.”

“I have tried several times, don’t think they understand financial implications to my family if I did what they wanted me to do.”
Managing Care Across Multiple Conditions

**I already had enough to deal with. I didn't have the time or energy to deal with an illness/another illness**

- **Adults Ages 35-64**
  - Agree: 72%
  - Disagree: 28%

- **Adults Ages 65+**
  - Agree: 51%
  - Disagree: 49%
Fear of Burdening Caregivers

I Didn’t Want to Burden My Family Members or Caregivers With Being Sick

- Ages 35-64:
  - Disagree: 21%
  - Agree: 79%

- Ages 65+:
  - Disagree: 31%
  - Agree: 69%
### Recent Care Experiences

Which of the following statements, if any, are true about your most recent care experience?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>My doctor asks me about new problems or changes.</td>
<td>47.66%</td>
</tr>
<tr>
<td>I feel knowledgeable about my physical health condition.</td>
<td>46.73%</td>
</tr>
<tr>
<td>My doctor takes time to explain treatment options for my physical health problems.</td>
<td>46.17%</td>
</tr>
<tr>
<td>My doctor takes the time to explain the causes and symptoms of my physical health problems.</td>
<td>45.98%</td>
</tr>
<tr>
<td>I feel comfortable bringing up new concerns with my doctor.</td>
<td>43.18%</td>
</tr>
<tr>
<td>I feel knowledgeable about my mental health condition.</td>
<td>42.06%</td>
</tr>
<tr>
<td>I have been asked about or screened for my mental health as part of my care.</td>
<td>36.45%</td>
</tr>
<tr>
<td>My doctor takes time to explain treatment options for my mental health problems.</td>
<td>31.03%</td>
</tr>
<tr>
<td>My doctor takes the time to explain the causes and symptoms of my mental health problems.</td>
<td>24.30%</td>
</tr>
</tbody>
</table>
## What Individuals Want From Their Providers

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide me with tools I can use on my own to help with my physical or mental health.</td>
<td>363</td>
<td>67.85%</td>
</tr>
<tr>
<td>Take time to listen to and address my goals and priorities in care (both physical and mental).</td>
<td>347</td>
<td>64.86%</td>
</tr>
<tr>
<td>Give me more information about medications or referrals to treatment for physical and/or mental health.</td>
<td>344</td>
<td>64.30%</td>
</tr>
<tr>
<td>Take the time to explain treatment options for my mental health problems.</td>
<td>340</td>
<td>63.55%</td>
</tr>
<tr>
<td>Take the time to explain treatment options for my physical health problems.</td>
<td>324</td>
<td>60.56%</td>
</tr>
</tbody>
</table>
Moving Towards a System of Better Care

• Proactively engage in conversations about mental health, and then ensure that those conversations are ongoing
• Work with patients to help them navigate the costs of different treatments and choose care that is accessible to them
• Integrate mental health care into general health care settings, communities, and workplaces
• Invest in digital resources and other tools that can be accessed within communities and in spaces where people spend most of their time
• Engage in shared decision-making
Additional Resources

• To access the full report and accompanying worksheet visit: https://mhanational.org/research-reports/creating-better-care-adults-comorbid-chronic-conditions

• For more resources on supporting individuals with co-occurring conditions: https://mhanational.org/conditions/co-occurring-mental-health-and-chronic-illness

• To take a mental health screen: www.mhascreening.org
Supporting Older Adults with Comorbid Health Conditions: Integrating Behavioral Health into Primary Care

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PACE-A Program of All-inclusive Care for the Elderly
Disclosures

• No financial conflict of interest
• Board Certified in Internal Medicine and Psychiatry
• Fellow American College of Physicians
• Fellow American Psychiatric Association
• Member, APA Council for Geriatric Psychiatry
• Vice Chair, National PACE Association Primary Care Committee
Goals

To describe an example of a PACE (Program of All-inclusive Care for the Elderly) program integrating physical and behavioral health for older adults with multiple chronic conditions in practice (ie, an example of holistic health care for clinically complex older adults)
Comorbidity and Multimorbidity

- **Comorbidity** more often describes the combined effects of additional diseases in reference to an index disease (eg, comorbidity in cancer).
- **Multimorbidity** is more often meant to describe simultaneous occurrence of 2 or more diseases that may or may not share a causal link in an individual patient.
- ~80% of Medicare beneficiaries have at least 2 chronic conditions.
- More than 60% have at least 3 chronic conditions.

What is Frailty?

Frailty is a common and important geriatric syndrome characterized by age-associated declines in physiologic reserve and function across multiorgan systems, leading to increased vulnerability for adverse health outcomes.

PACE: Program of All-inclusive Care for the Elderly

• To qualify for PACE, a person must be age 55 or over, live in a PACE service area, and be certified by the state to need a nursing home level care (using state Medicaid criteria) however, not living in a nursing home at the time of enrollment

• The typical participant is an 80-year-old woman with 8 medical conditions and limitations in 3 activities of daily living

• 49 % of PACE participants have dementia

• Nearly 60% of PACE participants have Serious Mental Illness

• More than 90% of PACE participants are Medicaid and Medicare dual eligible

• More than 90% of PACE participants live in the community
Serious Mental Illness (SMI) & PACE

• National stats June 2019 (all # are %)
  – Schizophrenia: PACE avg 5.7 (0-25.5)
  – MDD/Bipolar: PACE avg 41.3 (10.8-74.8)
  – Dementia/0 Complications: PACE avg 19.4 (0-46.6)
  – Dementia/w Complications: PACE avg 25.8 (0-47.3)

• How do those with Serious Mental Illness meet criteria for PACE?
  – Functional impairment, executive dysfunction
  – Impoverished due to structural challenges with US health care and carving out behavioral healthcare
  – *68% of those with schizophrenia are already living in community settings, not in institutions
Severe Psychiatric Disorders in Mid-Life and Risk of Dementia in Late-Life (Age 65-84 Years): A Population Based Case-Control Study *Current Alzheimer Research*, 2014. 11 (7), 681-693
In 2020, here are the rates of illness:

- 5.27% had schizophrenia
- 3.60% had Schizoaffective Disorder
- 8.34% had Bipolar Disorder
- 49.38% had MDD
- 68.63% had dementia
- 31% had a Substance Use Disorder
- 6% had no MH, SUD, Dementia diagnosis
Providence ElderPlace PACE Oregon

• 2014
  – 2 Psychiatric Mental Health NPs (0.7 and 0.8 FTE) = 1.5 FTE
  – 2 LCSW Mental Health Case Managers = 1.2 FTE
  – Just added 0.2 FTE Psychiatrist for Collaboration, Clinical Supervision
  – 14 PCPs (12 FTE): Physicians and NPs
  – 1200 participants
  – 7 PACE centers

• 2017
  – 3 Psychiatric Mental Health NPs (0.7, 0.8, 0.9) = 2.4 FTE
  – 2 LCSW Mental Health Case Managers = 1.2 FTE
  – 0.2 FTE Psychiatrist for Collaboration, Clinical Supervision
  – 16 PCPs (14 FTE): Physicians and NPs
  – 1450 participants
  – 9 PACE centers
Different types of BH integration

Consultative Model
• Psychiatrists or those with less training seeing patients in consultation in his/her office – away from primary care

Co-located Model
• Psychiatrist or other BH provider sees patients in primary care

Collaborative Model
• Psychiatrist or other BH provider provides caseload consultation about primary care patients; works closely with primary care providers (PCPs) and other primary care-based behavioral health providers (BHP)
Prior to 2014

Consultative Model
- Adult Psychiatrist sees 1-3 participants for traditional assessment or treatment consultation at 1 of our 7 PACE sites once per month

Co-located Model
- 2 Psychiatric Mental Health Nurse Practitioners small caseload, attend to urgent MH crisis at request of SW/PCP/RN. They have 1 hour of supervision with the adult psychiatrist per month.
- 2 Mental Health Case Managers (LCSW who do therapy)
Benefits of 2011-2014 Model

- The PMHNPs were PACE employees
- 2 part time Mental Health Case Managers (LCSWs) who did some 1-1 counseling with some participants
- Access to EHR and the team
- PMHNPs/MHCMs understood the PACE model of care
- Fewer No-Shows for MHCM/PMHNP then for psychiatrist
- Increased use of Evidence Based Practices
  - Example: clozapine for those with chronic psychosis who failed 2+ antipsychotic medications
Challenges of 2014 Model

- Stigma common
- Mental Health notes required you to “Break the glass” to view
  - Few, if any, PACE team members ever accessed MH notes
- Many outside therapists with no interaction with team
- Team members uncomfortable with caring for participants with MH and SUD diagnoses
- Criteria for inpatient psychiatry units misunderstood-not for those who are delirious, most Oregon inpatient psychiatric care do not do well with those with Dementia and Behaviors
- Psychotropic medication use done with a Geriatrician lens
  - Familiar with side effects, less aware of benefits AND most importantly not aware of evidence based use
Challenges of 2014 Model

• Consulting psychiatrist was an adult psychiatrist not experienced with older adults and geriatrics

• Geriatricians/PCPs/PharmD’s lowered and often stop psychotropics without knowledge of evidence base around this
  – Ex-someone with Schizophrenia/Schizoaffective D/O would need to be off antipsychotics for 5 years before a taper can be considered successful; often a taper is clinically contraindicated

• Participants regularly refused to travel to site to see Psychiatrist so there were many no shows

• Due to large number of crisis/urgent calls to 2 part-time PMHNPs for ~1200 participants, and minimal system for case load management-PMHNPs skillset not well utilized
Collaborative Model - choose the correct psychiatrist-must have excellent understanding of chronic medical comorbidity
—Geriatric Psychiatrist: education, case consultations; works closely with primary care providers (PCPs) and other behavioral health providers (includes SW, RN, PMHNP, OT, MHCM)
—Train PMHNP to be collaborative with PCP/SW/RN
—Focus on the health of the entire population
  • Education including Leadership about Mental Illness
  • Education about capacity issues
  • Education about substance use disorders
  • Education about neuropsychiatric disorders (dementia, Multiple Sclerosis, Parkinson’s Disease etc)
—Occasionally see participants
Collaborative Care Geriatric Psychiatrist

- Successfully eliminated “break the glass” in EHRecord
- Increased use of evidence based mental healthcare
- Analyzed PEP MH and Dementia prevalence, increased collaboration and reorganized model of care from co-location to partial integration
- Supervision: 1 hour per month to group of PMHNPs, 1 hour per month to each PMHNP & daily PRN consultations (0-5), daily PRN consultations to PCPs on participants with SMI, late life MH sx, SUD, Dementia and Behaviors, Neuro/Neuropsych Disease Tx, capacity assessment, PRN consult to PharmD/MH Case Manager/SW/RN
- Provided regular education on behavioral health disease and appropriate to treatment to PCPs, MH team, SW, Rehab (PT, OT) and RNs
Example of a Behavioral Health intervention in PACE at Providence ElderPlace PACE Oregon
Project to increase use of Dementia Specific Meds

- Dementia is a syndrome based on the Triad of Behaviors, Functioning and Cognition. Many different etiologies
- Serious Mental Illness is exceedingly common in PACE participants
- Serious Mental Illness significantly increases the odds of an older adult developing dementia
- Dementia is exceedingly common in PACE participants
- Using the substantial evidence base supporting the use of dementia specific medicines to decrease and prevent behavior disturbance related to dementia
- This allows for decreasing inappropriate use of antidepressants, sedatives, and antipsychotics

Project to increase use of Dementia Specific Meds

- PCPs and PMHNPs were educated about properly coding dementia (Major Neurocognitive Disorder) and Behavior Disturbance using the Neuropsychiatric Behavioral Inventory for defining and measuring behaviors.

- Education about the evidence base behind the recommendation shared with the PCPs, PharmD’s, Behavioral Health staff.

- PharmD’s sent out Neuropsychiatric Behavioral Inventory with every new Rx for dementia specific meds and then a 3 month then 6 month follow up and collected data.
Neuropsychiatric Inventory-Q form

Circle "Yes" only if the symptom(s) has been present in the last month. Otherwise, circle "No". For each item marked "Yes":

SEVERITY of the symptom (how it affects the patient):

1 = Mild (noticeable, but not a significant change)
2 = Moderate (significant, but not a dramatic change)
3 = Severe (very marked or prominent, a dramatic change)

DISTRESS of caregiver due to that symptom (how it affects you):

0 = Not distressing at all
1 = Minimal (slightly distressing, not a problem to cope with)
2 = Mild (not very distressing, generally easy to cope with)
3 = Moderate (fairly distressing, not always easy to cope with)
4 = Severe (very distressing, difficult to cope with)
5 = Extreme or Very Severe (extremely distressing, unable to cope with)
NPI-Q questions 1-3

• Delusions
  – Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?

• Hallucinations
  – Does the patient have hallucinations such as false visions or voices? Does he or she seem to hear or see things that are not present?

• Agitation/Aggression
  – Is the patient resistive to help from others at times, or hard to handle?
NPI-Q questions 4-8

- **Depression/Dysphoria**
  - Does the patient seem sad or say that he/she is depressed?

- **Anxiety**
  - Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?

- **Elation/Euphoria**
  - Does the patient appear to feel too good or act excessively happy?

- **Apathy/Indifference**
  - Does the patient seem less interested in his/her usual activities or in the activities and plans of others?

- **Disinhibition**
  - Does the patient seem to act impulsively, for example, talking to strangers as if he/she knows them, or saying things that may hurt people's feelings?
NPI-Q questions 9-12

• Irritability/Lability
  – Is the patient impatient and cranky? Does he/she have difficulty coping with delays or waiting for planned activities?

• Motor Disturbance
  – Does the patient engage in repetitive activities such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?

• Nighttime Behaviors
  – Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?

• Appetite/Eating
  – Has the patient lost or gained weight, or had a change in the type of food he/she likes?
Of the PACE participations who have dementia, what percent of them were on a Cholinesterase Inhibitor (donepezil/aricept, rivastigmine/exelon, galantamine/razadyne) or NMDA receptor antagonist (memantine/namenda). These are the two classes of dementia medications at the moment.
What happened to behaviors when people with dementia were on a dementia specific medication? Over time, behavioral disturbances decreased. The longer the person was on the medication, the more the behaviors improved.
This graph shows how specific domains of the NPI changed before and after the use of dementia specific medications. Agitation/aggression, Depression/dysphoria, Apathy/indifference and appetite/eating improved the most. No behaviors worsened with these medication use.
This graph is showing the change in severity of behaviors before and after the use of dementia specific medications. The biggest surprise in this data was how few people had severe behavior disturbance after treatment.
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