The Intersection Between Physical and Mental Health in Older Adults: An Integrated Approach to Care

Steve Bartels MD, MS
Herman O West Professor of Geriatrics
Professor of Psychiatry, Community and Family Medicine, and
The Dartmouth Institute
Geisel School of Medicine at Dartmouth
Director, Dartmouth Centers for Health and Aging
Director, Population Health Collaboratory
Disclosures

• Grant Funding:
  – NIMH
  – CDC
  – HRSA
  – CMS

• Consultant:
  – National Council of Behavioral Health Care
Overview

• The intersection of physical and mental health in older adults
• Integration of mental health care in primary care and in home-based care
• Integration of health care for serious mental illness: health promotion, health coaching, self-management
• The Annual Wellness Visit and Chronic Care Management
• Innovation and technology solutions
• The Big Picture: Health care reform, Applied Research in Primary Care, and an Integrated Geriatric Primary Care “Learning” Health System
Gus:

- 68 yo living in subsidized supervised housing in Boston
- Obesity, Hypertension, CHF, Diabetes, COPD, Atrial Fibrillation, Asthma, Sleep Apnea, Bipolar Disorder
- Hx of frequent ER/Hospital Use
- 30+ medications daily
- Goal: Live Independently in the Community
  Personal action plan: increase exercise, improve healthy eating, learn strategies to cope with daily stressors
Older Americans with Mental Illness Doubling in 3 Decades

![Graph showing the increase in the number of older Americans with mental illness from 2000 to 2030. The graph indicates a doubling in the number of people with mental illness across different age groups.](image-url)
Mental Health in Older Adults is a Health Care Problem
Depressed Home Health Care Patients: More likely to Have an Injurious Fall

![Bar chart showing the percentage of matched controls and fallers depressed at the start of care.]

Sheeran et al., Home Healthcare Nurse 2004
Byers et al., Research in Gerontological Nursing. 2008
Depression Kills Older Women 7 Years After Hip Fracture

Depressive Symptoms

Mortality (%)
Depression and Greater Likelihood of Mortality After Heart Attack

Survival free of cardiac mortality, cumulative %

Time after discharge for MI, days

No Depression
Mild Depression
Moderate Depression
Severe Depression

Severe Depression 3.7 X More Likely to Die
\[ P \leq .001 \]

N=896

Lespérance, 2003
Rediscovering the Neck
Depression Kills Older Men
Mental Illness Can Double or Triple Dually Eligible Costs
Depression in Older Adults is Different

• **Aging-related risk factors for depression:**
  - Medical Illness
  - Disability
  - Cognitive Decline
  - Social Isolation
  - Loss And Other Negative Events

• **Depression increases risk of same factors**

• **Prevalence of major depression in older adults:**
  - On average, lower than younger adults/youth
  - Rates increase in settings characterized by risk factors:
Treatment of Depression in Older Adults is Often More Complicated and Time Consuming

• Assessment can be difficult:
  - Medical comorbidity and disability
  - Beliefs that depression is a “normal”
  - Beliefs that is a character flaw

• Treatment
  - Competing priorities
  - Preferences, stigma
  - Barriers to accessing psychotherapy
  - Multiple Medications
  - “Start Low, Go Slow” → “Start Low, Stay Low”
The Question:
What is the Most Effective Way to Organize and Deliver Mental Health Services to Older Persons in Primary Care Settings?

Improving Access to Geriatric Mental Health Services: A Randomized Trial Comparing Treatment Engagement With Integrated Versus Enhanced Referral Care for Depression, Anxiety, and At-Risk Alcohol Use

Stephen J. Bartels, M.D., M.S.
Eugenie H. Coakley, M.A., M.P.H.
Cynthia Zubritsky, Ph.D.
James H. Ware, Ph.D.
Keith M. Miles, M.P.A.
Patricia A. Areán, Ph.D.
Hongtu Chen, Ph.D.
David W. Oslin, M.D.
Maria D. Llorente, M.D.
Giuseppe Costantino, Ph.D.
Louise Quijano, M.S.W.
Jack S. McIntyre, M.D.
Karen W. Linkins, Ph.D.
Thomas E. Oxman, M.D.
James Maxwell, Ph.D.
Sue E. Levkoff, Sc.D., M.S.W., S.M.
PRISM-E Investigators

Objective: The authors sought to determine whether integrated mental health services or enhanced referral to specialty mental health clinics results in greater engagement in mental health/substance abuse services by older primary care patients.

Method: This multisite randomized trial included 10 sites consisting of primary care and specialty mental health/substance abuse clinics. Primary care patients 65 years old or older (N=24,930) were screened. The final study group consisted of 2,022 patients (mean age=73.5 years; 26% female; 48% ethnic minority) with depression (N=1,390), anxiety (N=70), at-risk alcohol use (N=414), or dual diagnosis (N=148) who were randomly assigned to integrated care (mental health and substance abuse providers co-located in primary care; N=999) or enhanced referral to specialty mental health/substance abuse clinics (i.e., facilitated scheduling, transportation, payment; N=1,023).

Results: Seventy-one percent of patients engaged in treatment in the integrated model compared with 49% in the enhanced referral model. Integrated care was associated with more mental health and substance abuse visits per patient (mean=3.04) relative to enhanced referral (mean=1.91). Overall, greater engagement was predicted by integrated care and higher mental distress. For depression, greater engagement was predicted by integrated care and more severe depression. For at-risk alcohol users, greater engagement was predicted by integrated care and more severe problem drinking. For all conditions, greater engagement was associated with closer proximity of mental health/substance abuse services to primary care.

Conclusions: Older primary care patients are more likely to accept collaborative mental health treatment within primary care than in mental health/substance abuse clinics. These results suggest that integrated service arrangements improve access to mental health and substance abuse services for older adults who undergo these services.

(Am J Psychiatry 2004; 161:1–8)
PRISMe Study:  
Primary Care Research in Substance Abuse and Mental Health for the Elderly  

Older Adults with Depression or At-Risk Alcohol Use  
Randomized Trial Comparing:  

• Integrated/Collaborative Care   
  — Co-Located, Concurrent, Collaborative  

• Enhanced Referral to Specialty Mental Health and Substance Abuse Clinics   
  — Preferred Providers and Facilitated appointments, transportation, payment
Rates of Engagement in MHSA Care: By Diagnosis/Condition

(n=2022, mean age 73.5)
Collaborative Care in Older Primary Care Patients

• Guideline-based treatments
  - Antidepressants and/or
  - Evidence-based psychotherapies

• Depression Care Manager Role
  - Monitor symptom severity and course of illness
  - Communicate with MD and specialists *(psychiatry)*
  - Monitor side effects and treatment adherence
  - Educate patients and families
  - Promote self management, goal setting, pleasurable activities

• Large Evidence Base
  - IMPACT *(Unützer et al., JAMA 2002)*
  - PROSPECT *(Bruce et al., JAMA 2002; Alexopoulos AJP 2009)*
Primary Care: IMPACT

• Collaborative care model includes:

  – Care manager: Depression Clinical Specialist
    • Patient education
    • Symptom and Side effect tracking
    • Brief, structured psychotherapy: PST-PC

  – Consultation / weekly supervision meetings with
    • Primary care physician
    • Team psychiatrist

• Stepped protocol in primary care using antidepressant medications and / or 6-8 sessions of psychotherapy (PST-PC)
Substantial Improvement in Depression
(≥50% Drop on SCL-20 Depression Score from Baseline)

Effective Treatment Saves Lives and Pays for Itself
Integrated Care is More Cost Effective Than Usual Care

IMPACT participants had lower mean total healthcare costs $29,422 compared to usual care patients $32,785 over 4 years.

Objectives: To determine the long-term effects on total healthcare costs of the Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) program for late-life depression compared with usual care.

Methods: Participants were randomly assigned to the IMPACT intervention ($270) or to usual primary care ($270). Intervention patients had access to a depression care manager who provided education, behavioral activation, support of antidepressant medication management prescribed by their primary-care provider, and problem-solving treatment in primary care for up to 12 months. Care managers were supervised by a psychiatrist and a primary-care provider. The main outcome measure was healthcare costs during 4 years.

Results: IMPACT patients had lower mean total healthcare costs ($23,422; 15% confidence interval, $28,479–$32,365) than usual care patients ($32,785; 95% confidence interval, $28,548–$36,921) during 4 years. Results of a cost-effectiveness analysis suggested an 87% probability that the IMPACT program was associated with lower healthcare costs than usual care.

Conclusions: Compared with usual primary care, the IMPACT program is associated with a higher probability of lower total healthcare costs during a 4-year period.

For author information and disclosures, see end of text.
RCTs of Geriatric Mental Health Community Outreach Models
% Recovered from Depression*

* Greater than 50% reduction in symptoms or meeting syndromal criteria
Homebound Older Adults

• **Characterized by risk factors for depression:**
  - Medical Illness
  - Disability
  - Cognitive Decline
  - Social Isolation
  - Loss And Other Negative Events

• **In community samples:**
  - 2.5 higher prevalence
  - 2 times high incidence depression

• **Homebound ➔ Barriers to mental health care**

*Bruce and McNamara, J. Am Geriat Soc, 1994*
*Bruce and Hoff, Soc Psych Psych Epi,, 1994*
Prevalence of Depression in Home Health vs. Primary Care Patients

Bruce et al., AJP 2002
Lyness et al., 1999
Depression CAREPATH
Depression Care for Patients in Homecare

1. **Every nurse provides Depression Care Management (DCM)**
   - Teach DCM in the context of other chronic disease management
   - Provide clear signals for consultation or referral
   - Teach to refer patients using “MD-ese”
   - Do not ask Nurses to give psychotherapy

2. **Intervention has two components**
   - Depression Care Management Protocol
   - Implementation Strategy
Depression CAREPATH Outcomes:
Change in Depression by Baseline Severity

Bruce, JAMA Internal Medicine Nov. 2014
Preventing Late-life Depression in Age-Related Macular Degeneration

Barry W. Rovner, M.D., Robin 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 = 125) or usual care (n = 125). PST therapy consisted of six PST sessions over 8 weeks in subjects’ homes. Measurement: Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition Diagnoses of Depression Disorders, Hamilton Depression Inventory, State scores, and rates of rehospitalization were assessed at 2 months for short-term effects and at 6 months for maintenance effects. Results: The 6-month incidence rate of depressive disorders in PST-treated subjects was significantly lower than controls (11.6% versus 25.2%, respectively; OR = 0.43, 95% CI: 0.20-0.93). PST also reduced the odds of rehospitalization at 6 months (OR = 0.46, 95% CI: 0.24-0.86); this effect maintained 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 were disabling and predicted incident depressive disorders. Conclusions: PST prevented depressive disorders and loss of valued activities as a short-term treatment but these benefits were not maintained over time. To sustain PST’s effect, an intervention that uses a problem-solving framework to enhance rehabilitative skills may be necessary. (J Am Geriatr Soc Psychiatry 2008, 16:454–459)

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 response if not full 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%, however, maintenance of quality of life is far from satisfactory. Thus, the illness-related burden of depressive illnesses, particularly in old age, continues to be an important public health challenge and looms 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 treatments for depression in old age can and 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. Two-minute mental health visits are the rule; limiting the scores of patients to adequate treatment and guaranteeing suboptimal outcomes. This state of affairs underscores the need to prevent old age depression. That is, if the efficacy of treatment while good, is still limited with respect to reversing illness-related burden, and if difﬁculty of evidence-based practices to general medicine is limited, particularly in minority populations; then the need to prevent old 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.

Smit 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 characterize relatively small segments of the elderly population, and that if one could identify the adverse effects associated with such risk factors, then the incidence of persisting depression could be substantially reduced (i.e., high attributable fraction). A reasonable efﬁciency is possible, assuming acceptable and effective interventions (as indexed by a number needed to treat of approximately 3).

What type of preventive intervention could make the most sense scientiﬁcally and be acceptable to patients at high risk? The review by Cole reminds us that brief psychosocial interventions, especially those that are learning-based, are acceptable and feasible, as evidenced by good enrollment and completion rates. Furthermore, based upon the available studies, reductions in absolute and relative risk for incident depression appear to be promising and thus justify the effort of mounting further prevention research in high-risk older people. What is meant by high risk?

Rovner et al. have done ground-breaking research into adjuvant 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
The Other Side of Integration

Middle Aged and Older Adults with Major Mental Illness and Medical Comorbidity
The Hidden Health Disparity of Early Mortality for Patients with Major Mental Illness
Mean Years of Potential Life Lost

<table>
<thead>
<tr>
<th>Year</th>
<th>AZ</th>
<th>MO</th>
<th>OK</th>
<th>RI</th>
<th>TX</th>
<th>UT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>26.3</td>
<td>25.1</td>
<td></td>
<td></td>
<td>28.5</td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>27.3</td>
<td>25.1</td>
<td></td>
<td></td>
<td>28.8</td>
<td>29.3</td>
</tr>
<tr>
<td>1999</td>
<td>32.2</td>
<td>26.8</td>
<td>26.3</td>
<td></td>
<td>29.3</td>
<td>26.9</td>
</tr>
<tr>
<td>2000</td>
<td>31.8</td>
<td>27.9</td>
<td></td>
<td></td>
<td>24.9</td>
<td></td>
</tr>
</tbody>
</table>

Compared with the general population, persons with major mental illness lose 25-30 years of normal life span

Colton CW, Manderscheid RW. Prev Chronic Dis [serial online] 2006 Apr [date cited]. Available at: URL:http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm
Cardiovascular Disease Is Primary Cause of Death in Persons with Mental Illness*

Colton CW, Manderscheid RW. Prev Chronic Dis [serial online] 2006 Apr [date cited].
Available at URL: http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm
• **203 studies** including **29 countries** over **six continents**

• mental health disorders **2.22 times higher mortality risk** compared to general population or people w/o mental illness.

• average of **10 years of potential life lost**

• **Medical causes 2/3 (67.3%)** of deaths, **17.5% “unnatural causes; remaining unknown.”**
Cardiovascular Disease (CVD) Risk Factors and Major Mental Illness: A Paradigm for High Complexity and Risk

<table>
<thead>
<tr>
<th>Modifiable Risk Factors</th>
<th>Prevalence Compared to General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Obesity</td>
<td>4.4 X</td>
</tr>
<tr>
<td>Smoking</td>
<td>3-4X</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2X</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1.4 X</td>
</tr>
<tr>
<td>Metabolic Syndrome</td>
<td>2.4X</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>2.7X</td>
</tr>
</tbody>
</table>

Vancamfort et al., 2013: Meta-analysis of 136 studies
Can Health Coaching Decrease Obesity and Cardiovascular Risk in Adults with Mental Illness?
Integrated Health Promotion for Obesity in Persons with Serious Mental Illness: In SHAPE

- Nurse Evaluation and Consultation
- Initial Fitness Assessment
  - Individualized fitness and healthy lifestyle assessment
- Individual Meetings with a “Health Mentor”
- Vouchers to Local Fitness Centers
- Individual and group nutrition education
- Smoking cessation referrals
- Group Education/Motivational “Celebrations”

Promoting Health and Functioning in Persons with SMI: CDC - R01 DD000140 (PI: Bartels)
Health Promotion and Fitness for Younger and Older Adults With SMI: R01 MH078052-01 (PI: Bartels)
1st RCT (n=133):
At 12 months: **49%** in intervention group achieved either **clinically significant increased fitness** (>50 m on 6MWT) or **weight loss** (5% or greater)
2nd RCT Boston, Mass
(Multiple Sites: n=210; half underserved minorities)
51% achieved either clinically significant increased fitness
(>50 m on 6MWT) or weight loss (5% or greater)

Pragmatic Replication Trial of Health Promotion Coaching for Obesity in Serious Mental Illness and Maintenance of Outcomes

Stephen J. Bartels, M.D., M.S.
Sarah I. Pratt, Ph.D.
Kelly A. Aschbrenner, Ph.D.
Laura K. Barre, M.D.
John A. Naslund, M.P.H.
Rosemarie Wolfe, M.S.
Haiyi Xie, Ph.D.
Gregory J. McHugo, Ph.D.
Daniel E. Jimenez, Ph.D.
Ken Jue, M.S.S.A.
James Feldman, M.D., M.P.H.
Bruce L. Bird, Ph.D.

**Objective:** Few studies targeting obesity in serious mental illness have reported clinically significant risk reduction, and none have been replicated in community settings or demonstrated sustained outcomes after intervention withdrawal. The authors sought to replicate positive health outcomes demonstrated in a previous randomized effectiveness study of the In SHAPE program across urban community mental health organizations serving an ethnically diverse population.

**Method:** Persons with serious mental illness and a body mass index (BMI) >25 receiving services in three community mental health organizations were recruited and randomly assigned either to the 12-month In SHAPE program, which included membership in a public fitness club and weekly meetings with a health promotion coach, or to fitness club membership alone. The primary outcome measures were weight and cardiorespiratory fitness (as measured with the 6-minute walk test), assessed at baseline and at 3, 6, 9, 12, and 18 months.

**Results:** Participants (N=210) were ethnically diverse (46% were nonwhite), with a mean baseline BMI of 36.8 (SD=5.2). At 12 months, the In SHAPE group (N=106) had greater reduction in weight and improved fitness compared with the fitness club membership only group (N=104). Primary outcomes were maintained at 18 months. Approximately half of the In SHAPE group (51% at 12 months and 46% at 18 months) achieved clinically significant cardiovascular risk reduction (a weight loss ≥5% or an increase of ≥50 meters on the 6-minute walk test).

**Conclusions:** This is the first replication study confirming the effectiveness of a health coaching intervention in achieving and sustaining clinically significant reductions in cardiovascular risk for overweight and obese persons with serious mental illness.

![Graph showing In SHAPE and Fitness Club Membership and Education outcomes at 6, 12, and 18 months](image)
What About Self-Management?
Integrated Illness Management and Recovery (IIMR) Teaching Techniques

Health Coaching for Physical and Mental Health Conditions

• Motivational Interviewing
• Skills Training
• Cognitive Behavioral Therapy Techniques
If you have **DIABETES**, here are some health goals you can talk about with your health care provider.

To achieve good control of your diabetes, it is important to have practical goals. Set one goal now, and after you have achieved it, move on to another.

- **Diet**
- **Exercise**
- **Take all medications properly**
- **Monitor blood sugar**
- **Quit Smoking**
- **Annual eye exam**
- **Check feet daily**
- **Dental exam**
- **Personal goal**

### Staying Healthy With Diabetes
- Eat a balanced diet. A diabetes educator or nutritionist may help you develop a meal plan that is right for you.
- Stay active. Check with your doctor before starting a new exercise plan.
- Take medications as prescribed.
- Avoid alcohol and tobacco.
- Monitor your blood pressure and blood sugar levels.
- Have cholesterol checked regularly.
- See your doctor and specialists as needed. These may include dentists, podiatrists (foot doctor), and eye doctors.

### Hemoglobin A1c: Know Your Number
This is your Average Blood Sugar over the past 2-3 months and can be measured by a blood test. A Hemoglobin A1c of 7 or less is ideal.

- **RED:** “Stop and Think” 10.0%
- **YELLOW:** “Caution” Be Careful 8.0%
- **GREEN:** “Good Going” Great Control 7.0%

<table>
<thead>
<tr>
<th>HbA1c</th>
<th>Over years of high HbA1c, these problems can occur:</th>
<th>Avg Blood Sugar</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.0</td>
<td>Amputation</td>
<td>420</td>
</tr>
<tr>
<td>15.0</td>
<td>Kidney Failure</td>
<td>390</td>
</tr>
<tr>
<td>14.0</td>
<td>Blindness</td>
<td>360</td>
</tr>
<tr>
<td>13.0</td>
<td>Heart Attack</td>
<td>330</td>
</tr>
<tr>
<td>12.0</td>
<td>Stroke</td>
<td>300</td>
</tr>
<tr>
<td>11.0</td>
<td></td>
<td>270</td>
</tr>
<tr>
<td>10.0</td>
<td>Increased Risk of Alzheimer’s Disease</td>
<td>240</td>
</tr>
<tr>
<td>9.0</td>
<td>Decreased Healing</td>
<td>210</td>
</tr>
<tr>
<td>8.0</td>
<td></td>
<td>180</td>
</tr>
<tr>
<td>7.0</td>
<td></td>
<td>150</td>
</tr>
<tr>
<td>6.0</td>
<td></td>
<td>120</td>
</tr>
<tr>
<td>5.0</td>
<td></td>
<td>90</td>
</tr>
</tbody>
</table>
Integrated Illness Self-Management

n=71 older adults (mean age 60) with mental illness and chronic illness (diabetes, COPD, CHF, CVD, hypertension, arthritis)

**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**

Bartels et al., Psychiatric Services 2014
Value Proposition: Complexity as a major driver of costs

- 10% of Medicare population accounts for 70% of $91.7 billion in acute care costs
- Dually eligible individuals account for 36% of Medicare expenditures
- Highest cost group in the Medicare and Dually Eligible population is associated with mental illness, substance abuse, heart failure, diabetes, and cancer
The Affordable Care Act and The “Good News” Older Patients

• ACOs
• Medicare Wellness Visit
• Health Care Transitions
• Complex Care Management
• Hospice and Palliative Care
Good News for Primary Care Providers?

- Top 5 common chronic conditions for 2,500 patients - 6.7 hours per day (Østbye, et al., 2005).
- 7.4 hours to provide preventive services most strongly recommended by the U.S. Preventive Services Task Force (Level A or Level B evidence) (Pollak, et al., 2008).
- 4.6 hours acute care

How to get it done?
It’s About the Team!  

This Team!
HRSA Geriatric Workforce Program
Redesigning Primary Care for Complex Older Adults

Conventional Model

- Physician
  - Medical Assistant
  - Patient

New Model

- Physician
  - Nursing – AP, RN, Diabetes Educators, LPN
  - PERSON AND FAMILY
    - Care Coordinators, Aging Social Services Providers
    - Health Coaches and Medical Assistants & Technology

- Patient
- Patient
- Patient

- Annual Wellness Visit
- Complex Care Management
- Dementia Care
- Advance Care Planning
Primary Care Geriatric Transformation Sites
Medicare Annual Wellness Visit Pre-Visit Flow

Practice:
- Data Report of Medicare Part B Patients
- Within First 12 Months of Medicare Part B Coverage Period?
  - Yes: Previous PPE?
  - No: Eligible for IPPE (Within First 12 Months of Medicare Part B Coverage Period)
- Eligible for AWV (Greater than 12 Months from IPPE or Last AWV)
- Send Message Offering PN AWV via Patient Portal Conventional Mail

Patient:
- Patient calls to Schedule Appointment

Scheduler:
- Verify Enrollment Date for Medicare Part B
  - No: Within First 12 Months of Medicare Part B Coverage Period?
    - Yes: Previous PPE?
    - No: Book IPPE within First 12 Months of Medicare Part B Coverage Period
- Schedule AWV Greater than 12 Months from IPPE or Last AWV
- Acute/Chronic Conditions?
  - No: Offer/Explain Nursing AWV Option vs. Annual Physical Exam
  - Yes: Queue:
    - Pre-Appointment Letter
    - What to Bring Letter
    - HRA Questionnaire
- At patient request Book Annual Physical Exam (not AWV)
  - Yes: WANTS AWV?
    - Yes: Has my DM?
    - No: No
  - No: Yes
- Book MD/AP Acute/Chronic Time

MA:
- Opens Scheduled Patient Chart (starting Day -5)
  - Has my DM?
    - Yes: HRA 100% done?
      - Yes: Call to Patient AWV Appointment What to Expect/Bring
      - No: No
    - No: Call to Patient AWV Appointment What to Expect/Bring Offer Assistance with HRA (scribe overnight)
  - No: Notify: if HRA not completed prior to appointment time, reschedule required
  - Flag immunizations needed for nurse review and sign off! *Prior to Visit*
The Northern New England Geriatric Education Center (NNEGEC) is one of 44 federally funded programs sponsored by the Health Resources and Services Administration (HRSA), focused on supporting quality care for older Americans across the nation. The NNEGEC is currently funded by a Geriatric Workforce Enhancement Program (GWEP), and is working in cooperation with HRSA, and partners across our region, to provide the best care possible to our rapidly aging northern New England population. We will do this by supporting primary care practices who are seeking to provide innovative care to their older adult patients, providing geriatric care educational content to health professions students, opportunities for continuing education for an inter-professional audience of health professionals, and learning opportunities for patients, caregivers, and families.

If you or your practice are already GWEP Participants, CLICK HERE

Northern New England is already one of the most rapidly aging regions in the United States, and parts of our region will more than double in proportion of individuals over 65 within 15 years. Geriatric specialists alone...
The Medicare Annual Wellness Visit (AWV) is a benefit for people who have had Medicare for more than one year. It is not a physical exam, but a preventative visit, and during the visit the provider will develop or update a personalized prevention plan to prevent disease and disability based on current health and risk factors. The Northern New England Geriatric Workforce Enhancement Project developed this toolkit to provide health care practitioners in New Hampshire and Vermont with guidance and tools for performing the AWV, as well as local resources to help deal with issues discovered during an AWV. We hope you find the information useful.

This toolkit is provided as a guideline only; Medicare dictates the components of the AWV, and providers should use their clinical judgment in how to perform the components of the AWV. Several documents are available in MS Word for purposes of modification; please e-mail us to request a copy. The resource list is not meant to be a comprehensive reflection of all services available to seniors in New Hampshire and Vermont.

**Pre-Visit – Site Readiness**
- **NEW** - GWEP Press Release - (Word)
- ABCs of the AWV (PDF)
- **NEW** - Comparing Medicare Wellness Visits (Word)
- FAQs AWV (Webpage)
- Providing the AWV (PDF)
- AWV Practice Flow Check List (Excel)
- AWV Scheduler Training Tool (Word)
- AWV Scheduler One Pager (Word)
- AWV General Flow Map (PDF)
- Sample AWV Note, Female (Word)

**During Visit - Assessment Tools (cont.)**
- Mental Status Assessment:
  - MiniCog (PDF)
  - Montreal Cognitive Assessment (MOCA) Form (PDF)
  - MOCA Instructions (PDF)
  - Alzheimer’s Association Cognitive Assessment (Webpage)
  - Assessing Cognition and Diagnosing Dementia (PDF)
  - AWV Algorithm for Assessment of Cognition (PDF)

**Post-Visit – Referrals & Resources (cont.)**
- Bureau of Elderly & Adult Services (Webpage)
- Dartmouth-Hitchcock Aging Resource Center (Webpage)
- Dartmouth-Hitchcock Falls Prevention (Webpage)
- Dartmouth-Hitchcock Quit Tobacco (Webpage)
- Elderly Driver Safety (Webpage)
- Elder Abuse (Webpage)
- Falls Prevention, NH (Webpage)
- Falls Prevention, VT (Webpage)
- Financial Exploitation - Protecting Residents (PDF)
Welcome to the Medicare Wellness Checkup

Welcome to the Short Annual Wellness Checkup for Persons Aged 65 Years of Age or Older. This checkup requires less than 10 minutes to complete and will ask you about problems and concerns that are important risks to health.

Begin Here for Your Short Health Check-Up

For A More Thorough Health Checkup and other helpful tools go to HowsYourHealth.

Begin Here for Your HowsYourHealth Check-Up

Your Personal Guide for the best Health and Medical Care from your home, hospital, clinic, or workplace. It's easy, confidential, and it works! Because HowsYourHealth is more thorough it will require more time. It is best to complete it when you do not have a deadline, usually a few days before a medical office visit.

Information for Health Professionals

© Copyright FNX Corp. and Trustees of Dartmouth College

http://www.medicarehealthassess.org
It's also about........
Depression & Anxiety in India

Lay Health Counselor Model
- Locally recruited
- No background in health care
- 2-month training
- Acted as case manager
- Delivered interpersonal psychotherapy

Population: adults from 24 sites (public and private) who screened positive for common mental disorder (N = 2429)

Intervention: collaborative stepped care versus usual care

Results: intervention group recovery rate at 6 months for public facilities – 66% vs 43.5%

MANAS Trial: Patel, Lancet 2010)
HIGH TOUCH MEETS HIGH TECH
Automated Remote Telemedicine
Supported Self-Management

Feasibility and Effectiveness of an Automated Telehealth Intervention
to Improve Illness Self-Management in People With Serious Psychiatric
and Medical Disorders

Sarah L. Pratt and Stephen J. Bartels
Dartmouth College

John A. Naslund, Rosemarie Wolfe,
and Heather S. Pixley
Dartmouth College

Kim T. Mueser
Boston University

Louis Josephson
Riverbend Community Mental Health Center,
Concord, New Hampshire

Health Buddy: Electronic unit connected to a
phone line provides two-way communication
between healthcare providers and patients.

-100 participants with Major Mental Illness plus
CHF, COPD, Diabetes, or CAD) enrolled in 12
month RCT cross-over design (HB v. wait list control)
Health Buddy
Automated Daily:

- Self-monitoring
- Health Data Entry
- Self-management Education
- Remote Nurse Monitoring
Automated Telehealth and Adults Age 50+ with Mental Illness

63% (n=15) Fasting Glucose >130

At Baseline: 63% FG>130
After Telehealth
Majority (2/3) in range FG<120

3 and 6 Month Health Buddy Outcomes
N=15 with Baseline Glucose >130

- Glucose >120
- Glucose <120
Automated Telehealth and Service Use Outcomes for People with Mental Illness and Diabetes (both p<.05)
Gus:
• 68 yo living in subsidized supervised housing in Boston
• Obesity, Hypertension, CHF Diabetes, COPD, Atrial Fibrillation, Asthma, Sleep Apnea, Bipolar Disorder
• Hx of frequent ER/Hospital Use
• 30+ medications daily
• Goal: Live Independently in the Community
  Personal action plan: increase exercise, improve healthy eating, learn strategies to cope with daily stressors

Amalia:
Health Coach - providing illness self-management training and telehealth support
Which Works Best for Implementing Chronic Disease Self-Management in High Risk, Complex Patients?

- Automated Telehealth?
  Or
- Health Coaching and Self-management Training

NIMH Randomized Trial in Boston (n=300)
What do Astronauts and Older Adults in Rural Settings Have in Common?

Renée Pepin PhD  Post-Doc, Dartmouth Centers for Health

Jay Buckey MD Associate Professor of Medicine, Geisel School of Medici

Researchers combat astronaut blues

By JOSH SCHIEFELBEIN, The Dartmouth Staff
February 13, 2014
In Home Senior Monitoring
Innovative Healthcare Solutions for Older Adults

• **Reverse Innovation**: learning from professional workforce shortages in developing counties

• **Community Models of Care**: delivering health care in the home and community settings using a new type of health worker

• **Telehealth**: using technology to monitor and deliver health care solutions to isolated older adults
The Challenge

The Underside of the Silver Tsunami — Older Adults and Mental Health Care

Stephen J. Bartels, M.D., and John A. Nashlund, 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 1800 geriatric psychiatrists in the United States today and that by 2010 there would be only about 1600 — less than 1 per 6000 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 47% to more than 200% higher. Yet mental health services account for only 2% 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 resists declaring yet another “crisis” requiring the training of more geriatric specialty physicians — an alarm and recommendation that has been repeated in vain for more than 90 years. Instead, the unprecedented aging of the population has an unprecedented shift in the delivery paradigms 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 professionals in fundamental changes in health care delivery, with major implications for complex, high-cost patients. Included in this category would be older adults with mental health disorders, who are among the most challenging patient populations and account for a disproportionate amount of health care costs. What exactly does the ACA mean for geriatric mental health? Are there provisions within the ACA that support geriatric mental health services? What does the ACA mean for older adults with mental health conditions and for the workforce providing care to such vulnerable patient populations? About 6 to 8 million Americans aged 65 or older have a mental health or substance use disorder, and it is estimated that this number will nearly double to 14 to 18 million by the year 2030. A recent Institute of Medicine report— subtitled “In Whose Hands?”—concludes that this unprecedented demographic wave will overwhelm an inadequate mental health professional workforce unless major reforms are made with respect to financing, organizing, and delivering services to this high-risk, high-cost population. Innovative and effective approaches to financing and delivering mental health care are needed for this rapidly growing population if we are to overcome an alarming gap between workforce capacity, available services, and projected need.
Population Health “Collaboratory” for Accelerated Innovation

1. Solicit high value, high innovation ideas/proposals to improve health
   - Identification of:
     - Targets
     - Ideas
     - Innovations

2. Support rigorous development, refinement, research, and evaluation methods
   - Selection
   - Research design
   - Implementation
   - Process and outcome evaluation
   - Analysis
   - Reporting

3. Create primary care / community-based incubators for health innovation, research, and professional development

- Innovation Test Bed
  - Rapid Testing, Refinement, Discovery, and Implementation

Participants:
- Patients, Families, Community
- Primary Care and Community Service Providers
- DHH Leadership/Population Health
- TDI/Geisel, College Researchers + Academic Partners

Population Health Collaboratory
“Co-Creation of Health and Knowledge”

Rapid testing and refinement

20 Innovation Scholar Teams
(15 DH + 5 COOP)
Providers
Patients + Families Researchers

Rapid “Fail” and Stop

Discovery

Rapid “Success” Refinement and Scale