GROWING OLDER

Providing Integrated Care For An Aging Population

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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U.S. Department of Health and Human Services
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THE NUMBER OF AMERICANS AGE 65 AND OLDER INCREASED BY 25 PERCENT FROM 2003 TO 2013 AND THE NEXT 25 YEARS PROMISE ANOTHER 50 PERCENT INCREASE. FROM 2018 TO 2038, THE NUMBER OF AMERICANS AGE 85 AND OLDER IS EXPECTED TO MORE THAN DOUBLE FROM 6 MILLION TO 14.6 MILLION.[i]

Nearly one in five older adults have one or more mental health or substance use conditions (referred to in this document under the umbrella term, "behavioral health").[ii] About 16 percent of women and 11 percent of men age 65 and older experience symptoms of depression.[iii] The majority of older adults' behavioral health issues are identified and treated in primary care settings instead of specialty behavioral health settings.[iv]

Older adults are distinct from other populations in key ways:

- **Complex chronic health conditions.** Older adults are more likely than any other age group to have complex chronic health conditions, including mental health conditions, substance use disorders and cognitive impairments.[v] About two-thirds of older adults have two or more chronic conditions.

"WHAT DOES THIS MEAN FOR MY PRACTICE?"

If you serve 100 adults 65 and older, it is likely that 20 of them have a behavioral health condition.

- **Drug use and abuse.** Older adults receive a high proportion of prescription drugs in the U.S. due to increased likelihood of being prescribed long-term and multiple medications.[vi] Improper use is common, whether because of cognitive decline or attempting to save money by using their medications sparingly or taking another person's remaining medications. Additionally, commonly prescribed medications – opioids for pain and benzodiazepines used to treat anxiety and sleep disorders – are addictive and can increase the risk of falls and memory/retention issues affecting up to 17 percent of older adults.[vii] Co-morbid health conditions, age-related changes in drug metabolism; potential interactions with prescribed drugs, over-the-counter medications, dietary supplements and alcohol; and cognitive decline make drug misuse a special concern.[viii]
- **Health disparities.** Life expectancy and overall health have improved for most Americans in recent years, but factors related to economic status, race, sexual orientation, gender identity and rural status, as well as limited access to adequate housing and transportation services, keep many older adults from benefiting from these gains.
- **Safety concerns.** Individuals become more frail as they age and their risk of falls and injury increases. One in every three adults aged 65 or older falls each year and falls are the leading cause of both fatal and nonfatal injuries for older adults.[ix]
- **Loss is common.** Some older adults may experience loss. Loss of spouses, friends, physical functioning, independence, routine and sense of purpose affects overall health, including

mental health and substance use. Health care providers and older adults often mistake depression for a natural response to aging. This can lead providers to not screen for or treat depression and older adults to not seek help.

- **Elder abuse.** Elder abuse is a serious problem, with an estimated 8 to 10 percent of older adults experiencing abuse, not including financial exploitation.[x] Other estimates found that between one and two million older adults are mistreated each year, while only 27 percent of hospital emergency departments have elder abuse protocols (compared with 75 percent for child abuse).[xi]
- **Negative attitudes and discrimination toward people with behavioral health concerns.** These attitudes can be a barrier for all age groups. Generational and cultural differences may be a barrier to identifying concerns, treatment follow-through and active engagement in behavioral health treatment.[xii, xiii]

While providers, family members, peers and community stakeholders must be aware of these concerns, it is also important to be skeptical of antiquated stereotypes and assumptions about older adults' health status. Older adults remain physically active for longer than ever before, continue to be active learners and frequently use health technologies to manage their health. Most older adults do not have a cognitive impairment. Recovery from depression, back pain and other injuries or illnesses *is the norm*. The overall category of older adults (age 65 and older) is further divided into subgroups – "young old" (65-74 years), "middle old" (75-84 years) and "oldest old" (85+ years) – to help understand variability in patients' experiences. However, it is important to consider an individual's functional age as well as their chronological age.

Patient-centered care requires that you treat all of your patients, regardless of age, as individuals with unique strengths, histories and needs.

Successful practices establish outcome measures that meet the range of behavioral health and primary care needs of older populations.

BE AWARE OF THE SIGNS AND SYMPTOMS OF ABUSE AND KNOW WHO TO CALL TO REPORT SUSPECTED ABUSE.

SALLY IS 83 and recently fractured a hip. She has severe osteoporosis, high blood pressure, chronic pain and a history of depression. She is cared for by her daughter who is trying to get her to move into an assisted living center, but Sally refuses, saying she can live on her own. Using a standardized screening tool, Sally's integrated primary and behavioral health care program identified increasing depressive symptoms. An assessment for pain management prompted a full review of medications for effectiveness and risk of abuse, leading to changes in her prescriptions to decrease side effects and increase function. An in-house social worker provided support and intervention for Sally and her daughter regarding care decisions and ultimately connected them with an external caregiver support provider. Together, they identified the resources Sally needed in her home to manage her health.

CAREGIVER CONCERNS: UNDERSTANDING THE ROLE OF THE FAMILY

As some adults age, they may begin to rely more heavily on spouses, children, grandchildren and other loved ones for assistance with daily living activities and navigating the health care system. Unlike the pediatric population, where parents legally and functionally act as caregiver and decision-maker for their child, caregiver relationships for older adults are much less straightforward and obvious. In conditions like dementia, capacities are slowly lost and there is often not a clear point at which patients require surrogate decision-makers.

Family caregivers, as well as paid home health workers, often advocate for their loved one in addition to providing needed care to compensate for workforce shortages and gaps in service. Primary care providers integrating behavioral health must support patient empowerment, encouraging as much patient control over treatment and life decisions as possible, while also building caregivers into decision-making to improve outcomes.

Providers must not only care for the patient, but also the caregiver; one-third of caregivers report their health as being fair to poor.[xiv] Caregivers need resources on mental health and substance use disorders, including support on how to handle their stress and obtain treatment for behavioral health concerns and other chronic conditions. The best models for promoting the caregiver relationship and supporting caregivers are those that are easy to access and culturally informed.

BEHAVIORAL HEALTH AND PHYSICAL HEALTH: RELATIONSHIP CHART

In older adults, physical, behavioral and cognitive conditions often present differently than younger adults. To assist in understanding these differences, the following chart presents some of the common conditions, impairments and physical symptoms, keeping in mind that:

- Physical health conditions often present as behavioral health concerns or cognitive impairments.
- Behavioral health conditions often present as physical conditions or cognitive impairments.
- Many medications have side effects that may present as symptoms of another illness. The interaction of multiple medications can exacerbate symptoms and even cause health problems. Further, sometimes having a condition, such as dementia, prevents older adults from being able to take medications for other conditions due to potential interactions.
- Depression often occurs with physical health conditions. Symptoms of dementia and delirium frequently emerge in conjunction with many behavioral health and physical health conditions.

CONDITION	BEHAVIORAL HEALTH/ COGNITIVE SYMPTOMS	PHYSICAL SYMPTOMS
Infection/urinary tract infection	Decreased appetite or fluid intake Sudden onset of confusion Change in functioning	Pain, burning on urination Frequent urination
Myocardial infarction	Fatigue Decreased functioning	Chest pain Nausea Vomiting Shortness of breath For women, pain in upper chest area
Thyroid disease	Confusion Agitation Fatigue Diminished energy and apathy Impaired memory	Hair loss Weight gain Changes in bowel movements Dry skin Muscle aches, stiffness, pain in joints
Depression (can be confused with normal reactions to loss and aging)	Agitation Change in appetite Concentration and memory loss Sleep disturbance	Gastrointestinal symptoms/constipation Pain Headaches
Alcohol misuse	Cognitive decline/confusion Sleep disturbance Self-care deficits	Injuries/falls Osteoporosis Gastrointestinal problems Infection Unstable hypertension
Prescription drug misuse	Delirium Dementia Daytime sedation/sleep disturbance Problems with attention	Physiological arousal Injuries/falls Psychomotor abilities Malnutrition/weight loss Blurred vision Slurred speech

This is not a comprehensive list of common conditions or all symptoms for each condition. It is not intended to serve as a diagnostic tool, but demonstrates the complexity of diagnosing and treating older adults.

ENSURING AN INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE WORKFORCE FOR AN AGING POPULATION

Given the unique and complex needs of older adults, what can be done to ensure that the safety-net primary care workforce is prepared to meet the behavioral health needs of this aging population? Since it is unlikely that there will ever be enough specialty behavioral health providers, primary care organizations are now focusing on adapting their systems and expanding their existing workforce skill sets to include behavioral health. The coordination of primary and behavioral health services is also called integrated care. In January 2014, the SAMHSA-HRSA Center for Integrated Health Solutions described the Core Competencies for Integrated Behavioral Health and Primary Care. The following lists specific strategies for serving older adults as they relate to each of the core competencies:

I. **Interpersonal Communication.** Provide anticipatory guidance for patients and caregivers, especially related to advanced care planning. Actively engage family members who may not accompany patients to appointments but are part of the patient's care. Accommodate for the impact of dementia, language and hearing barriers. Avoid confusing medical terminology. Clearly explain medication and treatment options, repeat when necessary and provide in writing using friendly, helpful, accessible language. Tap into the patient's strengths to promote self-management and communicate positive views of aging. Recognize sensory changes that occur with age such as diminished peripheral vision and differential auditory strength.

II. **Collaboration and Teamwork.** Recognize that one provider cannot address all medical and behavioral health needs in 15-20 minutes. Use an informed team approach to provide comprehensive services, with all team members aware of their responsibilities. Train non-medical staff to conduct environmental, social and medical histories and screenings. Establish working relationships with other internal and external members of the care team. Listen to patient and caregiver and recognize that the desired outcome for older adults may be a change in function, not a change in symptoms. Refer to specialty behavioral health care or aging services as needed or use telebehavioral health, especially in rural settings.

DESIGNATE A CARE MANAGER
who can help connect patients with community resources and specialty care and can check in to ensure the patient followed the treatment recommendation.

CONSIDER USING NON-CLINICAL LANGUAGE
to discuss behavioral health systems (e.g., "stressed" instead of "anxious," "sad" instead of "depressed").

III. **Screening and Assessment.** Screen for depression, anxiety, substance use, chronic pain, risk of falls — including any recent stressful events that can elevate risk of a fall[xv]— and abuse. Identify general health concerns that affect or manifest as behavioral health symptoms. Be cognizant of gender differences in prevalence of behavioral health conditions

— women are more likely to experience depression, dementia and trauma, while men are more likely to abuse alcohol and prescription drugs. It is especially important that providers differentiate between depression, delirium and dementia. Implement a protocol for suspected abuse and ensure that all members of the care team, including front desk staff, know the warning signs of elder abuse. Be aware of the risk of pain medication abuse/opioid dependency. Monitor for suicide risk. Have a consultation arrangement in place with geriatric mental health and substance use disorder specialists that includes conducting a medication review.

TRAIN YOUR STAFF TO HELP older patients understand and use their benefits.

INCORPORATE STRATEGIES such as medication reconciliation and prescription monitoring into your EHR to alert providers of medication interactions and over-prescribing to avoid associated risks (e.g., abuse, falls, delirium).

IV. **Care Planning and Care Coordination.** Engage unpaid and paid caregivers in care planning. Identify and use aging system resources like peer support and advanced care planning supports (see "Resources" for additional ideas). Collaborate with the pharmacist to ensure proper prescribing and dosage to avoid medication risks. Older adults may need additional help accessing follow-up care. Employ warm hand-offs to ensure continuity of care. Recognize the appropriateness of short, time-limited interventions for addressing many mental health and substance use concerns (e.g., Florida BRITE).

V. **Intervention.** Understand common ailments of older adults that should trigger a primary care evaluation. Physical symptoms are often caused by stress, trauma, loss and mental health conditions while physical health conditions may manifest as behavioral concerns. Implement evidence-based practices that are known to be effective for older adults and refer to specialist behavioral health providers who use best practices in your community (see "Resources" for suggestions). Avoid inappropriately prescribing antipsychotics to alter behavior in older adults with cognitive impairments.[xvi]

VI. **Cultural Competence and Adaptation.** Check if your physical space is accessible for older adults (e.g., wider doorways, exam rooms with space for caregivers, handrails, smooth transitions at doorways). Recognize and respect cultural differences with patient and caregiver involvement. Understand the role negative attitudes and discrimination can play for various cultural groups and older adults. Accommodate generational differences in use of technology and cultural acceptance of questioning or not questioning providers. Use formal and informal community resources to overcome geographic and transportation barriers in rural areas.

VII. **Systems-Oriented Practice.** Understand and explain Medicare benefits, including Part D and preventive benefits (e.g., alcohol misuse screening, depression screening) to patients and their caregivers. Coordinate benefits for dually eligible Medicaid/Medicare beneficiaries, including certain social services that are available with lower cost sharing. As the health care landscape changes (for instance, accountable care organizations [ACOs] are established), ensure that a staff member is equipped to help patients understand and use their benefits.

VIII. Practice-Based Learning and Quality Improvement. Measure patient and family caregiver satisfaction. Provide continual staff training related to major competencies and best practices for older adults. Learn to recognize behavioral disorders. Monitor avoidable negative health outcomes that are more prevalent with older adults and implement quality improvement protocols (e.g., injuries, infections, adverse reactions to multiple medications).

IX. Informatics. Establish electronic health records that include multiple providers, all prescriptions, social service notes and clinical decision support tools. Use large print informational materials. Ensure kiosks and other touchpad technologies have large buttons. Address privacy concerns related to sharing health information.

Evidence-based guidelines are a great resource for identifying clinical, organizational and systems level changes to improve care for older adults. The National Coalition on Mental Health and Aging has compiled a directory of competencies, standards and guidelines for providers working with older adults encountering behavioral health concerns. Many other national provider organizations have practice guidelines and protocols to consider when working with older adults (See the resource list at the end of this document).

THE ROLE OF THE COMMUNITY

Primary care providers are not alone in caring for the aging population. Caregivers, neighbors, friends and community-based organizations also play a vital part in supporting older adults' primary and behavioral health. Rural communities with workforce shortages are of special concern and older adults may have to depend on community partnerships and existing informal networks of friends and neighbors to promote healthy behaviors and allow them to remain in their own homes and engaged in community life. As part of care coordination, providers must know the community resources equipped to address social determinants of health, elder abuse and isolation, and appropriately connect patients to those services.

ENGAGE PATIENTS AND THEIR CAREGIVERS EARLY IN ADVANCED CARE PLANNING FOR END-OF-LIFE CONSIDERATIONS AND CONNECT THEM WITH AREA LEGAL AND SOCIAL RESOURCES AS NEEDED.

Your community may have the following organizations and services available to serve as partners in the health promotion and disease prevention of older adults:

- Adult protective services
- Nutrition programs
- Senior centers
- Transportation services

The Eldercare Locater can help you find these resources in your community.

In addition, Mental Health First Aid for Older Adults provides community members with the required tools to identify a behavioral health problem and get their neighbor, friend or loved one help. A more informed community can be integral to addressing gaps in services and promoting the health of all its

citizens, especially older adults with potential mental health and substance use concerns.

OLDER ADULTS RESOURCES

BEHAVIORAL HEALTH IDENTIFICATION AND TREATMENT

The Treatment of Depression in Older Adults Evidence-Based Practices KITs — A SAMHSA publication that provides an array of evidence-based programs to treat depression and dysthymia

Substance Abuse by "Mature" Adults: Is Your Patient Using or Abusing? — A video with Louis A. Trevisan, MD that describes how to identify and address substance abuse in older adults

Preventing Suicide in Older Adults — An issue brief from SAMHSA and the Administration on Aging to help health care and social service organizations develop strategies to prevent suicide in older adults

SAM'S SON brought him to see his primary care provider saying that Sam was increasingly confused over the past week. His wife died last month and now Sam lives alone, but his children check in on him daily. Sam's primary care provider evaluated him for physical causes of confusion (e.g., dehydration, urinary tract infection, stroke) and for depression. His primary care provider also asked Sam's son about his own level of stress. As a result, the provider connected Sam with their in-house counselor to provide grief counseling for Sam and identified outside resources to support Sam's son as a caregiver.

Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities — A SAMHSA publication that includes guidelines for integrating suicide prevention into ongoing programs, hands-on tools, and training manuals for senior living communities

EVIDENCE-BASED INTEGRATED CARE PRACTICES FOR OLDER ADULTS

Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) — Collaborative care approach to treat depression or dysthymia that involves a trained depression care manager, patient, primary care provider and psychiatrist.

Wellness Initiative for Senior Education (WISE) — Health promotion program related to health behaviors, the aging process, managing care, medication management and signs of alcohol misuse and depression.

EnhanceWellness — Helps older adults with chronic health conditions manage their illness and avoid psychiatric medications, physical inactivity, depression and social isolation.

Senior Reach — Training for community partners to identify older adults experiencing mental health and related concerns and help get them into recovery-oriented behavioral health treatment.

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) – A program that integrates depression awareness and management into existing case management services.

Program to Encourage Active, Rewarding Lives (PEARLS) — Community-based intervention for individuals with depression or dysthymia that helps reduce symptoms and suicidal ideation through problem-solving, social and physical activation and pleasant activity scheduling.

Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) — Primary care intervention to recognize depression and suicidal risk and manage treatment.

Resources for Enhancing Alzheimer's Caregiver Health II (REACH II) — At home and telephone-based intervention to reduce caregiver burden and depression, improve self-care and offer social support.

BRIEF SCREENS FOR PRIMARY CARE PROVIDERS

Depression Screen — Patient Health Questionnaire (PHQ-9)

Anxiety Screen — Generalized Anxiety Disorder 7-item scale (GAD-7)

Cognitive Measure for Dementia — The Mini-Cog

Cognitive Impairment Screen — Montreal Cognitive Assessment (MoCA)

Dementia Functional Assessment — Functional Activities Questionnaire (FAQ)

Delirium Assessment Tool — The Confusion Assessment Methods Diagnostic Algorithm (The CAM)

Brief Alcohol Screen — Alcohol Use Disorders Identification Test (AUDIT-C)

Opioid Abuse/Chronic Pain Medication Abuse Screen — The Opioid Risk Tool (ORT)

INTEGRATED CARE WORKFORCE RESOURCES

2012 Institute of Medicine Report — The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?

2013 Institute of Medicine Report — Elder Abuse and its Prevention: Workshop Summary

American Association for Geriatric Psychiatry — Geriatric Psychiatry Core Competencies

Association for Gerontology in Higher Education — Online Directory of Educational Programs in Gerontology and Geriatrics

National Institute on Aging - Talking with Your Older Patient

SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) — Workforce Resources

FINANCING INTEGRATED CARE RESOURCES

— Medicare is the major payer of integrated health care for older adults. The following resources provide information for understanding Medicare's role in the financing of primary care, behavioral health and other specialty medical care.

Medicare Accountable Care Organizations — Overview of the ACO model

Center for Medicare and Medicaid Services Financial Alignment Initiative — Financing for Medicare-Medicaid enrollees

GENERAL RESOURCES AND ORGANIZATIONS RELATED TO CARE FOR OLDER POPULATIONS

AARP — www.aarp.org/health

Administration for Community Living — www.acl.gov

Elder Abuse Resources — www.aoa.acl.gov/AoA_programs/elder_rights/EA_prevention/WhatToDo.aspx

The American Geriatrics Society — www.americangeriatrics.org

American Association for Geriatric Psychiatry — www.aagponline.org

Caregiver Action Network — www.caregiveraction.org

Center for Medicare and Medicaid Services — www.CMS.gov

Family Caregiver Alliance-National Center on Caregiving — https://caregiver.org/national-center-caregiving

National Alliance for Caregiving — www.caregiving.org

National Clearinghouse on Abuse in Later Life — www.ncall.us

National Council on Aging — www.ncoa.org

National Institute on Aging — www.nia.nih.gov

Veterans Administration — www.va.gov/geriatrics

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