

*This session was captioned live during the webinar. For your convenience, realtime transcript is pasted here. This text is being provided in a rough draft format. Communication Access Realtime Translation (CART) is intended to facilitate realtime access to oral and aural communication. It is not meant to produce a verbatim record of the proceedings. Let your coordinator know if you would prefer a more verbatim transcript.*

⇒

>> ROARA MICHAEL: Good afternoon, everyone.

And welcome to the SAMHSA-HRSA Center for Integrated Health Solutions webinar titled "Aging Well: Addressing Behavioral Health with Older Adults in Primary Care Settings "

I'm Roara Michael and your moderator for today's webinar. As you may know, the CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in behavioral health or primary care provider settings. In addition to national webinars to help provide integrated care, the center is continually posting practical tools and resources to the CIHS website, providing direct phone consultations to providers, and directly working with many SAMHSA behavioral healthcare and safety net settings

So before we get started, a couple of housekeeping items to download the presentation slides. Please put the drop down menu event resources on the bottom left of your screen. The slides are available on the CIHS national council website located under the "About Us," backslash webinars.

And today your slides will be automatically synchronized with the audio. So you don't need to flip through slides to follow along. You will listen to the audio through your computer speakers. So be sure they're on and the volume is up.

You may want to submit questions to speakers at any time during the presentation by typing a question into the "Ask a Question" box in the lower left portion of your player.

Finally, if you need technical assistance, click on the Question Mark button in the upper right corner of your player to see a list of Frequently Asked Questions and contact info for tech support if needed.

Okay. So research suggests that the older adult population is increasingly experiencing substance use and behavioral health conditions and treated in a primary care settings. The number of Americans age 65 and older increased by 25 percent from 2003 to 2013. And the next 25 years is expected to more than double from 6 million to 14.6 million.

With an integrated workforce and understanding the role of families and collaboration with the community, safety net provider settings will enhance care efforts to meet the unique needs of older adults. This is key because the majority of older adults behavioral health issues are identified and treated in primary care settings instead of behavioral settings.

The IHS believes the older adults adjust to the unique needs of older adults in integrated care settings. And we hope that it will serve as tool for all of you on the line along with today's speakers.

So as a follow-up to the brief, our presenters are here to share key takeaways and takeaways from the response to the health needs of our aging population. For primary care providers, um, in the audience who are integrating behavioral health, this is an excellent opportunity to focus on the needs of the older adult population.

So here are the learning objectives that you'll obtain from today's webinar.

So these are the speakers today. Amanda Pettit, Ashley Hady, and Dr. Steven Bartels.

Amanda is a clinical nurse manager at Crossing Health Behavioral Health Clinic and Center for Specialty Care Clinics.

We have Ashley Hady, a social worker at Crossing Rivers Health who years of experience in counseling adolescents and adults.

And Dr. Steven Bartels, who is the Herman O. West Professor of Geriatrics and Professor of Psychiatry, Community and Family Medicine, and the Dartmouth Institute Geisel School of Medicine, professional and clinical practice.

He's the director of Dartmouth Centers for Health and Aging where he oversees the Dartmouth Center for Research and Northern New England and the Dartmouth Centers for Health and Aging Center. And he's a contributor to the Older Adults Issue Brief.

We're excited to have them with us today.

And without further ado, we'd like to go to Crossing Rivers Health.

>> AMANDA PETTIT: Good morning. And good afternoon for some. This is Amanda Pettit at Crossing Rivers Health. And I'm the clinic nurse manager for the Primary Care Clinic Behavioral Health and Center for Specialty Care.

So working with a lot of primary care providers, you know, we're identifying the mental health needs in the older adults here in rural Wisconsin. So we're in a town of about 7,000, very rural area. So finding -- finding some struggles out there.

And we're trying to collaborate with the behavioral health and develop some integration with -- using the telehealth platform as we try to bring in the services. So like I said, we're Crossing Rivers Health. And we're an independent health clinic, which is under the umbrella of the Clinical Health Center and Crossing Rivers Health Center.

We are -- our behavioral health opened about two years ago. And primary care clinic was bought in 2014. So the [indiscernible] of that, we have been able to collect since we purchased the primary care clinic so that we have approximately 901 patients that are in the age range of 65 and older in the primary and behavioral health clinics.

And within those clinics we see anything. Patients from -- from the whole age range, prenatal to death, and wellness and preventive care and medication management. And our behavioral health clinic, we see adolescents to geriatrics and counseling services, medication management, and diagnostic evaluation and screening and referrals.

So a little bit more about our workforce. At our primary care clinic, we have two board-certified family medicine doctors and one board-certified internal medicine doctor and two board-certified nurse practitioners and a board-certified family practitioner who is also a midwife.

Care at the behavioral health clinic. We have Ashley, the Licensed Clinical Social Worker. And the psychiatrist who does medication management. We have telehealth and an RN who is our telehealth facilitator and care coordinator and the glue that ties the patients from medication management here at behavioral health and as well as back to primary care. So very important role there.

So what our data shows is that specific to the age population of 65 years and older with diagnosis of depression and anxiety, we have 126 diagnosed patients from the primary care clinic. What we can find is that five of the patients are currently seeing a counselor here at Crossing Rivers Health, behavioral health. And there may be outliers where it's difficult to track if they go elsewhere out of our system.

What that leaves us with is 3.9% of this diagnosed population actually receiving behavioral health services.

And two of the referrals that were sent from primary care refused. The patients refused the service.

So -- which opens up another barrier to creating what we need to do to get the patients seen.

So what our primary care providers are hearing from our patients is that, you know, they've lived through worse than this. So whether or not they think it's important enough that a counselor be involved or a medication be prescribed, you know, a lot of the elderly population have lived through worse than this. And they think they should be able to deal with it. And then they trust their primary care provider. So they say, they can take care of it really, you know. They don't want to tell somebody else their story when they've already explained it to one person.

So...another barrier is transportation. They do not or cannot drive anymore. And who's going to take them to their appointments? You know. There's a cost involved sometimes with that, transportation as well as fixed income.

And insurance barriers. Is their coverage for visits with the prescriber or with the counselor? And then if there is a medication prescribed, is there insurance coverage there?

And that's what the providers are hearing when they talk about behavioral health needs.

What we have heard primary care providers say is that they are they already know the patients so they'll take care of it. And they know that trust is a hard thing to build up. Once it's built up, they keep it going as long as they can. So they'll just take care of it.

And telehealth has brought a new -- new viewpoint that, you know, it doesn't feel quite as personal and that's where we get -- get some people pushing back with having telehealth on-site now. It is not the case for everybody. It's been a good. It's been received well. So I think if we can help the primary care providers understand that really -- I guess when push comes to shove, it's a -- it's a great way to make that connection and have that access when you can't have a person right there. So "it's not personal" isn't quite as -- doesn't have quite as much clout anymore because it can be very personal.

And primary care providers say, I can't make them go, which is very true. So the patient hardly comes in to see the primary care provider. And how to do we get them to see a psychiatrist and counselor? And you take advantage of the appointments you get when you get them.

And this patient doesn't need another medication. It causes side effects and everything else. It's the stigma that goes along with psychiatric medicine that we're going to have a patient come back onto two or three more meds. And we're having a hard enough time getting them stabilized on the chronic medications they take for health issues.

So they don't want to risk, you know, upsetting the apple cart with more medications. So relationship, that's what we heard from some primary care providers.

So what our primary care providers do. They continue to routinely screen patients. They use the PHQ-2, which is the Medicare Wellness Exam. And then based off of that, they expand to PHQ-9 with the depression screening and add in the GAD-7 for anxiety and anxiety screenings.

Determining when to introduce different treatment modalities. You know, it's a little different for every provider. Do we watchfully wait and see how they are the next time they come in and take that chance that, you know, there's maybe not a next time.

Do we add medications in, you know. Primary care providers, you know, adding something in just to start them off. And ease them into it and get the conversation going.

Offer therapy? You know. We have a therapist available. Help them feel connected. It would be nice too. And we'll speak to that later. And have their close connection too. So it's maybe down the hall, which is a little bit easier for elderly patient to say we'll try it if it's not a whole ordeal to get them there.

And how is this decided? Every provider is different and the relationship with the patient is different. They don't want to sacrifice a patient being compliant with medications for health, you know, like heart health or diabetics health, if they're going to push them away after offering behavioral health services. So it can be picky and choosy, it sounds like.

So you know, at this point in time it's inserting the standardized process here would be ideal. But deciding what that standardized process is, is the ongoing battle.

>> ASHLEY HADY: So we're trying to work with primary care as a team. With rural health being, we're still working on formulating those relationships with primary care providers. I think here in rural Wisconsin that works really well to have behavioral health under the same umbrella as primary care because they give us a little bit more respect than what I've seen from coming from the county system and trying to work with local providers. So the primary care providers know us here at the clinic and know what we do, that they have confidence in us, which I think boosts the confidence that the patient has and what they receive when they come here for service.

We really work to empower patients and their families to, you know, make the decision that's in their best interest, but also in the best interest of what they're also doing with primary care.

I think here we do a good job communicating back and forth with primary care provider. One of the biggest things is having the electronic health record that we both use and document in, which then offers us, in behavioral health, the opportunity to view, you know. It's really obviously to view the medical records so we see how they've been doing. And then also send a note back to primary care. Yes, they've been seen. Here's what I've seen and can make a recommendation to go back and forth. And it allows us to stay in contact with how they're doing with functioning and how they're doing with their mood. And primary care can make a decision about what they're prescribing and how they make those adjustments.

And we also work well with the long-term care model here in Wisconsin we have the family care program, which offers in-home services based on patient need. And sometimes it's those people in the long-term care programs that recognize patients who need care and support and refer them to primary care who then refer them to us. And we try to keep the communication open so that whoever's going into the home can report back to us on how they're doing. And we can work with the primary care on how to get that person back to their baseline of functioning.

And we also work -- work well with the adult protective services unit at the county level and making referrals for the people who are vulnerable adults and those who need to have screening for guardianship or even possible protective placement. And, again, going back to primary care and asking them to offer their own at a diagnostic referral and maybe screening and CT scan or MRI to determine what's going on that maybe they have a UTI. And keeping the communication open so that, you know, we can determine what's best for each patient.

Here at the behavioral health clinic we do individualized assessments. These are strength-based assessments on each person. And then we engage them in patient-centered planning, which includes the primary care providers. There's 99.9% of the time we have release of information so that we can communicate back and forth with that provider.

We also have the telehealth funding through HRSA. So we're branching out our telehealth providers. And we don't know how many of you are living in rural health areas. But you have great,

you know, hardship here trying to find psychiatrist to provide care. We don't need somebody five days a week. But we need somebody for a day. And it's really hard to find that contract. So through HRSA, we've been able to purchase telehealth equipment and have a provider available. We have a telehealth consortium and three of us together. And we contract with two other county systems to also provide telehealth psychiatry to their patients as well. And this is really been helpful to lift the load off of the psychiatry limited time.

So how we can affect change? So we're looking at, you know, how can we best -- best do a hand off of patients? And how can we best provide that continuity of care? How can we get patients here and to see us? And we've determined that it really works well with the hand off from primary care providers. So putting ourselves out there and being at the primary health clinics saying, "Hi, this is who I am. And this is what I do," to give them a little bit more confidence in us so that when they're making a referral they know who they're referring to. And then also the phone care from the primary care clinic. I'm here with so-and-so parent. And they'd like to set up an appointment. And we offer them something within usually a couple of days.

We get feedback from our patient surveys. Like was mentioned for our telehealth services. One of the patients surveys came back completely satisfied with telehealth services. And then patients are also saying that they -- that services really aren't very different.

We were consistently collaborating with the community service, like the long-term model and like the APS. Just I guess putting ourselves out there having patients say that it's not different doing telehealth versus in-person is helping to build up people's confidence in accessing those services.

Currently our health clinic is a few blocks away from the primary health clinic. And some day we want them on the same site. So that is currently in development through Crossing Rivers Health organization.

And we're hoping that being in the same location as our primary care providers, will allow us to walk down the hall and be introduced face to face with patients, which might also ease their stress and anxiety about the providers and seeing somebody in mental health and the behavioral health clinic. And then, like, it will help to foster that relationship.

>> AMANDA PETTIT: So our vision for the future. We talk about our vision in that it changes, you know, in minor areas. But overall, we want to continue to refine the evidence-based model and integrate behavioral health into the primary care setting and using the telehealth. You know there's -- we don't want to put our eggs in one basket, but it's nice to have the option for patients, you know, and help them to see that this -- this makes sense.

And building that professional relationship with other providers with behavioral health is important. So increasing the access to care. And that's what telehealth does for us.

Maintaining provider continuity. And not having a lot of background in behavioral health myself, it was a new world to me that the turnover was keeping providers and making sure that they're engaged in the work they're doing. And not many out there, whether it's nurse prescribers or psychiatrists, you know, it's -- you don't ever stop looking because you don't know when it's going to change. So whether it's an employed or contracted or maintaining that provider continuity, we found the patients just really, you know, they want that person to be there and stay there. So that's our goal.

And sustaining the services. If we say we have therapy now, we know we have therapy in five years, you know, in ten years. And -- and continue to meet those needs.

And decreasing the negative stigmatism in behavioral health. We've had people say, you should call it something else. And don't call it mental health and not behavioral health. But I think instead of changing the name of it, let's change the stigma around it, you know, that this is part of a whole --

whole human. You know. And this is just as important as your heart working the way it should be. So we can speak to that rather than changing it to -- for the trends of the time. Or I think we can make a big dent in what people are thinking.

And then integrate behavioral health as part of the overall health management, like I said.

And really just keep the conversation going. It's the topic that is uncomfortable for some but so important. And we used to think -- we used to not talk about it much because of HIPAA laws and what can you talk about and what can you not talk about. As we keep talking, it's not so different. Our prescribers can -- can document it in the medical record. And it's received via a primary care provider. Just kind of figuring out those areas. So there's no question on whether or not we can be speaking about this or not and getting the proper releases and making sure all those boxes are checked.

So -- so our vision is to be here in the future. And it'll maybe look a little bit different and immediate. We need to bend and flex a little bit. But we want to be here because we know how important it is, especially in rural areas. So we were looking forward. and telehealth opportunities do that and integration.

Any questions? We can --

>> ROARA MICHAEL: Yeah. Yeah. Thank you so much. Now we're going to take a few minutes to go ahead and answer some of these great questions that are coming in now from the audience.

So let's start with this question.

We had someone ask: Are there placement options for people with challenging behaviors?

Are there also -- or is this -- do our therapies and engagement ever play a role?

>> ASHLEY HADY: This is [indiscernible].

>> AMANDA PETTIT: Yeah go ahead.

>> ASHLEY HADY: Um, so just you repeat the question, we're trying to get a read it at the same time.

>> ROARA MICHAEL: Yeah. Sure.

So we had someone ask: Are there any placement options for persons of with challenging behaviors? And roles of therapy and engagement in your clinic at all?

>> ASHLEY HADY: Currently we don't have anything with art therapy, you know. We're an up-and-coming clinic. We just opened, like she said, two years ago. We offer group therapy and we do individual sessions with art therapy in them and do art work. With youngsters that I see, I do some play therapy. But we don't offer anything as far as groups.

>> AMANDA PETTIT: There's a big need. And we're hearing from the community and the schools especially, the big -- big one in the community that, you know, the need for child -- child therapy is so huge. So as we're looking to who we can bring in and what -- you know where we focus our attention, that the child and the adolescent side of the world is so huge too, you know, with the adults as well. But -- but with -- that's still being developed, I guess, is the answer.

>> ROARA MICHAEL: Great.

Thank you.

So are you billing for therapy in your clinic right now?

>> AMANDA PETTIT: Yes.

>> ROARA MICHAEL: Great. So we also had another question come in that was in reference to Slide 11, talking about the data. And this person asked: What can we do to close the 4% gap? And what type of psych education would be needed?

>> AMANDA PETTIT: So I -- I think it's a big part of it is just having that communication wide open with our providers, you know, and in that referral. We don't -- to fine tune that referral process, you know. What information does behavioral health need or want that can -- can kind of be standardized but yet really have that patient specific connection made? And I guess, you know we look at that a lot. We have a lot of conversations with our primary care providers. And it's really seeing a lot of different mindsets is what we're trying to do. Everyone has their own little, I guess, opinion of what behavioral health is. And -- and are they going to change the mind of their patient? You know. And is it their place to change the mind of their patient? How hard do you push?

And I think initially too when we hear it, we get referrals from the primary care. And the number one thing we hear is that people are fearful to come. And they don't know what to expect. And they don't know what's going to happen. And I think if you put a face to the name and do the introduction right there in the medical appointment, which, you know, might be some model we look at in the future, I think that might be also very helpful because then it doesn't seem quite so -- so scary for them.

>> ROARA MICHAEL: Great. Thank you.

So could you expand on any liability issues in particular, primary care position they have about addressing behavioral or mental health issues with their senior patients because that's not necessarily the area of expertise.

>> ASHLEY HADY: It's every medical provider. I mean, what we've talked about, you know, when it comes to prescribing, if they're stimulant medications or such. And I think primary care has had to be a jack of all trades. So that the older providers, I think, are a little bit more comfortable doing that and popping the medications in there. I don't -- to speak to liability, I guess I might be a little bit far out of my range. But it's really their comfort level and what else is going on with the patient, you know. If the patient is compliant and high functioning in their -- in their -- with their diagnosis, it's not such a worry. But once they start, like, okay, getting any kind of question with it, they're going to -- they're going to look to find that service. So it's hard to say, I guess. I don't know that I can answer that question real accurately with the liability part of it. It's each provider's comfort zone.

When we bought the practice from an older couple, there was quite a few patients with major depressive disorder. And like I said, these patients at the time they didn't -- they didn't go to behavioral health. It's like, I don't want to. So you kind of felt that obligation to treat them so they would have some kind of treatment.

But then the younger providers aren't feeling that way as much anymore. Let's get you to where it's appropriate to be. We can at least confirm you're stable. And then we can maybe take over the management of the medicine since you're already coming to us. But they want other people's eyes on it now, others with specialty eyes on it.

>> ROARA MICHAEL: Okay. Thank you. And I [indiscernible] using the IMPACT model?

>> AMANDA PETTIT: No.

>> ROARA MICHAEL: The IMPACT? No. Okay.

And that's -- for those on the phone, it's Improving Mood -- Promoting Access to Collaborative Treatment for Late-Life Depression, improved, measurable, positive, cost worth, actions, and timed.

So we did have another question come in. In relation to PCP what would you say to a PCP who is resistant to this kind of communication, you know, communication/collaboration between the behavioral health coordinator and the PCP because they feel it's too much work, because they don't really want to deal with the behavioral health piece of it, et cetera?

>> ASHLEY HADY: That's a good question because we -- I've heard it.

Is that they're dealing with it anyway. So 90% of their 40-minute visit for an urinary tract infection is behavioral-health related or, you know, the primary care is dealing with it anyway. So really, I think we've come from the side of the world that this is -- this is going to allow you to get to the root of the medical problem, you know, that the -- the problem that they're coming to you with is not everything else that had just kind of come out of that patient's mouth at the same time.

Oh, while I'm here, going to tell you what happened in my, you know, to affect my mood today.

And so I think the primary care providers are having to handle so much of that anyway. So this -- this is going to ease up. And then not really good at saying, oh, yeah, you can take care of that, you know. Some of them want to keep it all to themselves.

But, I mean, if we can make that connection, if they -- we offer -- if you want to come see, how, you know, talk to our nurse face to face and talk a to therapist face to face and voice your concerns.

We've had a psychiatrist in the telehealth unit, we wheeled him into the room and had a meeting face to face with the providers and able to vet through a lot of questions. And, you know, I think it's just keeping -- keeping the conversation going. It's hard to build that trust up, if -- if it's somebody that you don't have access to talk to and just kind of throws questions out there.

So I'd say that the primary care providers are already dealing with it. So let's help them make it, you know, make their lives a little bit easier and take care of the patients, you know. I don't want to say they're not taking care of them appropriately because it's not out of their realm, but let's be able to focus in one area. So...and that seems to make them stop and think a little bit.

>> ROARA MICHAEL: Great. Thank you.

And we just have a question in relation to billing. So are the services for primary care and behavioral health billed on the same day? Do you ever experience any payment issues as a result?

>> AMANDA PETTIT: Our billing happens when the note is complete and our policy is notes have to be completed within 48 hours. So once the note is complete, then the billing department does bill that. And we have not had any issue with reimbursement.

>> ASHLEY HADY: With the different levels of, like, in respect to a practitioner seeing a patient at primary care and then a psychiatrist seeing the patient at behavioral health, as long as it's not the same type of provider seeing the patient, that's, like, where sometimes they'll throw in a red flag. And this should be considered the same, you know, one visit.

But we haven't run into any of that yet, you know. I don't foresee -- especially when it's the counseling versus a primary care visit. But I don't foresee any -- it's a different specialty. So that makes it different in the eyes of the insurance companies, is my understanding.

>> ROARA MICHAEL: Great. We're just going to do one more question here.

Are there any community health peers in place who identify with what a senior may be going through?

>> AMANDA PETTIT: Yeah. I mean, we have -- so in our community, we actually have two other clinics, primary care clinics. And within each of those clinics is the -- there are some behavioral health providers. So it's been really interesting to me as we started the primary care clinic up, you know. It was two other primary care clinics in town. I don't know how much we wanted to talk to each other. Let's all try to play in the same sandbox. And a little bit of competition. As soon as we opened the behavioral health services up, the other two clinics were calling. And we were calling and setting up meetings to meet and greet and talk. What can you do? What can you do? And who can I send to you?



So it was actually really refreshing that everybody knows there's a need. We also had our -- wheeled our psychiatrist in with the telehealth as well and had the meeting so they could make the connection. And I think it's more knowing that you're not the only one out there that's trying to make that dent into the needs of the behavioral health population.

That makes us all kind of stronger. And then like Ashley said, we're in the consortium with Crawford County and Richland trying to get to meet the ongoing access needs with the prescribers. And we know the same prescribers' needs. And one's at one job for a while and then comes to the other job for a while. So it's -- it's a small world when it comes to behavioral health and finding those providers. So everybody's feeling that -- that burn right now.

Does that answer the question?

>> ROARA MICHAEL: Yeah. And I'm sorry. I know I said last question. But I thought this one question would be beneficial too for the audience just to gather your experience.

But what differences do you notice between treating older patients and younger patients?

>> ASHLEY HADY: I think, with the older patients seem to be struggling more with adjustments of life and depression and anxiety versus younger patients who might be struggling more with behaviors. Or you might see more stressors in the home and family functioning, you know. Older patients, they have control over their environment for the most part. And young people don't, That makes a really big difference in treatment.

>> AMANDA PETTIT: I've been speaking with our -- we have patient family service department at the hospital. So trying to integrate them as well with: When they do discharge planning for patients? You know. Recognizing the need for some, maybe, behavioral health to be on board once they go home. And our home care department does have support staff as well. But, you know, if it's a -- we can't -- our behavioral health providers don't see patients in the hospital. But how can we connect those dots so that, you know, we just -- we're dealing with physically getting better. This patient is -- and not being as mobile as they were and stagnation from age and health. And maybe it'd be a good idea to talk that out with somebody so it doesn't continue to spiral out of control. And trying to make the connections with the in-patient departments as well.

And then it has been important because it's a different -- different thought process because of older people.

>> ROARA MICHAEL: Thank you so much. And we'll have some time for questions at the very end.

But right now, we're going to go ahead and hear from Dr. Bartels.

>> DR. STEVEN BARTELS: Thank you. And that was really a terrific presentation to follow.

I'm going to be taking a somewhat more broad approach. But I'll comment on some of the points that have been made thus far.

And to let people know, I'm a geriatric psychiatrist. So this is pretty familiar territory. And I'm happy to answer questions about issues having to do with older adults also so going to talk a bit more about how things are a bit different for older adults and what's different and talk a bit about evidence-based practices, and then do an overview of a series of models of care. And think forward about where we're likely to go in addressing the workforce issues with respect to older adults that are going to be become overwhelming over the coming decades.

Now, you've heard about the so-called silver tsunami already. And you know about the doubling of the population as we go forward in terms of older adults. What you might not know as we look forward, that people with mental health conditions are going to equal in a number. The number of people who are in these younger cohorts that you're more familiar with treating, age 45 to 64, or 30 to

44, or 18 to 29, that the younger cohorts that are traditionally dominant are going to be coequal with the older adult population. And you can count on it. And certainly in primary care or any mental health delivery setting a burgeoning need for the older adult as we move forward.

And -- and what I want to do is talk a little bit about -- about what's perhaps different. The question that was asked just -- just a moment ago about what's different about older adults. I think one of the things that I'd say is there's several things.

One is multimorbidity and comorbidity is everywhere. So in contrast, I used to be a medical director for the state's mental health system. So it wasn't unusual to have somebody that was young with just a mental health problem, just with depression. And those who do geriatric knows everybody that walks in has multiple medical problems, number one.

Number two, cognitive impairment is always in the background and something to think about, whether it's dementia or a metabolic issue and complicating feature of mental health problems.

And thirdly polypharmacy is everywhere. So unlike one person who might come into the practice in a primary care who's 28 and they're on no medications or one medication, as you know the older adult populations it's not unusual to have people on many medications. And the drug-drug interactions are huge. And as you know, the more likely you have drug-drug interactions, the more likely you're going to have an adverse drug event. And falls are a major risk factor for individuals who are older.

And then, also in addition to multimorbidity and cognitive impairment and stigma, it's also the case that the other feature is that many people have family caregivers or individuals that they come in with and not unlike pediatric. And someone comes in and someone else is involved. And that becomes a feature.

And then finally, we think a lot about functioning and not just symptom resolution and global functioning for people who are older. And trying to think forward about what matters to that person.

And sometimes as someone's really older and has -- has multiple health conditions, including ones that are untreatable, you know, metastatic cancer and palliative care comes into play.

So those are things that I think about that are different. And we do know also -- and I'd like to say that behavioral health care for older adults and behavioral health care for older adults is a healthcare problem. It's not a, quote, mental health problem that we accommodate. But in every place you look, it's the case that mental health symptoms affect physical health. And in turn physical health affects mental health.

And you can see here a study that was done a number of years ago that focused on a number of depressive symptoms and mortality after hip fracture in older adults. And probably if you think about this for a few minutes, you can speculate as to why that is. And we think it probably has to do with a number of factors. Older adults who have, for example, hip fracture and depression are less likely to follow rehabilitation instructions. And their immune system is more compromised and more likely to be sedentary and all sorts of things happen with depression. And so it's a healthcare problem. And also we know that after an MI the presence of depression and particularly severe depression is much more likely to result in mortality after an MI as opposed to cardiovascular event. And depression in older adults is not a normal part of aging. It's not something that we expect to see. It's diagnosable and treatable and a medical condition. And it dramatically affects pretty much every health outcome.

And you could add in here chronic pain. And depression occurs substantially in chronic pain. And opiate epidemic we know about that as an issue that's emerging with older adults as a serious consideration.

And cancer. And we know T-cell counts are lower and people are more likely to have relapses and not do well when they have untreated depression with cancer and depression in older adults and a healthcare problem not just a, quote, behavioral or mental health problem.

And then if you step back from the medical interaction, we also know that the highest suicide rate is among older men, particularly older white males.

Unfortunately, women are beginning to catch up. But that 80-year-old recently widowed and alcohol-using and retired, living alone man who also happens to have and own and possess a gun, high risk. And so we know that depression kills both also by suicide. And the highest suicide rate of any group are older, again, Caucasian men.

Now if you don't -- if when you think about arguing for improving depression care or mental healthcare for older adults and integrating that into a primary care practice, if you can't make the argument to your administrators or to policy makers based on mortality, based on quality of life, based on so many things, you can absolutely make the argument based on -- based on finances.

So we know across the lifespan -- and this is a study we did a number of years ago, looking at dually eligible people and those on Medicaid and Medicare. And if you add depression on top of being a Medicaid and Medicare beneficiary, it doubles the cost.

And if you add -- if you look at schizophrenia and serious mental illness, it's triple the cost. And you can see dementia is a high-cost issue across the lifespan. So by and large, pretty much when you add depression, for example, two to three times the cost. More serious mental illness and certainly three to four times. And so these are extremely costly.

And what I like to say when I've been asked to testify and have before Congress and state legislatures, when I that say, how to do we afford this? And when I say, you're already paying for it. You're paying for it in emergency room visits and hospitalizations and revisits and relapses. You're just paying for the wrong thing. You're paying for bad care. You're not paying for preemptive care and care that's effective. And it's costing you in increased hospital use and emergency room use. So let's invest in the right thing. So what's the right thing?

So over a decade ago, I would give these sorts of talks and people would say: Is there any evidence-based for geriatric mental health practices? And is it evidence-based?

We did a bunch of evidence-based practice reviews. And you can see now they're a decade old that you get -- that there are randomized trials specific to older adults, not just generic ones applied to older adults. And in a number of areas, those include integrated delivery in primary care and mental health outreach services, home visit programs, mental health consultation, and treatment, and long term care, family caregiver support interventions for people who have a cognitive impairment disorders.

And then, yes, pharmacological and psychological treatments are just as effective in older adults as younger. And as you know, start low and go slow and lower dosages and -- and slower increases in dose for most of these aging, due to increased sensitivity and metabolic changes. But by and large, again, the evidence base is robust and certainly is one that's in place.

So over a decade ago, almost 15 years now, there were three separate randomized trials asking this -- the basic question: Does integrated mental health in primary care improve mental health outcomes for older adults? So what you may not know is an entire field of integrated behavioral in primary care was spawned from the three studies. And all were geriatric. And the IMPACT study, which I'll talk about in a minute, was geriatric and a prospective study on preventing suicide in older adults was geriatric. And then the PRISM study, of which I was one of the PIs and funded by SAMHSA was geriatric. And we were all together asking similar questions but in different way.

What I can tell you is one of the interesting things about the PRISM study -- and I don't have a slide to show you. And I took it out -- actually was what we know about engaging older adults is quite traumatic, which is to say in that study what we did was we ran randomized individuals in over 15 sites across the country, including VA medical center. And 2,000 older adults all over the age of 60 with depression/anxiety disorders or at-risk drinking and randomized them either to an embedded co-located individuals in -- in the primary care set or we referred them to a specialty geriatric mental health clinic, which is the Cadillac of referrals in the sense of what maybe nexus -- whatever you call it these days.

And in the sense that we provided copayment, we allowed -- we had people get the specialty referral appointments within two to three weeks and even provided transportation. You cannot have a better referral process to specialty care. The option was a master's-level person in the primary care setting.

What we found was dramatically better engagement in the embedded care model. What that told us was that older people, when given even under the best of circumstances, even when they've even agreed to be in a clinical trial, that the vast majority of people individuals even make it to the referral or engage in specialty referral treatment. So the only hope, in my opinion, of really providing good mental health care for older adults is it's embedded in primary care. And the small number of people who are treatment refractory and really need specialty consultant to see a geriatric specialist is small and should be carefully chosen and then supported.

So we saw that engagement was much, much better and double the rates of engagement for embedded substance abuse treatment and same sort of thing. If you want to help someone with at-risk treatment it's better to be in a primary rather than a specialty setting.

So what -- what is -- though the major study, that really has spawned, I think, a tremendous amount of implementation. And that's the so-called IMPACT study of collaborative care. It was done by a colleague of mine. Unützer and accomplished in JAMA. And that model, which I think you're all familiar with, is there and embedded care manager and depression care clinical specialist and could be a Master's level or Bachelor's-level person who -- who does a number of things.

One, everyone gets screened with a PHQ-9 or PHQ-2 with a step down to the -9 when people have a threshold and positive score in one of the first two questions. That PHQ-9 is repeated on a regular basis.

And the individuals were given one of two choices. They could either engage in problem-solving therapy that was designed for a primary care, a six to eight-manualized session of cognitive behavioral therapy or enrolled in a stepped-care protocol with antidepressants.

And the outcome of this was quite clear. The individuals who were in the collaborative-care model versus usual care had significantly greater reduction in terms of psychiatric symptoms, depression symptoms, in particular, and greater rates of remission.

And so this is clearly an evidence-based practice. We all are, you know, many sites across the country have implemented it.

And again, the magic sauce is not just that there's an embedded provider, but that that person does follow-up. It's most people started on medications who are older, and antidepressant medications, the majority often stop them prematurely. And so checking in with people and putting them on something they tolerate.

And then the other magic part of this or important part is that something substantial happens, which is that the mental health provider actually talks to the primary care physician. And they have a collaborative conference or conversation about the care plan.

So this is really about collaborating. This is about supporting the very busy primary care physician and working as an embedded consultant and provider within the primary care setting and involving that primary care physician, as necessary, in the care plan and clearly evidence-based. And you can see here clinically significant improvement defined by at least a 50% drop on depression scores at three months, six months, and twelve months.

So people ask: Well, how can we -- how can we afford this sort of thing? Is there any fact or cost offset? And does it pay for itself?

And Dr. Unützer did the study and published it in the American Journal of Managed Care. And not an immediate pay back, but what he found is over the course of four years, the people that were in the IMPACT model, the collaborative care model has a lower overall cost of aggregate healthcare compared to usual care patients, which more than -- more than compensated for the cost of the intervention so. It pays for itself, but not immediately. It pays for itself over the long run. And actually, in this study, it took four years to actually be -- show the fact that by patient that it actually more than paid for the cost of the intervention.

So we know that integrated care works. And it can pay for itself. And it can be delivered by a Master's and Bachelor's provider that are integrated into the care. And then it's all about following the algorithm. And the specific approach is well laid out and very clear and can be taught to many individuals.

So that's embedded care in primary care.

What about outreach?

So, again, we would often have the question: Is there an evidence-based for doing care in the community doing outreach models, having either behavioral providers or health coaches go out into homes and into the community providing screening and treatment?

Well, we did a review paper a number of years ago and looking at the same thing, the outcome being at least 50%, clinically reduced reduction in depressive symptoms and meeting in syndrome criteria. And you can see four separate randomized trials showed the same thing. And the intervention can play a significant role. So mental health outreach works. It's an evidence-based practice. And why is this also an important study?

We know that older adults, if they're going to get any mental healthcare, they're going to get it and engage in treatment, it's got to with be where they seek services and where they reside and where they seek services for primary care or senior citizens and where they reside at the senior housing projects. And many of these were outreached and home base and models for evidence-based. And this is through home healthcare nurses also. And this is what we know and how we need to provide care, by reaching out to people not expecting they're going to go to see a geriatric psychiatrist, like me, in a specialty clinic.

We know the prevention and its time is here. And the prevention working in geriatric patients and the first prevention study, which I show here, which is an interesting one by Barry Rovner was because it's based on the observation that older people who develop macular degeneration have a very high rate of depression. And it's very predictive. So he actually observed this phenomenon. And we -- he happened to have the geriatric psychiatry practice placed in the building in Philadelphia with the common waiting room of the eye clinic and saw this phenomenon and decided: What if we started to treat depression with problem solving and psychotherapy and focused on here and now problem solving and behavioral activation? What if we do it at the point of the diagnosis of the macular degeneration. And he shows that we can significantly prevent depression in the medical episodes that are highly associated with depression by starting a brief psychotherapy right out of the

gate, seven sessions, and significant outcomes and repeated in other cases with severe accidents and arthritis and a number of other conditions. Again, prevention in old age, a real phenomenon we can prevent. And as you know all know, geriatric is about prevention. And people don't think about that. Prevention, preventing falls and adverse outcomes and preventing the predictable onset mental health conditions. And it also can be the case when you think about prevention that is the case that the SBIRT not modeled Screening Brief Intervention and Referral to Treatment model has been tested. And the Brief Alcohol Intervention and BAI, which is the manualized, manually driven intervention for those who are at-risk drinkers In the whole constellation of those who are older adult drinkers that the greatest number are not people who are, in fact, addicted to alcohol. People who are, again, showing symptoms of withdrawal, but actually the people that are drinking who are at-risk drinkers and women who are drinking more than one drink a day every day and men drinking more than two.

They're at much more risk of falls and cognitive impairment and more risk for adverse outcomes and interacting with other drugs and medications. And so targeting that as an at-risk drinker has been shown to be effective and can be done in brief intervention by primary care and has been tested in primary care settings. And we have effective models for that. And recently, you know, there's great interest in moving into the area of pain management and non pharmacological ways and using both the physical therapy relaxation approaches, as well as nonsteroidal anti-inflammatories and things like that in lieu of opiates due to opiate epidemic, which is breaking over older adults and is a huge problem.

So we have evidence-based. It is the case that if you're interested in some of these kind of quick snapshots, the older Americans mental health and that, I helped to co-lead. We put together the issue briefs, the administration on aging and SAMHSA. And here's one on alcohol use and misuse. And you can look on web and you can find these. And they are available for you. And they're nice, condensed, kind of easy-to-use descriptions of -- that are both at the high level of people who are patients and families can read or providers. I think they can be helpful also. And then there's depression toolkits. You saw the most recent description of a KIT that's available for older adult mental health now available that you can access on the web that we put together.

So that's -- that's kind of a quick tour of a number of areas that have to do with depression and substance abuse in older adults. It's also the case that you may be finding an increasingly -- particularly in FQHCs, you have aging people with serious mental illness that come into your practices. And we know that people who have severe and persistent mental illness are dying 25 to 30 years earlier due to cardiovascular disease. And those with schizophrenia and bipolar disorder is in fact cardiovascular and associated with high rates of obesity and tobacco use and hypertension and dyslipidemia is off the map due to the pharmacological and the antipsychotics being used.

So this is a very, very serious health disparity. We're doing a lot of research on that in the group here, trying to think about ways to help people with mental illness not have a reduced life expectancy of 30 years due to cardiovascular disease. And these very, very prevalent factors of obesity and smoking and diabetes and cardiovascular disease. Now we have -- there are a number of measures and things out there. We've been doing work around health coaching and exercise and a program called In Shape. And we've developed and researched, along with others, studies, ways of helping people with mental illness to self manage their health through psychoeducation and cognitive behavioral techniques. We, for example, have seen with your patients with major mental illness, and in fact helping them to self manage, can help with hospitalizations and significant improvement in terms of self management skills. And particularly with diabetes, we've seen great results with those

with diabetes and mental illness maybe being able to self manage their illness if again focused and tailored diabetes education is used for the high-risk population.

Lastly, I'll say a few things about dementia. It's frequently not thought about as a mental health condition, which is curious, because all of these have biological etiologies since schizophrenia and depression has a biological diathesis, you're moving through with your practices, you're having more and more older adults coming in with cognitive impairments. And those with dementia have a mental health symptom of depression or hallucinations about paranoia. And certainly for primary care physicians, this has become an increasingly challenging group of individuals who occupy a huge amount of time because of the need to do the assessment disclose diagnoses work with family caregivers, and the lack of dementia care trained staff is a real challenging problem.

So -- and, as you know, those who are working with the Medicare wellness visits and your wellness visits, all the things you need to screen for, including cognitive impairment and depression, falls, and substance abuse, and obesity. How do you do this? How do you get it done?

And increasingly as you're being hearing about integrating these into the care plan and into your -- into your services, you know, that's all well and good for the specialist, but -- but what's -- what's the clue? How do you do it? And clearly I have -- with apologies to many people across the country, because I put this slide together before the Super Bowl. It is about the team. And being a New Englander, you know what I was thinking about. And it's not about the well-paid team lead by a juggernaut of a quarterback, but a team that is largely nurse based and nurse lead with the individuals who are health coaches and others working at the top of their licensure. And the only way to, in my opinion, to work with the complicated patients who have both mental health conditions and cognitive impairment, is it's a team-based approach. And we're engaged in the [indiscernible] funded geriatrics. And we're redefining care around the complex mental health and geriatric dementia patient.

Here you can see the traditional model. On the left-hand side of a physician with a medical assistant who rooms the patient. And then the 1:1 contact and treatment. And send the person out the door. And trying to convert toward a team-based model. And here is the team. It's actually not just the physician with his or her nurses or LPNs or -- or medical assistants, but also working in concert with the aging social service provider network that's out there.

So you do have, you know, senior centers and Alzheimer's groups and a whole bunch of things that will become a service to you if they're integrated into the primary care setting along with using the family caregiver as part of the triad. And the triangle is the physician with the team along with the social service providers, along with the family member who becomes that team for you, working in team-based care settings. And we've developed tool kits on this that we'll be happy to share.

We know that actually another thing -- and I mentioned or alluded to is caregiver support interventions are critical. And the thing that launches people into nursing homes is literally the breakdown of the family caregiver. Those family caregivers who take care of those with dementia have the high rates of depression and the high rates of substance use disorder and uses of chronic -- and taking care of the caregiver is as important as taking care of the person with dementia. Because they're at high risk. And the key often in maintaining that individual dementia independently in the community as long as possible and lots of data on effective caregiver support interventions that exist.

So at the end of the day, what about the work force? We -- I was on the Institute of Medicine panel and we published this paper in the New England Journal of Medicine on the issue of geriatric workforce. And the number of people trained will never, ever meet the need in terms of specialty training. And this is the -- the -- the Institute of Medicine Report that we put together in whose hands

-- and clear to those who work in area, it's about thinking more broadly. If you're working as a community provider and FQHC and primary care, thinking about how in the long run we can work together with social service providers during home-delivered care providers and working on the project where we're having the home delivered care, home delivered care individuals actually screen people for depression and referring people in for treatment.

We also have -- there's a lot of work on health coaches and individuals who are engaged in the community, screening for a depression. And much of this technology or some of these models come from other countries that are under-resourced, that have done randomized trials of depression care using indigenous providers and people in the community and training them in approaches and manualized approaches with effect. And we can do that in rural areas where we are very, very short on people trained in geriatrics.

And then technology. And older adults are the fastest users of technology, by far, in terms of growing numbers and are increasingly accessing the web.

Coupled with that is a growing area of mobile health technology and remote sensor technology. And we've conducted studies of a number of devices such as those shown here that not only monitor the individuals with respect to glucose and blood pressure and weight, if they have congestive heart failure, but also their depression.

And then based on how they're doing, they get not only instructions, but they quickly come up on an imagine monitored by a nurse hierarchy arranged into an at-risk category where we can contact them if they've rated themselves as being very depressed or having more chest pain or having trouble with diabetes. And they get a text message or phone call within minutes as opposed to ending up in the emergency room a day and a half later needing to be hospitalized. And we've had nice data showing dramatic impact on hospitalizations and emergency room visits using mobile health technology. And, yes, people with mental health conditions who are older.

And what's in store for us in the future as we look forward into aging? Well, in the community, I'd say there's several features we've thought a lot about. We look into the future, particularly in rural settings, and nationally. And one is the idea of reverse innovation, which means that in under-resourced, developing countries where they figured this out and providing care to people in rural, you know, India and Pakistan and China using community health outreach workers, we can adapt that and learn from that and do it here. But that also needs to be not only smart use of people, but smart use of technology that it doesn't take much to equip them with a smartphone where they can in fact, not only show you a picture of a -- of an inflamed diabetic foot, but have you briefly talk to someone who is using Facetime or Skype who is depressed and to help diagnosis and treat someone remotely and an community outreach worker and certainly community outreach and health coaches and self management and technology to monitor and deliver home health care. All things that are really going to be critical in terms of the workforce challenges we have before us.

And as you probably know and have seen, there are smart homes that are sensor detecting individuals gait speed as they walk passively through the hallway and early signs of confusion and metabolic problems and depression and all of these things in the -- in the offing and have to be put together in a different way if we're going to address, again, this very, very large and looming numbers of older adults with mental health needs coming down the pike in the next decade.

And I'll, as a broad overview, I'd be happy to take questions.

>> ROARA MICHAEL: Thank you, Dr. Bartels. We're going go ahead and go straight into questions. We've had a number of them come in. So we'll try to get to all that we can.



So we had a question come in here. And someone wants to know your ideas on patient-centered medical home for mental -- behavioral mental health disorders.

>> DR. STEVEN BARTELS: Sure. As you know, there's a large demonstration that's being funded by SAMHSA and PBCH and patient behavioral health integrated home for people with mental health conditions. And a couple of thoughts on those.

First of all, people with mental health needs -- and this is not just older people, but younger people -- have had notoriously poor access to good primary care. And there's a number of studies that showing routine screening for diabetes. And treatment is often poor. And the idea of integrating primary care within behavioral health services has a lot of -- a lot of traction and makes a lot of sense.

However, in -- and this is the big "however." The actual outcomes of these -- and we reviewed the literature for this for the grant we put in. And we're writing a paper. The actual health outcomes have been disappointing. People get more screening and seeing more primary care docs. But the downstream impact on things like diabetes and obesity and smoking, congestive heart failure, have not been particularly robust. And what we think is that it's -- and, you know, this. It's necessary, but not sufficient to have people screened and simply and provide a medication. Health behavior change accounts for 40% of health. And 10% of health is healthcare. And so helping this high-risk population to engage in programs that decrease obesity and decrease smoking and enhanced medication, you know, adherence and healthy lifestyles is really, really, important. And so I think that's the next wave, I think, adding to the behavioral health homes. And SAMHSA is requiring in the behavioral health homes, but in addition to integrated primary care that also are adopting a wellness to program focused on weight reduction or smoking and illness self-management program and helps to support people with mental illness in managing their mental health and physical health condition.

>> ROARA MICHAEL: Great. Thank you. I did have a question coming in about the team-based model. Can you explain how the team-based model works as an integrated unit?

>> DR. STEVEN BARTELS: Sure. This is about dementia care. That's what I was referring to. But I can talk about the both sets. I'll start with dementia and get depression. There's models that exhibit, if yourself interested, it's called the PREVENT model. And it was published and put together by Chris Callahan and published in JAMA in 2006, if you're interested in it. And you can look it up. And it's about integrated care and dementia care in the integrated model.

There is a team that has a social psychologist, a geriatric psychiatrist and geriatrician involved in developing the model and a focuses on caregivers and spotting the caregiver in that -- in counseling and in care. And the primary care physician is given a set of algorithms around both screening for delirium and dementia and problem behaviors and dementia. And that was proven effective in a randomized trial. That's really -- that was really very nicely done in JAMA. The challenge of that model, as you probably heard, is that it -- it's pretty heavy duty in terms of -- in terms of intensive team members. Probably not practical for most smaller, primary care practices.

So what we're proposing right now and developing through the grant through HRSHA administration are a series of toolkits and off loading the screening for problem behaviors and for cognitive impairment disorders off of the family caregiver. And they come into the primary care physician as a member of the team already, providing information about problem behaviors, and functional impairment and memory problems and brief screens for cognition and then embedded in the primary care setting is somebody's who was one of the nurses or LPN or medical assistant who's been trained in screening and following through on that dimension and kind of management strategies with family caregivers. And then also incorporating support from the Alzheimer's Association in that.

And so it becomes kind of a virtual team with social services agencies and home-based meal programs, the senior citizen centers, kind of coordinating with that embedded kind of care manager in the primary care setting, working with the family caregiver, and then working in tandem with the physician around managing that dementia patient. Kind of similar with the -- same thing with depression care, as you know. It really is a team-based function in the sense there's a primary care physician or nurse practitioner who's working with the embedded provider who is a -- a master's level often, clinician who is providing screening and psychotherapy where the physician may be providing the prescription for medications. And sometimes the embedded provider can be a psychologist. And that's a rough way, the kind of the way we're thinking that the single physician and single patient contact doesn't work for multimorbidity and complex health conditions, particularly if there's cognitive and mental health and it's too overwhelming and you need a team.

>> ROARA MICHAEL: Great. Thank you. Can you [indiscernible] the power of the senior centers and especially in relation to social isolation and the development of depression in older adults?

>> DR. STEVEN BARTELS: Yeah. I think we know that social isolation -- and some people have said that the biggest and most common illness and most devastating illness in older adults is loneliness. We know that older adults who are socially isolated have much worse health outcomes in every domain. And social support is really important so senior centers are important.

Transportation, though, is a challenge especially in rural settings. And looking out the window, as the snow is falling, we run a -- an aging resource center. I can tell you it's kind of empty right now. So there are challenges.

But I can tell you in a senior center, we are working closely with local senior centers and having them become partners in screening for depression, providing some support groups, but also providing, you know, social support activities that are really important particularly for that isolated, older adult who's, for example, may have lost a spouse, critical in terms of long-term outcomes.

>> ROARA MICHAEL: Great. Thank you. The organization has some resistance too. And how do you handle it? How do you handle chronic diazepam for elderly and chronic anxiety. The organization finds great resistance to change from these meds.

>> DR. STEVEN BARTELS: Yeah. I mean, I think that long term benzodiazepines and Xanax and Librium, they're not good for older adults. And that's why the question is being asked about the incident of falls. And cognitive impairment and use of benzos should be very short term at best and not -- it's not a long-term solution.

So I think part of it is perhaps to remind people that there is -- there are, in fact, guidelines. There are if you look at the BERS and for drugs not to be used and long term benzodiazepines are contraindicated if people are assuming much more legal risk due to falls and other sorts. They're on a long-term benzo. I don't think that's the best idea to threaten them. But remind people that there are standards and other agents. There are -- SSRIs are equally often equally effective in terms of anxiety disorders, as well as behavioral treatments for anxiety disorders. So slowly tapering people, though, not stopping abruptly is really important.

But that getting those individuals off of long-term benzodiazepines. Better for the patient and in the long run will enhance functioning. The data is really clear on this.

>> ROARA MICHAEL: Great. The fact that the research about macular degeneration, are there other examples in behavioral or of using prevention strategies?

>> DR. STEVEN BARTELS: Yeah. There's been some work in stroke and sort of accident in terms of starting with people who have had a stroke and doing preventive treatment in anticipation of depression. I think also there is some work in -- in -- in the palliative medicine around cancer

treatment and supportive in preventing depression. Also that often is pretty common in people who have been given a terminal diagnosis. And, as I mentioned, there is some work done also with people who have debilitating diagnoses of arthritis in terms of preventing depression. So those are several that I'm aware of.

>> ROARA MICHAEL: Okay. So are there any premorbid indicators that can be identified for adults about 40 to 6 years of age?

>> DR. STEVEN BARTELS: Premorbid with respect to what?

>> ROARA MICHAEL: It seems -- I guess the person thought about it in general. They did not elaborate.

>> DR. STEVEN BARTELS: I wonder if it's people who are at risk for depression for -- maybe.

I think we do know that people who are middle-aged, who are at greater risk for mental health conditions, it pretty much -- you'd probably be able to predict most of these things if you thought about it.

Certainly any episodes in the past of having a major depressive episode or a major depressive disturbance and alcohol use, significant alcohol use or any history of addictions, history of multiple failed intimate relationships. In other words, having a -- having a track record of being able to maintain a solid marriage is protective. Multiple relationships and multiple fractured relationships is not -- not protective. And certainly individuals who have been recently diagnosed with a chronic and unremitting health condition. So.

And if you -- one example where there's one of my PhD candidates has done work on prevention is around multiple sclerosis. And you get diagnosed with that as middle-aged, you are very likely to get depression. And starting to address that early. But any chronic health conditions that are remitting and relapsing, but not really treatable are also places people have -- are at a high risk. And substance abuse and chronic health condition, past history of -- of mental health conditions or depressive episodes. And then a history of unstable relationships.

>> ROARA MICHAEL: We just have time for just a couple more questions here.

What should be the role of primary care with older adults who misuse alcohol or medications or where the risk level is lower than having a substance use disorder?

>> DR. STEVEN BARTELS: Uh-huh. If you talk to Fred Blow, who is at the University of Maine, he's done studies. And he would say that the role of the primary care physicians is critical. That we should be asking about alcohol use, not talking about abuse. How -- how many drinks on an average do you have in a week or in a day? And, again, if a man who has two or more drinks every day, or a woman who has one drink every day or more -- and again, that's based on a four-ounce kind of glass of alcohol -- is potentially at risk. And advising people and simple advice works. Dr. Blow has shown that taking five seconds or ten seconds to say, you know, given all the medications that you're on and given your risk of falls, and the fact you've had a fall, and you're having trouble with memory, I would recommend you cut back on your drinking and not drinking -- cut back on the amount of alcohol you're consuming. Without saying you're on alcoholic. And use no labels and no stigmatizing. But say, we know from research -- we know you're at risk. And we know you can decrease your risk if you decrease the amount of alcohol. And fine, have a glass on the weekend. But -- but really would be helpful to you and your health if you -- if we tried an experiment of having you cut back. That in itself can be helpful. And there are motivational interviewing approaches that have been shown to be effective. We would say it's within the wheelhouse of the primary care physician who can make a big difference in simply inquiring about alcohol use and making a simple advice comment. And then if

that person is at significantly more risk, engaging in brief motivational interviewing. And can take five to ten minutes and also be effective.

>> ROARA MICHAEL: Thank you. We could ask maybe one more question. What are your thoughts on the use of peer mentors and [indiscernible] providers can deliver care.

>> DR. STEVEN BARTELS: Sure. We're doing a number of studies in that area. And we're very optimistic about it. We think there's a huge role. We think that people should have lived experience, whether that's having lived with diabetics. And you probably -- anyone in the healthcare system knows some of the best people helping older people with diabetics are the people who mastered taking care of diabetes. And same thing with cancer survivors.

And no different with mental health. The only caveat is we need to be careful about not having peer counselors who are still working through the recovery and volunteering in part because they're still figuring out how to get their own mental health condition adequately addressed.

We've had challenges at times when that occurs. So making sure the person is fully in recovery and somebody who brings a sense of experience and balance and not there for themselves, but to help others. Hugely powerful. And, again, people are much more likely to identify with somebody who seems like they are like them and have had similar experiences. And it can be extremely powerful.

We have a young researcher doing this with chat rooms and -- and social media where, in fact, there is a lot of work that's being done with peers that's actually being done virtually.

>> ROARA MICHAEL: Thank you so much, Dr. Bartels.

So right now we're going to go ahead and move into resources. And CHHS has a wealth of resources on our website. We've listed a couple here.

We have also -- our folks on the APA have a couple resources here that are also on the website. And I'll just go ahead and go over here. And the additional resources and older resources and go to - you'll see that we have an older adult page. And you can access all of the resources, plus more, that are listed here on the presentation.

All right. So that is all the time we have today. Once again, a recording and transcription will be available on the CHHS website.

Once you exit, you'll be asked to have a survey and offer your feedback. And your input is important to us. And it forms the development on our national council webinars.

I'd like to thank our presenters for joining us on today's webinar. And thank you all so much for joining. And stay tuned for more webinars in the near future. Have a great day.

---