Geriatric Care Management Journal

Geriatric Care Management: Integrating Community-based Services for Older Adults with Mental Disorders

By Stephen J. Bartels, M.D., M.S.

Over the next three decades, the number of older adults with major psychiatric illnesses will more than double, from 7 million currently to 15 million individuals in the year 2030 (Jeste, et al., 1999). Mental disorders in older persons are associated with poor health outcomes, increased morbidity, greater risk of mortality, and increased service use, including greater rates of emergency room visits, acute hospitalizations, and institutionalization in nursing homes (Bartels, 2002, Druss, et al., 1999, Druss, et al., 2001, Luber, et al., 2001, Unützer, et al., 1997, Unützer, et al., 2000). A substantial body of research documents effective approaches to the recognition and treatment of late life mental disorders, yet there is a major gap between research knowledge and the provision of adequate and appropriate treatments in the community (Bartels, et al., 2002). Older adults with psychiatric illness are more likely to receive poor quality medical care services compared to older adults without a mental disorder (Bartels, 2002, Druss, et al., 2001). Furthermore, older adults compared to younger adults with psychiatric illness are more likely to receive inappropriate psychiatric treatment (Bartels, et al., 1997). A variety of barriers to care have been cited, including lack of financial resources, lack of transportation, stigma associated with mental illness and psychiatric services, ageism, lack of trained providers with expertise in aging and mental health, and an inadequate array of services. Frag-

mentation of services has been cited as among the most significant impediments to adequate and appropriate treatment (Bartels, 2003). This issue presents a series of articles addressing major challenges in providing services to older adults with psychiatric illness living in the community, and offers insights into the role of the geriatric care manager in helping to enhance access and coordination for services.

Key settings in need of coordinated mental health and physical health include assisted living and home health care. In the first paper of the series, Watson and Boustani provide an overview of mental health problems in assisted living, as the fastest growing sector of long-term care. Recent surveys reveal that one in four residents in assisted living have significant depressive symptoms and less than 40% of these individuals receive treatment for their depression. Depression in Assisted Living is associated with poor outcomes, including premature placement in nursing homes. Watson and Boustani provide an overview of common disorders in assisted living and suggest that geriatric care managers can play an important role by promoting screening and coordinated management of mental disorders.

Home health care is another service delivery setting for older adults that is associated with high rates of medical and psychiatric comorbidity. Mlodzianowski, Fyffe and Bruce report that approximately

13.5% of home health care recipients have a major depressive illness, and provide an overview of the syndrome and associated poor outcomes, including greater mortality from poor health and suicide. The presence of medical illness and functional disabilities contributes to under-recognition and under-treatment of depression in this high-risk population. The authors suggest that GCMs can play an important role in addressing these needs by facilitating identification, coordination, education, advocacy, support, and counseling.

Although depression is the most common major psychiatric illness affecting older adults, older adults with severe mental illness are a rapidly growing subgroup. Pratt, Bartels, Mueser and Van Citters describe the special needs of the growing subgroup of older adults with schizophrenia and other severe mental illnesses. This article suggests that older adults with severe mental illness comprise a challenging subgroup who have complex psychiatric presentations including psychotic symptoms such as hallucinations and delusions, as well as disorders of thought and cognition. These symptoms combined with medical comorbidity place older adults with severe mental illness at especially high risk of poor community functioning, poor health outcomes, and premature placement in nursing homes. Pratt and colleagues describe a biopsychosocial model of care management that supports coordination of medical care, rehabilitative services, and social supports.

In the following article, Miles, Seifert, and Duford describe a community-based wraparound model of care for older adults with mental illness and the key role of geriatric care managers. This model is based on an adaptation of successful wraparound management of high-risk children in the community and includes a routine wraparound team meeting consisting of representatives from different community agencies and provider groups. The authors describe ten practices for successful implementation of the model. In

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addition, practical recommendations are provided based on lessons learned from implementation of this model in a demonstration project in New Hampshire.

Finally, Van Citters and Bartels describe the current and future challenge of care management in the context of a growing population of older persons with mental disorders and a major workforce shortfall. This article reviews the current status of geriatric training programs and recruitment for mental health and general health care providers. The authors conclude that substantial reforms are needed in the training, recruitment, and reimbursement of geriatric providers if we are to address the emerging mental health needs of older adults.

The recent report on Older Adults for the Presidents New Freedom Commission on Mental Health cited three major areas for policy reform in order to meet the mental health needs of older Americans: (1) improving access, (2) improving quality of services, and (3) addressing the workforce shortfall of geriatric providers (Bartels, 2003). This timely collection of articles suggests that geriatric care managers should seek training opportunities to become knowledgeable in the evaluation and service coordination of mental disorders and should play an important role in helping to meet the growing need.

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The State of Mental Health in Assisted Living

By Lea C. Watson, M.D., MPH and Malaza Boustani, M.D., MPH

The State of Mental Health in Assisted Living

Due to discontent over the current long-term care system in the United States, older adults have expressed strong preferences to avoid living in nursing homes (Mattimore, et al., 1997). Assisted living (AL) has been put forward as an alternative long-term care setting that promotes resident autonomy and choice in an attractive and home-like environment. The Assisted Living Federation of America estimated that there were close to one million residents of assisted living in 2001 (ALFA, 2001). The annual growth rate of AL is estimated at 15-20% (Cummings, 2002), and it is projected that the number of AL beds will equal or exceed that of nursing homes by 2005 (Meyer, 1996; Meyer, 1998).

Older adults entering assisted living are usually making this move due to a decline in physical or mental functioning. They also face significant life transitions and may be vulnerable to depressive illness. Although often conceptualized as an alternative or intermediate step to nursing homes, AL facilities house a significant burden of illness, including a high prevalence of dementia with its related agitation, as well as depression. Because the mission of AL is grounded more in a "social" model (having emerged from the hospitality industry, where the focus is on attractive surroundings and available amenities) of care than a medical model, stakeholders need to consider the implications of potentially unmet mental health needs in this setting.

What is Assisted Living?

The term assisted living (AL) refers to any residential setting not licensed as a nursing home that provides or arranges supportive and health care services for individuals who require assistance with daily activities (Kane & Wilson, 1993). AL facilities provide congregate meals, laundry and housekeeping services, assistance with activities of daily living (ADLs), and some social activities. Such facilities are regulated by each individual state. Each state oversees AL facilities in different ways, in some cases requiring no licensed nursing presence, and in other cases, ensuring licensed staffing levels similar to nursing homes. Because of the marked heterogeneity of these facilities and lack of mandate to assess residents for possible mental illness (in contrast, nursing homes are required to screen for dementia and depression), very little is known about the detection and management of psychiatric problems in this setting.

A national survey commissioned by the Department of Health and Human Services in 1995 provided the first overview of the modern notion of assisted living in this country (Hawes & Phillips, 2000). They found that 67% of these facilities had more than 100 beds, 21% had 51-100 beds, and 12% had fewer than 50 beds. Annual resident turnover was 41% (with a complete turnover in 2.5 years), and 70% of payments came from private funds at an average cost of $1800 per month. The health services included in the base fee were highly variable, but most often consisted of provided or arranged (meaning the facility helped bring in the necessary services for an additional fee) nursing care.

Staffing issues were also found to be a large problem in AL. The cycle of low pay and staff turnover has prevented recruitment of high quality direct care staff, in many cases thwarting attempts to ensure continuity of high quality care. Although most AL facilities employ certified nurse assistants (CNA's), only 70% employ an RN or LPN (Kovner & Harrington, 2003). Staffing ratios vary dramatically from facility to facility, ranging from one staff member to 6 residents to as few as one for over 100 residents at night (National Center for Assisted Living, 1998). CNA's were interviewed and 88% thought confusion was normal, even when it was of sudden onset. Seventy-eight percent thought that depression was normal, 60% did know how to properly manage agitated behaviors and a majority thought that any psychiatric symptom was just a part of normal aging (Hawes & Phillips, 2000). Although most acknowledged relative satisfaction with their jobs, CNA's had a 200% turnover rate within one year. The number one complaint when asked about addressing psychiatric issues was not having enough time to do anything but the

TABLE 1
Demographics of Assisted Living
50% are over age 85
The majority are white, widowed females
30% have 3 or more ADL dependencies
Half have 5 or more medical conditions
1/3 have serious hearing and vision problems
ADL = activities of daily living

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mandatory tasks, such as feeding and bathing. Adequate training on the recognition and management of mental health issues needs to be included in any future workforce initiatives.

What do Residents of Assisted Living Look Like?

Assisted living facilities house an old and frail population, with significant medical problems and functional deficits (Table 1). It is also overrepresented by white, educated and economically advantaged residents. More than half require help with personal hygiene, the majority require assistive devices for mobility, and on average, AL residents take five to six prescription medications daily (Sloane, et al., 2002).
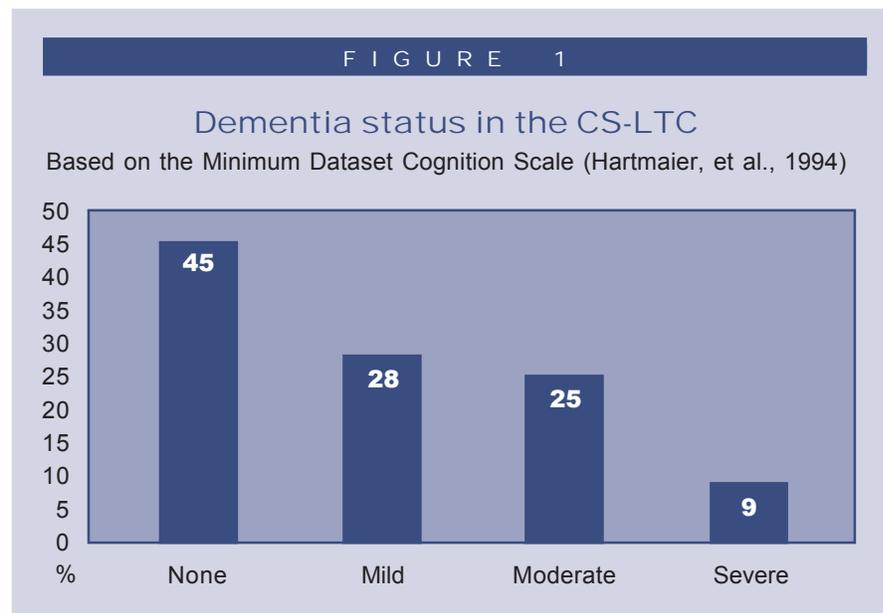
Prevalence of Psychiatric Diagnoses

Within the context of a social model of care, several research groups have begun trying to understand the *medical* implications of mental health issues in AL facilities. In the Collaborative Studies of Long-Term Care (CS-LTC) investigators interviewed more than 2000 residents living in approximately 200 facilities from four different states, along with their caregivers and facility administrators, to determine the overall process and quality of care in assisted living (Zimmerman, et al., 2001). In another study designed specifically to address psychiatric diagnoses, a group in Maryland has interviewed approximately 200 residents of assisted living, and is currently following them over time (the MD-AL study) (Rosenblatt, et al., 2003). Findings from these two studies shed light on the face of mental illness in the fastest growing sector of long-term care. These studies do not include facilities targeted to older patients with a predominant diagnosis of schizophrenia or mental retardation.

Dementia

Dementia is by far the most common psychiatric diagnosis in AL. The CS-LTC sample showed that greater than 50% of assisted living residents suffer from a dementing illness (Figure 1), and in the study that used extensive diagnostic interviewing by trained geriatric psychiatrists, there was an even higher prevalence of 68% (Rosenblatt, et al., 2003). The majority of these residents had mild to moderate cognitive impairment,

FIGURE 1

Dementia status in the CS-LTC
Based on the Minimum Dataset Cognition Scale (Hartmaier, et al., 1994)

although only 30-40% of these were receiving cholinesterase inhibitor medications that are the standard of care for this level of dementia. Because such medications have been shown to delay functional decline and preserve independence, it is in the interest of AL advocates to address the underuse of these proven treatments (Boustani, et al., 2003).

Agitation

Agitation, disturbed behavior, and behavioral problems, terms that have been used to describe inappropriate verbal, vocal, or motor activity exhibited by older persons with dementia or other psychiatric disorders (Cohen-Mansfield & Billig, 1986), are common in this setting of long-term care. In the CS-LTC sample, approximately one-third of subjects (with or without dementia) were

reported to demonstrate agitated behaviors at least once a week. Thirteen percent had aggressive agitated behaviors, 20% had physically non-aggressive agitated behaviors, 22% had verbal agitated behaviors, and 13% resisted taking medication or assistance in care. Those with dementia, depression, psychosis or greater need for assistance with ADL's had the most problems with agitation (Gruber-Baldini, et al., 2002).

Depression

Late-life depression is particularly difficult to detect because many older adults do not complain of typical depressive symptoms such as sadness. We found that many residents displayed symptoms of depression such as worrying, tearfulness, or irritability (Table 2). Thirteen percent in CS-LTC and 24% in MD-AL met criteria for *clinically significant depression*, although of those depressed, only 18% and 42% respectively, were receiving antidepressants (Watson, et al., 2003).

In the CS-LTC sample, depression was more common in those having more medical conditions, social withdrawal, psychosis, or agitation. Of particular interest to those wishing to remain in assisted living is the

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association of depression with nursing home transfer. When controlling for measures of illness severity, residents depressed at baseline required transfer to a nursing home 50% sooner than non-depressed residents. Similar to other studies of

T A B L E 2	
Most frequently noted signs of depression in the CS-LTC	
Anxious, rumination, worrying	37%
Sad expression, sad voice, tearful	25%
Unable to enjoy pleasant events	18%
Easily annoyed, short-tempered	28%
Adapted from the Cornell Scale for Depression in Dementia (Alexopoulos, et al., 1988)	

depression and mortality (Rovner, 1993; Unutzer, et al., 2002), severely depressed residents also had 2.1 times the rate of dying within the year compared to non-depressed residents (even when accounting for medical illness) (Watson, et al., 2003).

Other Psychiatric Diagnoses

The current state of research is largely limited to dementia and depression, but we know that anxiety disorders, sleep disorders, and alcohol dependence are common in older adults (Lenze, et al., 2000; Oslin, 2000). The MD-AL research team is beginning to analyze relevant data for these diagnoses, but until these and future data emerge, clinicians should consider these problems likely and treatable. Alcohol abuse and dependence is a special problem in assisted living, because in many facilities residents are allowed if not encouraged to maintain their "normal" routines as they make this transition. This works in favor of preserving their autonomy; however, the purchase, storage, and consumption of alcohol

are not routinely monitored, and impaired residents may go unrecognized.

Service Utilization

Very little is known about whether or not residents of assisted living receive mental health services, and if so, where they receive these services. Data from the MD-AL reveal that only 30% of those with depression or dementia have a usual source of psychiatric care, and a negligible number receive those services in the facility where they live. Making services accessible will be central to the successful management of these common disorders. The congregate nature of assisted living is a wonderful opportunity to centralize these efforts by bringing in mental health specialists, but will require action on the part of facility managers, providers and family members.

Future Directions

Professional geriatric care managers (PGCMs) are uniquely positioned to play a valuable role in the fragmented system of service delivery for mental health in assisted living. They can advocate for consistent mental health screening and management for existing clients without known psychiatric conditions, they can help to coordinate services once psychiatric diagnoses are made,

and they can provide continuity for patients and families trying to negotiate the various services required of impaired clients. Specific training on the recognition of depression and dementia is feasible and would further empower Geriatric Care Mangers not only to facilitate services, but also to identify clients in need of mental health intervention.

AL is a part of the senior housing market that is certain to have continued growth. More states are beginning to offer subsidies for AL services, hopefully opening the door to these facilities for individuals with fewer economic means. Concurrent with this growth, there is much debate about how AL should be regulated, and by whom. This debate reflects the difficult balance between assuring that health needs are addressed, while preserving the creativity, innovation and autonomy that distinguish AL from other long-tem care options. The demographics reveal a population that looks more suited to a nursing home than a resort, but will "medicalizing" assisted living ensure better detection and management of mental illness? The nursing home experience has produced mixed results (Snowden, et al., 1999), so we should not assume that merely mandating screening will translate into improved outcomes.

The U.S. Senate Special Committee on Aging has established an Assisted Living Workgroup to address the growing concerns about how these facilities are managed, and they have recently proposed guidelines for operations (http://www.aahsa.org/alw.htm). Although the issue of screening for health issues was introduced, specific plans to detect and manage mental health

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issues are not addressed. Some level of standardization is inevitable, however, and advocates for quality mental health care in older adults should not be left behind when these decisions are made.

Conclusions

The mission of AL is to help older adults retain autonomy, privacy, and quality of life in a personalized setting. There is growing evidence of unmet mental health needs in AL that may prevent the fulfillment of this mission. One in four residents is depressed, less than 40% of these are receiving treatment, and depressed residents require transfer to a nursing home 50% sooner than non-depressed residents. The *majority* of AL residents have some form of dementia, many with associated agitation, yet only one-third of those eligible are receiving medications. Overall, very few residents have any usual source of psychiatric care. Efforts should be made to detect and treat depression, dementia and agitation in AL, both to reduce suffering and prolong the resident's ability to remain in their preferred environment. The PGCM is exceptionally positioned to play a vital role in bridging this divide.

Dr. Watson is currently a fellow in geriatric psychiatry at Duke University Medical Center, and in July 2004 will be an Assistant Professor of Psychiatry at the University of North Carolina at Chapel Hill. In addition to providing clinical care and teaching, she performs research in the detection and management of late-life depression and dementia, with specific focus on long-term care settings.

Dr. Boustani is an Assistant Professor of Medicine and geriatrician at the Indiana University Center for Aging Research and Center Scientist at the Regenstrief Institute, Indianapolis, Indiana. Dr. Boustani's research focuses on improving the quality of life of patients with dementia in both long-term care and primary care settings. In particular, he is working on using an interdisciplinary team-based approach to advance the management of behavioral disturbances related to dementia.

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The Role of Geriatric Care Managers in the Identification and Management of Depression in Home Health Care

By Amy E. Mlodzianowski, MS, CSW, Denise C. Fyffe, Ph.D., and Martha L. Bruce, Ph.D., MPH

Introduction

Home health care is a growing sector in today's health care world, with older adults representing the largest percentage of home care recipients (72%) (Haupt & Jones, 1999). The mental health needs of older home healthcare patients have been minimally explored. In this article we will report on the prevalence of DSM-IV major depression in home healthcare patients, the nature of late-life depression in this population, and the role of professional geriatric care managers (PGCMs) in addressing this public health issue.

What is Depression?

Depression is an illness that is characterized by psychological, behavioral and functional symptoms. Major depression in late life is a significant public health problem affecting nearly one million Americans over the age of 65 (Lebowitz, 1996). The prevalence of major depression among older adults within the community varies across settings. According to the National Institutes of Health Consensus Development Panel on Depression in Late Life (1992), the prevalence of major depression among older adults living in the community is estimated at less than 3%, and 5% in primary care settings. Among home healthcare patients it is estimated that the prevalence of major depression is

13.5% (Bruce et al, 2002).

The discussion in this section about the assessment of depressive symptoms follows criteria for a Major Depressive Episode established by the Diagnostic and Statistical Manual-IV (DSM-IV) (APA, 1994), the accepted standard in the psychiatric community for diagnosing depression.

Depression is a complex mental disorder consisting of multiple symptoms (see Figure 1). Criteria that guide the assessment of major depression include:

(1) A diagnosis cannot be made without the presence of either *depressed mood* or *diminished interest* in work or activities (the two "gateway" symptoms.)

(2) Other symptoms such as sleep disturbance, appetite change, and difficulty concentrating must accompany the gateway symptoms.

(3) Symptoms must be pervasive and lasting (present for most of the day and nearly every day for a 2-week period or longer.)

(4) Symptoms are not due to the direct physiologic effects of a drug or general medical condition.

(5) If symptoms follow the loss of a loved one, they must persist for longer than 2 months.

FIGURE 1

Criteria for Major Depressive Episode (DSM-IV)

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood throughout most of the day, nearly every day.

2. Markedly diminished interest or pleasure in all, or nearly all, activities most of the day, nearly every day.

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in 1 month), or a decrease or increase in appetite nearly every day.

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive guilt nearly every day.

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

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There are other depressive disorders such as minor depression and adjustment disorders, which can present with similar symptoms as major depression, but are not as severe or pervasive. Often patients with these disorders can be treated with supportive counseling, but also must continue to be monitored for changes in frequency or severity of symptoms.

Nature of Depression in Home Health Care

Depression among older home healthcare patients is prevalent, but often is unrecognized and under treated (Bruce et al, 2002). Home healthcare patients are at higher risk of depression due to comorbid medical illnesses and functional impairment. Rehospitalization, increased service utilization, earlier mortality, diminished quality of life, and caregiver burden are common negative outcomes of untreated depression in older adults (Charney et al, 2003). For clinicians and PGCMs, the medical and functional burden experienced by home healthcare patients are complicating factors in the identification and management of depression.

Obstacles and Opportunities for Depression Management in Older Homebound Patients

With the medical and functional needs of older home healthcare recipients at the forefront of care, mental health needs often go undetected. Home healthcare providers are in the position of having regular direct contact with patients, but have indicated that they receive inadequate training in the assessment of depression and feel uncomfortable addressing

Patients' immediate needs, including personal care, medication management, and mobility issues, are a clear concern for patients, health professionals, and family members.

psychiatric disorders with patients (Brown et al, 2003).

Patients' immediate needs, including personal care, medication management, and mobility issues, are a clear concern for patients, health professionals, and family members. Caregivers often overlook signs of depression or attribute symptoms to the individual's medical problem(s) and/or disabilities rather than recognizing symptoms of depression. Medical illness, functional disabilities, and psychosocial stressors complicate the recognition of depression and create challenges in accurately assessing depression (Raue et al, 2002). A prolonged course of depressive illness as well as the risk of suicide and mortality result from a failure to recognize and treat depression (Brown et al, 2003).

Despite these challenges, the comprehensive knowledge of PGCMs makes them essential players in the depression management team. Home healthcare provides a treatment setting that promotes a multidisciplinary approach between medical, psychiatric, and social services. This setting offers the opportunity to bring together the expertise of professionals from a variety of backgrounds including nurses, geriatric care managers, social workers, psychologists and other health professionals. PGCMs are an important link between all professionals involved with the patient. Approaching identification and management of depression from a team perspective benefits the patient and the family and lessens the burden of care providers.

Role of the Professional Geriatric Care Manager in Depression Management

As a frontline service provider to older adults, the PGCM is in the unique position of having direct contact with older homebound adults and is often the first service professional to assist older adults and their families in meeting care arrangements. PGCMs serve as active participants in the lives of their patients and can have a "therapeutic" and administrative relationship that is unlike any other health professional. The PGCM's role is broad and encompasses many aspects of the patient's life. Consequently, PGCMs have an advantage of observing the psychological (e.g., negative self-statements) and functional (e.g., psychomotor retardation) outcomes of depression on their older patients' well being. PGCMs can serve in multiple roles in depression identification and management.

1) *Identification:* PGCMs with clinical background and training can assist in the assessment of depressive symptoms by screening for the gateway symptoms of depressed mood and/or diminished interest. PGCMs clinical sensitivity can be established through familiarity with the DSM-IV criteria as well as an awareness of changes in patient behavior (Raue et al, 2002). These clinical observations can indicate the need for further evaluations. Assessment tools are available to supplement clinical observations such as: the Geriatric

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Depression Scale (GDS; Yesavage et al, 1988), the Beck Depression Inventory (BDI; Beck & Steer, 1988), the Cornell Scale for Depression in Dementia (CSDD; Alexopoulos et al, 1988), and the Hamilton Depression Rating Scale (Hamilton, 1960).

2) *Coordinating Care:* Older adults often use multiple medical, psychiatric, and support services. Limited communication among service providers results in care fragmentation. Lack of contact between medical and mental health care providers is a barrier to appropriate care for late life depression. PGCMs can assist with this problem through their role in the coordination of care. For example, PGCMs can coordinate referrals to mental health services for the patients and family (Figure 2), as well as, liaison between mental health professionals and medical professionals working with the patient. In addition, the PGCM

> **Educating and training PGCMs in depression assessment and management is key in developing their strengths as active professionals in the mental health care of patients.**

can also serve as a link between the family and different medical, psychiatric, and social service providers.

3) *Educators:* PGCMs can educate the patient and their families about the various biological and psychosocial causes of depressive symptoms, the effect of depression on the patient (e.g., nonadherence), as well as treatment recommendations and community resources (Figure 2 and Figure 3).

4) *Advocacy:* PGCMs can serve as advocates for depressed frail patients who may suffer from limited self-responsibility and poor quality of life (Figure 2 and Figure 3).

5) *Support and Counseling:* PGCMs can offer social support and counseling to patients and their families about depression

management. For example, a PGCM can provide support to the patients and encourage depression treatment compliance.

All of these roles make PGCMs key players in the identification and management of older patients with depression.

FIGURE 3

Mental Health Resources

On the Web:

www.nimh.gov
(National Institute of Mental Health)

www.mentalhealth.org
(Substance Abuse and Mental Health Information Center)

www.nami.org
(National Alliance for the Mentally Ill)

www.dbaaliance.org
(Depression and Bipolar Support Alliance)

In Print:

NIH Consensus Panel on Diagnosis and Treatment of Depression in Late-Life. JAMA, 1992; 268(8):1018-1024.

AHCPR Clinical Guidelines for Treatment of Major Depression (Depression Guideline Panel, 1993)

FIGURE 2

Mental Health Services in the Community

- Family physician or health care provider
- Mental health division of your local health department
- Community mental health center
- Family services agency, such as Catholic Charities, family services, or Jewish Social Services
- Professional counselor who works in a mental health center, outpatient, clinic, private or group practice, general or psychiatric hospital or nursing home
- Pastoral counselor/member of the clergy
- Self-help or mutual support group
- Mental health or crisis hotline, drug hotline, or suicide prevention center
- Hospital emergency room

The Role of Geriatric Care Managers in the Identification and Management of Depression in Home Health Care

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Recommendations and Conclusions

The role of the PGCM in the identification and management of depression is critical to comprehensive care. Educating and training PGCM's in depression assessment and management is key in developing their strengths as active professionals in the mental health care of patients. It is not the goal to have PGCMs formally diagnose major depression, but rather to simply screen for symptoms of depression that may require further evaluation and referral (Raue et al, 2002). It has been shown that the overall health of elderly patients improves when depression treatment is implemented. Further evaluation by the treating physician, psychiatric nurse, social worker, or other mental health professional is essential once signs and symptoms of depression are recognized (Brown et al, 2003).

Incorporating depression management into PGCMs' practice can lead to overall effective care that meets patient needs and improves outcomes sought by the patient, family, and health professionals. PGCMs can provide their patients, family and health professionals with invaluable information in the assessment and management of depression and are a vital link to accessing mental health care for patients.

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> **PGCMs can provide their patients, family and health professionals with invaluable information in the assessment and management of depression and are a vital link to accessing mental health care for patients.**

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Integrated Services and Care Management for Older People with Severe Mental Illness

*By Sarah I. Pratt, Ph.D.,
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Approximately two percent of older Americans have a severe mental illness (SMI), including schizophrenia and other psychotic illnesses, bipolar disorder, and treatment refractory depression (Narrow, et al., 2002). With the aging of the general population, the number of older individuals with SMI is expected to double by the year 2030 (Jeste, et al., 1999). Many older individuals with SMI have significant difficulty maintaining a supportive social network, and SMI in old age is associated with a high prevalence of comorbid health and functional problems. These risk factors are compounded by a fragmented healthcare system that was designed to care for younger adults (Bartels & Colenda, 1998, Estes, 1995, George, 1992).

Most older adults with SMI reside in non-institutional community settings and prefer to remain in those settings (Bartels, Miles, et al., 2003, George, 1992, Meeks, et al., 1990, Meeks & Murrell, 1997). In addition, 40% to 50% of older adults with SMI who reside in nursing homes could be adequately served in community-based settings, and many may seek discharge from institutional care under the recent Olmstead Supreme Court decision (Bartels, Miles, et al., 2003). Expenditures for long-term care, combined with expenditures for ongoing mental health and medical health care, make the cost of caring for older individuals with schizophrenia more than the cost of caring for older individuals with any other mental disorder (Bartels, Clark, et al., 2003). The projected growth in the numbers of older persons with SMI, along with high healthcare costs, present a challenge for providing coordinated mental health, medical, long-term care, and social services to this population. Professional geriatric care managers (PGCMs) will increasingly be called upon to help coordinate the complex array of services needed to support community treatment for this high-risk population with special needs.

In this paper we provide an overview of the challenges and models of care management for older adults with SMI including: (1) the evolution of services from institutions to the community; (2) understanding SMI and the special needs of schizophrenia in older persons; (3) the biopsychosocial model of integrated treatment; (4) health care management, rehabilitation, and social support; and (5) geriatric care management and coordinating services for older adults with SMI.

The Evolution of Services from Institutions to the Community

In the first half of the last century, many older persons with SMI received long-term care in the nation's state hospitals. Beginning in the 1960s, closure of state hospitals and large-scale "deinstitutionalization" resulted in a shift to providing the vast majority of services in nursing homes and the community. Enrollment of older adults in public mental hospitals dropped precipitously across the country (American Psychiatric Association, 1993, Atay, et al., 1995). For some older adults, deinstitutionalization resulted in transinstitutionalization into nursing homes (Knight, et al., 1998). However, in the recent Olmstead decision, the U.S. Supreme Court ruled that it is a form of discrimination under the Americans with Disabilities Act to institutionalize a disabled person who wishes to live in the community when the individual is capable of benefiting from living in a community-based setting (Williams, 2000). States are now required to provide community placements for disabled individuals if community placement has been deemed appropriate by state treatment

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TABLE 1

Diagnoses Included Under the Category of Severe Mental Illness (SMI)

- Schizophrenia
- Schizoaffective Disorder
- Psychotic Disorder, NOS
- Delusional Disorder
- Major Depression with Psychotic Features
- Bipolar Disorder
- Treatment Refractory Depression

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professionals and the individual wishes to live in the community (Williams, 2000). Over 40% of older adults with SMI in nursing homes who do not have advanced dementia are appropriate for a home and community-based living setting according to consumers and their clinicians (Bartels, Miles, et al., 2003).

Most older adults with SMI reside in the community with support from social networks (Meeks & Murrell, 1997). In order to maintain community tenure, older adults with SMI typically require services from both mental health and aging long-term care systems (Moak, 1996, Robinson, 1990). Older adults with SMI are faced with navigating a fragmented system of care that includes services from primary care, long-term care, home health, public health, mental health agencies, specialty mental health providers, and aging network services. The lack of coordination between providers is particularly problematic. For example, mental health agencies frequently under-serve older adults, are ill-prepared to address cognitive or medical impairments, and are often unable to provide services to individuals with cognitive impairment (George, 1992, Light, et al., 1986). On the other hand, community-based support programs such as geriatric social services are likely to focus on individuals with chronic physical disabilities and may disregard mental health functioning (Robinson, 1990). Primary care physicians provide the most mental health care to older adults, often in the form of brief office visits and pharmacological treatment (George, 1992). For a variety of reasons, primary care physicians are often limited in their ability to detect and appropriately treat mental illness and have limited access to the specialty mental health services often required by individuals with SMI (Bartels, Horn, et al., 1997, Burns & Taube, 1990, Goldstein, 1994,

Goldstrom, et al., 1987). Home health agencies often provide few mental health services and are restricted by reimbursement mechanisms that only allow for episodes of short-term care (Bartels & Colenda, 1998). Assisted living facilities serve an increasing number of mentally ill older adults and are an important provider of long-term care services. Although early findings suggested inadequate mental health and medical services in residential care facilities (Gottesman, et al., 1991), recent findings suggest that individuals with schizophrenia residing in assisted living facilities were more likely to receive outpatient mental health services than those residing independently or who were homeless (Gilmer, et al., 2003).

Older adults with SMI are high utilizers of health care services (Bartels, et al., 2003, Cuffel, et al., 1996, Semke & Jensen, 1997), have high health care expenditures (Bartels, Clark, et al., 2003), and require comprehensive coordinated care from multidisciplinary providers (Moak, 1996). Components of appropriate care include specialized geropsychiatric services; integrated medical care; home and community-based long-term care; psychosocial rehabilitation services; and residential and family support services.

Understanding SMI and the Special Needs of Schizophrenia in Older Adults

Schizophrenia is a severe mental illness that is heterogeneous and characterized by a wide variation in the type and severity of symptoms across different individuals. It is diagnosed based on the presence of a minimum number of symptoms from a broad constellation of positive, negative, and affective symptomatology, and involves impairment in one or more major areas of functioning. Positive symptoms consist of the primary active symptoms of psychosis, the most common among them being delusions and hallucinations. Other symptoms that are considered in this category include thought disorder and bizarre behavior. Negative

symptoms consist of deficit symptoms and are characterized by lack of spontaneous or active behaviors, emotions or thoughts. Common negative symptoms include blunted or flattened affect, poverty of speech (alogia), social withdrawal (asociality), lack of interest in activity (apathy), and impaired attention. In addition to positive and negative symptoms, affective symptoms, depression in particular, are common in schizophrenia. As many as 60% of adults with schizophrenia suffer a major depression during the course of their illness and individuals are at particularly high risk for co-occurring depression in old age (Cohen, et al., 1996). In terms of functional impairment, most individuals with schizophrenia at some time experience problems initiating and maintaining meaningful interpersonal relationships, fulfilling major roles in society, and engaging in basic self-care or community living skills such as accessing medical care and maintaining adequate housing.

Longitudinal research on schizophrenia indicates considerable variation in long-term outcome. For most individuals, the illness is episodic, with some residual impairment between exacerbations. Many experience a trend toward gradual improvement over the years, and in some instances even total remission. However, a substantial minority of individuals with schizophrenia has enduring symptoms that require ongoing clinical care.

As models of care emphasizing community treatment have replaced traditional institutional care models, interventions focused on maintaining community tenure and normalizing life functioning have been developed. For younger people, this has included innovations in vocational rehabilitation, treatment of co-morbid substance abuse, and the development of assertive case management teams. Development of service models tailored for older adults with schizophrenia has lagged behind development of interventions for younger people with the illness. However, some progress is being made and early

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outcomes data exist on three promising psychosocial models designed for older individuals with schizophrenia.

The Biopsychosocial Model of Integrated Treatment

People with schizophrenia face several unique challenges as they age, which should be considered in the context of a comprehensive biopsychosocial treatment model. The aging process exacerbates several of the problems that represent major treatment targets for younger people with schizophrenia. First, older people are especially sensitive to the adverse side effects of medications, which requires more careful attention to choosing the appropriate type and dosage of medication. Second, the challenge of accessing health care, which is needed to an increasingly greater extent as people age, is greater for older adults. Third, as people age they lose many of the natural supports on which they have relied to assist with illness management and relapse prevention. Fourth, people with schizophrenia also begin to lose their social networks and have difficulty negotiating changes in social relationships as

they age. Finally, as older individuals develop physical problems, their need for assistance with self-care and residential support intensifies.

Medical Illness Management

Co-morbid medical illness is one of the major characteristics distinguishing the older person with schizophrenia from younger individuals with the illness. Serious health problems are common in schizophrenia and are often undiagnosed and under treated (Cohen, 1993). Common medical conditions affecting older people with schizophrenia include hypertension, heart disease, arthritis, diabetes, chronic lung disease, anemia, gastrointestinal disease, and neurological disorders such as stroke, movement disorders and seizure disorders.

For several reasons, people with schizophrenia are more likely to have difficulty obtaining medical services and are more likely to receive poor care (Druss, et al., 2000, Levinson Miller, et al., 2003). One such reason is that older people with schizophrenia often have difficulty communicating their medical concerns. Another reason is that psychiatric symptoms may interfere with receipt of medical treatment. For example, severe social withdrawal, negativism, and paranoia can make it difficult for medical providers to conduct appropriate physical examinations, medical tests, clinical procedures, and necessary treatments. Finally, in some instances, medical doctors prescribe different treatments for their patients with schizophrenia, perhaps assuming that they will not adhere to complicated regimens that require diligence and follow-up.

Assessment of physical health and adequacy of health care services are critical elements in the evaluation of the older person with schizophrenia. Medical disorders sometimes may cause or exacerbate

psychiatric conditions. For example, thyroid hormone deficiency may cause symptoms of depression. Likewise, worsening of psychiatric symptoms may lead to deterioration in physical health. For example, an acute psychotic episode in an individual with diabetes may result in failure to monitor glucose levels or adhere to dietary restrictions. Optimal treatment of the older person with schizophrenia therefore includes assistance from a medical professional who is involved in care in a regular, routine manner. For example, a nurse on a mental health treatment team is in an ideal position to encourage receipt of necessary preventive tests and services, to assist with monitoring of chronic health problems, to intervene when acute physical symptoms arise, and to teach skills for basic health management.

Development of Supports in the Natural Environment to Reduce Environmental Stress

Young adults with schizophrenia who have supportive parents and other family members substantially reduce their risk of relapse and rehospitalization. People with schizophrenia are less likely to marry or to have children, so the aging and eventual death of parents who serve as key supports places older individuals at risk for decompensation and inability to live independently in the community. In fact, one of the major differences between older adults with schizophrenia residing in the community and those living in nursing homes and other institutions is the presence of family and social supports (Meeks, et al., 1990). Although some older people with schizophrenia maintain regular contact with family members such as siblings or nieces and nephews, these relationships often do not serve as substitutes for supportive relationships with parents.

Broad implications for the loss of natural supports are that basic living needs may not be met; identification of early warning signs of relapse may not occur; and social affiliative needs

T A B L E   2
Care Needs of Older Adults with SMI
Shrinking Social Support Network
Social Skill Deficits
Need for Residential Support
Comorbid Medical Illness
Coordinated Services
Assistance with Self-care Skills

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may not be met. These are compounded by the difficulty that older people with schizophrenia have negotiating changes in social relationships toward an increased need for assistance. Assertive community treatment therefore is a critical component of care for older adults who have lost natural sources of support and are at risk of institutionalization owing to difficulty with illness self-management and various

communicating effectively, engaging in social activities, and asking for help (Bartels, Mueser, et al., 1997). As individuals age, there is a natural tendency for social networks to shrink. Poor social skills can make creating and maintaining a healthy social network particularly difficult for the older individual with schizophrenia. Helping aging individuals with schizophrenia improve skills for dealing with social situations can expand their social networks, improve their overall quality of life, and may even reduce their risk of nursing home placement (Meeks, et al., 1990).

Social skills training (SST) is an approach to psychiatric rehabilitation

training and cognitive behavioral treatment for older adults with schizophrenia (McQuaid, et al., 2000); and a combined skills training and health management intervention for community-dwelling older adults with schizophrenia and other severe mental illnesses (Bartels, et al., 2004). Each represents a manualized intervention with prospective outcome data reported in controlled pilot studies.

Integrated Care Management and Skills Training for Older Adults with SMI

A randomized, controlled study of a rehabilitative intervention that integrates health care management, mental health services, and skills training for older adults with SMI (HOPES or Helping Older People Experience Success) is currently underway (Pratt, et al., 2003). The health care management component consists of a model of care management for preventive health care and ongoing health care needs. For example, the health care manager ensures that preventive health care targets are met including routine physical examinations, blood pressure checks, cancer screening, and vaccinations. In addition, common health care conditions such as diabetes, hypertension, congestive heart failure, and other disorders are monitored for routine health care. The skill areas covered in the HOPES skills

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TABLE 3

Social Skills Training

Action	Systematically teach interpersonal skills
Aim	1. Achieve personal goals 2. Function effectively in community settings
Examples of Targeted Social Skills	1. Expression of feelings 2. Making and keeping friends 3. Basic conversational skills 4. Asking for assistance 5. Interacting with health professionals

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aspects of community functioning that were formerly attended to by supportive significant others. The need to bolster family capacity and social supports is an important consideration in service planning for older individuals.

Development of Social Skills and Social Networks to Improve Coping Ability

Many individuals with schizophrenia, young and old, experience profound difficulties in their social relationships and ability to interact with other people. Older adults with schizophrenia residing in the community have greater social skill deficits compared to older persons with other, less severe, psychiatric disorders, including greater impairments in accepting and initiating contact,

that involves systematically teaching interpersonal skills to enable individuals to achieve personal goals and to function effectively in community settings (see Table 3). Targeted social skills span a wide range of adaptive interpersonal behaviors including the expression of feelings, skills for making and keeping friends, and basic communication skills. Three promising SST interventions for older adults with schizophrenia have recently been developed and systematically evaluated. These include a SST program for middle-aged and older adults with chronic psychotic disorders (Patterson, et al., 2003); a combined skills

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TABLE 4

HOPES Skills Training Curriculum

1. Making and keeping friends

2. Making a visit to the doctor

3. Communicating effectively

4. Making the most of leisure time

5. Managing medications

6. Living independently in the community

7. Healthy living

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training curriculum are shown in Table 4. Choice of these skill areas is consistent with results of a recent survey of older adults with schizophrenia in which at least half of respondents identified improving physical health, communicating more effectively, and having more friends as high priorities (Auslander & Jeste, 2002).

Development of Self-Care Skills and Residential Support to Improve Community Tenure

Older individuals with schizophrenia are more likely than younger individuals to have deficient self-care skills, placing them at greater risk for institutional placement. Many very old individuals who were institutionalized as young adults may not have developed important community living skills. Younger individuals (in their 60s) who were among the first wave of patients that became ill when states were closing their long-term wards, may have developed some ability to reside independently in the community. However, when parents of individuals with schizophrenia die, their middle-aged children must not only cope with the emotional impact and loss of a primary source of social contact and support, but must also quickly adjust to a dramatic reduction in financial and instrumental support and potentially loss of residence. Unlike aging individuals with Alzheimer's disease, who often have adult children who act as direct caregivers, many individuals

with lifelong schizophrenia have never had children or have long become alienated from extended family, leaving them without this care-provider resource. Continued community tenure therefore requires a combination of remedial skills training to address deficient community living skills, comprehensive community support services, and consideration of communal living placements that offer varied levels of support and assistance with basic self-care and instrumental activities of daily living.

Geriatric Care Management and Coordinating Services for Older Adults with SMI

Professional geriatric care managers who are familiar with mental health, aging network, primary care, and residential care for older adults can perform the important task of tying together a diverse group of

> *Older individuals with schizophrenia are more likely than younger individuals to have deficient self-care skills, placing them at greater risk for institutional placement. Many very old individuals who were institutionalized as young adults may not have developed important community living skills.*

providers, settings, and services into a coherent and coordinated plan of treatment for the older adult with SMI. Part of this responsibility includes adapting services to meet the specific needs of older persons with SMI.

Several innovative programs provide mental health services to older adults with SMI in home and community-based settings (Knight, et al., 1995, Kozlak & Thobaben, 1994, Lipsman, 1996). In addition, a variety of other programs have been reported

to effectively address the needs of older adults with SMI, including intensive case management models (Blackmon, 1990); community support programs (CSP) (Schaftt & Randolph, 1994); home and community-based outreach (Raschko, 1991, Stolee, et al., 1996); outreach teams to residential care facilities and nursing homes (Seidel, et al., 1992); and specialty teams and units in nursing homes (Sloane, et al., 1991) and psychiatric hospitals (Kunik, et al., 1996). In addition, there are several care management models for individuals with prior institutionalization or who are at risk of institutionalization (Bernstein & Hensley, 1993, Fisher, et al., 1991). These care management models include a variety of supported residential options with patients receiving care from multidisciplinary mobile service teams at their residence; case management and day treatment; as well as education and support for caregivers. Evaluations of these programs suggest possible benefits in terms of improved patient and family satisfaction, as well as the potential for these programs to replace the functions of state hospitals if provided with adequate funding and coordination. Clinical improvement has also occurred among older adults with SMI who have been discharged into the community from long-stay hospitals (Trieman, et al., 1996). The Veteran's Administration health care system has also developed a model for providing long-term mental health community care, consultation, and outreach to older adults (Van Stone & Goldstein, 1993).

Multiple interventions that almost always involve different providers, disciplines, and systems of care are required to address the various care needs of older individuals with schizophrenia. PGCMs who are familiar with the needs and services of

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older adults with SMI can provide the necessary coordination of care that can bridge different care components from a complex array of providers. The PGCM can serve as a point person to facilitate coordination and communication among other service providers. As many state service delivery systems move toward privatization and fragmentation of mental health care, the need for a single individual to assist older individuals with the organization and coordination of care providers is essential.

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Adapting the Concept of a "WrapAround" Model of Care to Serve Older Adults with Mental Illness

Keith M. Miles, MPA; Bernie Seifert, LICSW; Jeanne Duford, MSW

Background

The concept of "WrapAround" gained recognition in the late 1980s and early 1990s in the area of children's services (VanDenBerg, 1999). This approach was designed to address the problem of a fragmented service system consisting of multiple agencies separately serving children with serious emotional disturbance by developing "Teams" of community and agency service providers who met regularly to address individual consumer's needs in an integrated fashion. In the mid-1990's many states began adopting the WrapAround approach as an integral part of a overall "System of Care" (1999). The WrapAround process is ideally suited for use by professional geriatric care managers (PGCMs), who in their customary role, act in a facilitating capacity to coordinate services to meet the needs of their older adult clients. It is particularly important in serving older adults with mental illnesses (MI) due to the complex service needs and medical co-morbidity associated with these disorders and the need to involve multiple agencies.

In simplified form, the WrapAround model involves coordinating providers and services to collaboratively meet the needs of older adults with mental health problems. Agencies and providers who are involved with serving the multiple needs of the older adult population with mental illness are initially identified. Representatives from these agencies are invited to form a community WrapAround Team that meets regularly. The team establishes criteria and referral procedures for identifying individuals to be served, sets procedures for reviewing individuals' needs and developing service plans, meets with individuals

> **The significance of the Elder WrapAround concept for geriatric care managers and the population of older adults with mental illness lies in the intense service needs of this population, the inadequate way in which they are currently served, and the key role of the PGCM in coordinating a variety of important health and social services.**

and family members to address needs, collaboratively applies appropriate agency resources to serve their consumers, and continually monitors the status of those served. Throughout this process, the Team notes, discusses, and addresses system barriers that are identified through the consideration of individual circumstances and needs.

Significance of the WrapAround Process for Professional Geriatric Care Managers and Older Adults with Mental Illness

Population Vulnerability

The significance of the Elder WrapAround concept for geriatric care managers and the population of older adults with mental illness lies in the intense service needs of this population, the inadequate way in which they are currently served, and the key role of the PGCM in coordinating a variety of important health and social services. Older adults with mental illness represent a population whose vulnerability is well known, and whose needs are more complicated due to the multiple problems they face. These problems are similar to those faced by adults and children with MI, including symptom management challenges, housing issues, and residential placement risks due to their impairment and dependency. However, in the case of older adults with mental illness, these challenges are often faced without the presence of a caregiver or advocate, as many are without spouses or do not live with children. Often their lack of physical mobility or transport leads to isolation, perhaps exacerbating depressive disorders known to be prevalent among this population. Poor health practices, problem behaviors, and difficulty with treatment adherence further contribute to poor health outcomes and the need for active coordination of medical and psychiatric services (Bartels, et al., 1999, Holmberg & Kane, 1999, Moak, 1996, Vieweg, et al., 1995). Service coordination is particularly problematic for

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older adults who may be unaccustomed or unequipped to navigate complex service systems with multiple eligibility requirements. Finally, older adults must deal with the usual decline of functioning and increase in medical needs associated with aging, which are both greater and more complicated due to the documented co-morbidity of mental and physical illnesses within this group (Sheline, 1990).

System Fragmentation

The vulnerability of older adults due to their complex and multiple needs is coupled with a service system that has evolved to meet older mental health consumers' needs in a fragmented fashion. Housing agencies operate senior residences, medical clinics address medical needs, mental health clinics address mental disorders, home health agencies address home-based medical care, and senior centers serve their nutrition and recreational needs as best they can. Meals-on-Wheels, Senior Transport systems, volunteer organizations, and others fill in the gaps.

Older persons with psychiatric illnesses are also affected by fragmented provision of medical health care. Most older adults who receive

> *The vulnerability of older adults due to their complex and multiple needs is coupled with a service system that has evolved to meet older mental health consumers' needs in a fragmented fashion.*

mental health services are treated within the primary care system, often described as the "de facto" mental health service system for older persons (Gray, et al., 2000). Older adults may seek mental health care from primary care providers (PCPs) due to both the stigma associated with receiving specialty mental health services and the convenience of receiving mental health care from their medical provider (USDHHS, 1999). However, most PCPs have limited training in mental health care and have limited time for addressing the multitude of health problems faced by older adults. These factors limit the PCP's capacity to deliver adequate mental health services and have contributed to high rates of under-diagnosis and under-treatment of mental health problems within primary care settings (Higgins, 1994, Kaplan, et al., 1999). Moreover, physical illnesses are often undetected or inappropriately treated in individuals receiving specialty psychiatric care (Koranyi, 1979). Older adults with mental disorders are also less likely to receive needed health care interventions (Druss, et al., 2001) and are more likely to receive inappropriate medications than individuals without mental illness (Bartels, et al., 1997, Bartels, 2002).

Geriatric care managers are familiar with this fragmented system and attempt to meld it into a coherent whole for consumers who may be among those least proficient at accessing the "system". **Yet, the complex needs of older adults with mental illness, and the multiple home and community-based service providers serving those needs, demonstrate the potential for geriatric care managers to utilize the WrapAround Process as a strategy to integrate services for the older population with mental illness.** Indeed, the argument can be made that the coordination of agency services is even more important from a safety perspective for older adults with mental illness, given the isolation and vulnerability of this group, and the desire to maintain community tenure and reduce reliance on institutional alternatives.

The WrapAround Process for Older Adults – Principles and Practice

The WrapAround concept is based upon principles and practices that can be equally well applied by PGCMs to older adults with mental illnesses. These guiding principles, developed by Stroul and Friedman, are summarized in Table 1 (Stroul & Friedman, 1986). We have substituted "Older adults with mental illness" for "Children with emotional disturbances" (as italicized) to highlight the applicability of the principles to older adults.

The WrapAround Process also includes ten practices deemed necessary for successful implementation to effect system change (Goldman, 1999). These are summarized in Table 2.

Evidence of the Effectiveness of the WrapAround Process

The effectiveness of the WrapAround model is well-documented, particularly for children, but also for older adults. Burns, et al (1999) reviewed fourteen published studies of children's WrapAround projects in nine states that contained

TABLE 1

Guiding Principles of the WrapAround Process for Older Adults

1. *Older adults with mental illness* should have access to a comprehensive array of services which address their physical, emotional, social, and educational needs

2. *Older adults with mental illness* should receive individualized services

3. *Older adults with mental illness* should receive services within the least restrictive, most normative environment that is clinically appropriate

4. Families and caregivers of *older adults with mental illness* should be full participants in the planning and delivery of services

5. *Older adults with mental illness* should receive services that are integrated, coordinated and linked among agencies

6. *Older adults with mental illness* should be provided with case management to insure coordination and continuity congruent with changing needs

7. Early identification and intervention with *older adults with mental illness* should be promoted

8. *Older adults with mental illness* should be assured a smooth transition among levels of care as needs change

9. The rights of *older adults with mental illness* should be protected and advocacy efforts promoted

10. *Older adults with mental illness* should receive services that are sensitive to cultural differences and special needs

TABLE 2

Ten Practices for Successful Implementation

1. A community collaborative structure (Multiple agencies contributing members to a WrapAround Team, which meets regularly.)

2. An administrative management organization (to assume responsibility for coordination and limited funding.)

3. A referral mechanism (to identify and refer individuals whose multiple and complex needs warrant consideration by the Team.)

4. A Resource Coordinator (the PGCM) to facilitate the process and provide focus for the Team.

5. A strengths and needs assessment (to form the basis of a service and treatment plan.)

6. Consumer and family involvement (with other caregivers included as appropriate.)

7. An interactive team process and formation of a partnership to develop an individualized plan.

8. Development of a crisis/safety plan (to address emergencies.)

9. Measurable outcomes monitored on a regular basis.

10. A review of plans by the community collaborative structure (with regular updates and follow-ups.)

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evaluation components and met the core requirements for the WrapAround process. All studies described improvement in at least one area, including increased behavioral, community, home, and school adjustment, decreased negative behaviors, decreased restrictiveness of living environments, and fewer behavioral problems (Burns, et al., 1999). Evaluation studies have shown that the WrapAround model has the potential to reduce institutional care and costs, to stabilize living situations in the community, and to offer other benefits in the realms of behavioral, family, and school adjustment (Goldman & Faw, 1999).

A related literature suggests that a home and community-based model of wraparound long-term care for older adults is effective as well. The PACE (Program of All-inclusive Care for the Elderly) Model of integrated care, individualized service plans, and pooled funding has reduced hospitalization of clients, length of stay, and nursing home use (Kunz & Shannon, 1996). The Southwestern Ontario Regional Geriatric Program's Model Project has also shown positive effects on provider assessment practices and confidence in addressing the needs of older adults (Harris, et al., 1999). In New Hampshire, the Riverbend Community Mental Health Center's (CMHC) experience with its Elder WrapAround Program has shown equally positive results, with reduced client hospital admissions and reduced average length of hospital stays (Duford, 1999). Riverbend has received awards for the Program's success as a Special Program for Older Adults by the National Council of Community Behavioral Health Care, as well as having been identified as a Promising Practice by the National Council on Aging.

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The New Hampshire Elder WrapAround Model and Experience

In New Hampshire, the regional Elder Mental Health Service Coordinators recognized the special needs of the older adult population with MI and the limitations of the existing service system to serve these needs. The New Hampshire experience with the WrapAround Process for older adults was modeled after the Riverbend CMHC's award-winning WrapAround Program for older adults. It's stated objective is: **"The coordination of efforts across systems, to provide a cost-effective way to increase service capacity and improve community access to services for older adults with mental illness. This includes collaboration among agencies, community and consumer education, flexible funding, and individualized treatment, with priority given to continuity of care and seamless service delivery."** This program now numbers 52 participating agencies, with representatives from 12 core agencies meeting regularly to discuss agency policies and practices, funding collaboration, service coordination, as well as the needs of specific clients and their families. This concept is being replicated in four other mental health regions in New Hampshire and is being evaluated by the New Hampshire-Dartmouth Psychiatric Research Center.

Recommendations and Lessons Learned in the New Hampshire WrapAround Project

Evaluation of the New Hampshire implementation process has identified several important lessons which may assist geriatric care managers in implementing a WrapAround program for older adults with mental illness.

1. **Team Membership:** *Key team members usually include aging and home care workers, other service providers who work with older adults, and particularly medical and mental health staff. Children, spouses, and friends may be included in Team meetings when addressing specific clients.*

2. **Complications:** *In older adults with mental illness, medical complications and mental health symptoms are almost always present, and act as stressors. Teams and PGCMs should detect and address these stressors and involve medical and mental health professionals in the process.*

3. **Cognition:** *Because cognitive impairment associated with dementia or psychiatric symptoms can impair the ability of an older adult with mental illness to provide "informed consent", guardianship status*

> **"The coordination of efforts across systems, to provide a cost-effective way to increase service capacity and improve community access to services for older adults with mental illness. This includes collaboration among agencies, community and consumer education, flexible funding, and individualized treatment, with priority given to continuity of care and seamless service delivery."**

and power of attorney assignments should be considered as needed.

4. **Special Needs:** *Problems with transportation and mobility are common issues with elders, as well as the need for medical equipment, personal care, and crisis intervention in mental health emergencies.*

5. **Substance Abuse:** *Medication misuse, and alcohol or non-prescription drug abuse are the most prevalent substance abuse issues for the elderly. Interactions among prescriptions for medical and mental disorders are also common and should be carefully assessed.*

6. **Safety:** *With elders with mental illness, threats to personal safety in the home are related to impaired self-care skills, self-neglect, and dementia or symptom-related injuries.*

7. **Use the Experience of Others:** *It is recommended that Teams draw on the experience of those who have implemented WrapAround Teams for older clients with mental illness. Specialized needs include psychiatric symptom recognition and management, emergency intervention, medication adherence, and community-based supports. A systematic approach to evaluating and addressing these needs is important and can aid in establishing criteria for accepting referrals, engaging mental health and medical participants, and serving clients with impaired cognitive functioning and problem behaviors.*

8. **Educate:** *Do not assume that administrators or agency participants already know about the principles of WrapAround as*

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related to the particular needs of older adults with mental illness. Educate all participants early and often about the vulnerabilities and needs of this group.

9. **Identify Existing Resources:** *One region drew upon its history of collaborative agency relationships, which made it easier to begin meeting on elder mental health issues. Those with a vested interest in dealing with older mentally ill clients such as nursing homes, visiting nurses, area agencies on aging, and geriatric mental health clinicians and psychiatrists*

TABLE 3
Potential Stakeholder Agencies

- Legal Services
- Consumers/Family Members/Caregivers
- Elderly & Adult Services
- Advocates
- Senior Centers
- Housing
- Public Health
- Law Enforcement
- Primary Care Providers
- Home Care Services
- Hospitals
- Visiting Nurses
- Nursing Facilities
- Substance Abuse Services
- Mental Health Clinics
- Nutritional Services
- Developmental Services
- Adult Day Care Services
- Welfare and Assistance

should be specifically included. Resources should be identified that address the mental health and co-morbid medical issues common to this population.

10. **Committed Leadership is Essential:** *One of the keys to a successful WrapAround program is the presence of a committed coordinator to provide initiative, coherence, and practical planning for the Team – an ideal role for the PGCM. Those regions and teams that had this leadership experienced fast progress, good participation, and quick resolution of problems.*

11. **A Core Team of Participants is Necessary and Evolves:** *Although the mental health focus requires participation of mental health clinics and clinicians, as well as emergency and hospital providers, a broad list of potential stakeholder agencies should be invited to the early meetings (see Table 3). From this larger group, a "core" group of agencies naturally emerges over time, and membership evolves, as some persons or agencies may find that they are not needed while others may later be called upon to meet the special needs of individual clients.*

12. **Clients and their Needs Define Team Participation:** *While the Core team consists of those agencies most directly involved with older adults with mental illness, it is necessary to identify for each individual client which agencies should be invited to address the complex and varied needs of this population.*

Summary

The Elder WrapAround model has significant potential as a means for geriatric care managers to coordinate services for their older adult clients with mental illness. The role of the PGCM can be crucial in both initiating and organizing an Elder WrapAround Team and in referring older adult clients with mental illness to the Team. The impact of such Teams on the population of older adults with mental illness can be felt in two ways: directly through better outcomes for clients and families served by the Teams, and indirectly through improvements in the coordination and functioning of the service system caring for older adults with mental illness.

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Caring for Older Americans with Mental Illness: Geriatric Care Management and the Workforce Challenge

By Aricca D. Van Citters, B.A. and Stephen J. Bartels, M.D., M.S.

There are serious concerns shared by health care providers, consumers, and researchers that current health care services are inadequate to meet the mental health needs of older persons. Moreover, this shortage is expected to grow as the population of older Americans increases over the coming decades. One in four older adults has a significant mental disorder (26.3%) including 16.3% with a primary psychiatric illness, 3% with dementia complicated by significant psychiatric symptoms,

and 7% with uncomplicated dementia (Jeste, et al., 1999). By the year 2030, the number of older adults with major psychiatric illnesses will more than double from an estimated 7 to 15 million individuals (Jeste, et al., 1999). As shown in Figure 1, relative to the need for mental health services in older populations, there is a lack of formal health care training in mental health and aging. A shortage of geriatric health care providers, accompanied by high fragmentation among different provider groups and

service delivery settings (AoA, 2001), increases the complexity of the health care system and often limits the older adult's ability to independently navigate through their health care options.

This article presents information on the current and projected shortfall in the health care workforce in a variety of health care disciplines that serve older adults with mental illness; summarizes recommendations for improving the capacity of health care providers to meet the projected need; and identifies ways in which the geriatric care manager can ease the navigation burden imposed upon the older adult by both fragmentation of the health care system and the shortage of providers with geriatric expertise. The population of older adults with mental disorders and an inadequate workforce of health care providers with training in geriatrics presents a significant challenge for care management that will only increase in the coming decades. This dilemma challenges professional geriatric care managers to be especially creative in coordinating health care providers from many different sectors.

Current and Future Workforce Needs

The specialized needs of older adults with mental illness present unique challenges that are best addressed by providers with geriatric expertise. Providing appropriate and effective care to older persons with mental illness requires specialized knowledge and clinical skills that enable the practitioner to assess complex interactions between medical illness, psychiatric disorders, cognition, functioning, and the general processes of aging, as well as the cultural, social, ethnic, and environmental factors that impact quality of life in older age. The following section provides an overview of the geriatric health care provider workforce in five categories including psychiatrists, physicians, psychologists, nursing staff, and other allied health care professionals

FIGURE 1

Estimated Prevalence of Major Psychiatric Disorders by Age Group

None

○ 18-29   ● 30-44   □ 45-64   ■ 65>
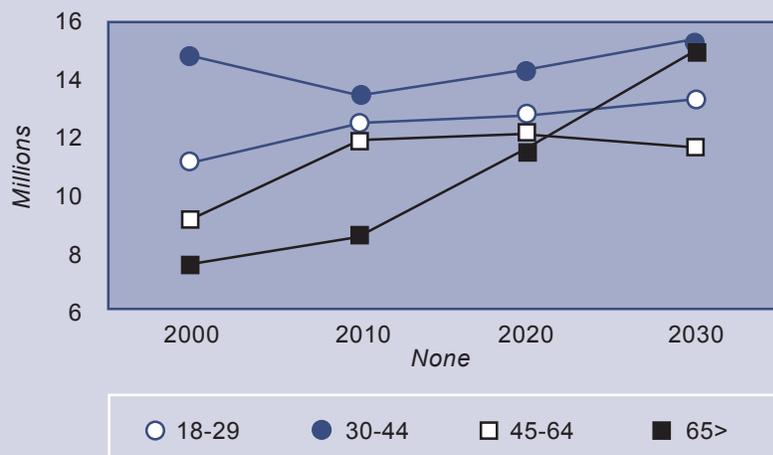
Source: Bartels SJ. "Improving the United States' system of care for older adults with mental illness: findings and recommendations for the President's New Freedom Commission on Mental Health". *American Journal of Geriatric Psychiatry.* 2003;11(5):486-497. Copyright 2003, the American Psychiatric Association; http://ajgp.psychiatryonline.org. Reprinted by permission.

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Geriatric Psychiatrists

Geriatric psychiatrists are physicians who have completed a residency training program following graduation from medical school, and have obtained additional expertise and qualifications in the field of geriatric psychiatry. Approximately 2,500 psychiatrists have received certificates for added qualifications in geriatric psychiatry (APA, 2002). This number of specialists dramatically falls short of the need. At the current rate of graduating approximately 80 new geriatric psychiatrists each year and an estimated 3% attrition due to retirement, there will be approximately 2,640 geriatric psychiatrists by the year 2030. While estimates vary, it has been suggested that there is a need for 4,000 to 5,000 geriatric psychiatrists who provide patient care (NIA, 1987), as well as 1,220 physician faculty members and 920 non-physician faculty members who provide training in geriatric psychiatry (Reuben, et al., 1993).

In addition to geriatric psychiatrists with specialized qualifications, general psychiatrists also provide treatment to older adults; 18.1% of general psychiatrists have at least 20% of their caseload devoted to patients age 65 and older, and only 23.0% have no older adults on their caseload (Colenda, et al., 1999). Despite these additional providers, the workforce of psychiatrists who provide treatment to older adults is inadequate to address the need. The majority of diagnostic and pharmacological treatment of psychiatric disorders in older adults is provided by primary care physicians.

Geriatric Physicians

Primary care physicians provide most treatment for mental health problems among older adults (George, et al., 1988). However, primary care physicians vary substantially with respect to training in psychiatry, and few have advanced training in geriatric medicine. Current figures suggest that there are 9,000 physicians with geriatric certification in the United States. However, this represents less than half of the current need. By 2030, the need for geriatric physicians is expected to increase to 36,000. Unless reforms are enacted, the shortfall of geriatricians may reach 25,000 doctors (AFAR, 2002). The current ratio of approximately 2.5 geriatricians to every 10,000 elderly patients is insufficient to meet basic health care needs (AFAR, 2002). Further contributing to a projected shortfall in geriatric physician providers, only six of the 144 US medical schools have geriatric medicine departments (Warshaw, et al., 2002) and the US has fewer than 600 medical school faculty (of 100,000 faculty members) with specialization in geriatrics (AFAR, 2002). In 1998-1999, more than 40% of medical schools reported that their curriculum in geriatric medicine was inadequate (AAMC, 2001).

In response to a recognized need for physicians with specialty training in geriatrics, medical schools have increased the number of specialty fellowship positions. Between 1996 and 2002, the number of geriatric training positions increased from 222 to 394 in family practice and internal medicine and from 82 to 137 in geriatric psychiatry. However, this increase has not been followed by a proportional increase in trainees. The proportion of filled positions has steadily declined over the last five to six years. In academic year 2001-2002, only 69% of geriatric medicine fellowship positions were filled, and only 61% of geriatric psychiatry fellowship positions were occupied. Despite a 67% increase in the number of available training positions in geriatric psychiatry, there has been virtually no overall change in the number of geriatric psychiatry fellows from 1996 (n=77) to 2001 (n=81) (Warshaw, et al., 2002).

Geriatric Psychologists

Only three percent of clinical psychologists in the American Psychological Association (APA) devote their practice to serving older adults. However, a majority (69%) of APA members provide some psychological services to older adults. Nearly 15,000 psychologists have an older adult on their caseload, which in aggregate equates to nearly 3,100 full-time equivalent (FTE) psychologists serving older adults (Honn Qualls, et

FIGURE 2

Supply and Demand for Geriatricians: 1990-2030

Source: *AFAR.* Medical Never-Never Land: Ten Reasons Why America Is Not Ready For the Coming Age Boom. *Washington, D.C.: Alliance for Aging Research; February 2002.*

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al., 2002). However, this falls short of the need for 5,000 to 7,500 FTE geriatric psychologists (Jeste, et al., 1999).

The inadequacy of training in geriatric mental health was recognized by this group of providers and most felt that additional geriatric training was desirable. Nineteen percent of APA members felt they needed more training in geriatrics before they could ethically provide services to older adults, 39% felt they needed training in some areas, and 32% believed that training was desirable, but not necessary to practice competently (Honn Qualls, et al., 2002). Members of the APA were most interested in educational programs that addressed geriatric depression and chronic mental illness within older adult populations (Honn Qualls, et al., 2002). However, opportunities for clinical training in working with older adults are limited. There are few formal programs that allow psychologists to acquire supervised clinical instruction and applied gerontological knowledge. Data from 1997 indicated the availability of only 13 postdoctoral fellowships and 65 pre-doctoral internships for receiving training in geriatric psychology (Hinrichsen, et al., 2000).

Nursing Staff

The demand for providers of nursing care is expected to experience substantial growth in the coming decades. However, recent enrollment in nursing education programs have declined, leading to high vacancy rates in existing positions. Even more striking is the lack of geriatric or psychiatric training among nursing providers.

The number of licensed registered nurses (RNs) increased only 5.4% between 1996 and 2000. However, between the years 2000 and 2020, the demand for RNs across all health care settings is expected to increase by nearly 31%. During the same period, licensed practical and vocational nurse (LP/VN) positions are expected to grow by 38.8% and certified nurses aids (CNAs) positions are expected to increase by 40.5% (Decker, et al., 2001).

Despite projections for increased need, enrollment in diploma, associate degree, baccalaureate, and master's programs has decreased by as much as 42% between 1996 and 2000 (Scanlon, 2001). This decline, along with other factors, has contributed to an abundance of vacant nursing positions. National rates of vacancies among nursing positions are highest for RNs (18.5%), LPNs (14.6%), and CNAs (11.9%). These rates translate into an estimated 16,100 vacant staff RN positions, 25,600 vacant LPN positions, and 66,900 vacant CNA positions (AHCA, 2002).

Increasing demand for nursing services and declining entrance into the nursing profession are accompanied by a lack of focus and training on geriatric care. Less than 1% of the 2.56 million registered nurses in the US are certified in geriatric care (AFAR, 2002). Moreover, in the ten year period between 1991 and 2001, only 4,200 nurses (of an estimated 70,000 to 80,000 advanced practice nurses) have been certified as advanced practice gerontological nurses (West, 2001). Training in mental health is also limited. Among the 4,000 members of the American Psychiatric Nurses Association, only 16%, or approximately 640 members, have a subspecialization in geriatrics (APNA, 2002).

Two initiatives have been promoted to assure geriatric proficiency among the general nursing workforce. These include preparing all newly licensed practicing nurses and registered nurses, as well as students graduating from nursing programs, with competency in geriatrics (Mezey & Fulmer, 2002). Other potential mechanisms for addressing the shortage in the nursing workforce include exploring recruitment and retainment efforts, improving the image of nursing, and supporting legislation aimed at rectifying the shortage (Janiszewski Goodin, 2003).
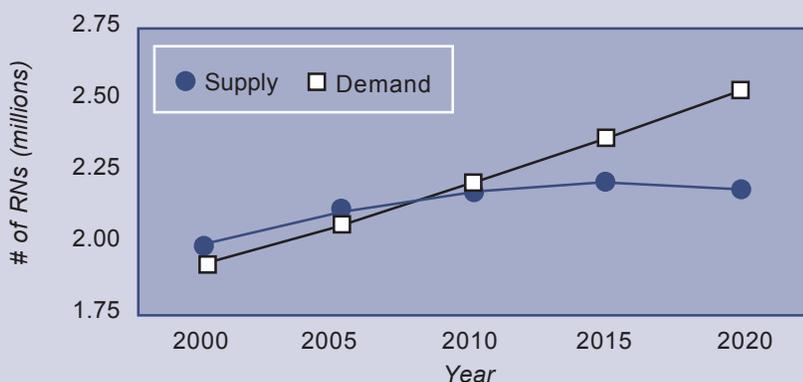
Other Health Care Providers

There is little recent data to guide estimates on the need for other health care professionals with geriatric clinical certification. However, available data suggests severe workforce shortages in many health care disciplines. Less than 0.3% of physical therapists are board

FIGURE 3

Supply and Demand for RN FTEs: 2000-2020

Source: *Decker FH, Dollard KJ, Kraditor KR. "Staffing of nursing services in nursing homes: present issues and prospects for the future".* Seniors Housing and Care Journal. *2001;9(1):3-26.*

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certified in geriatrics and less than 0.4% of pharmacists have geriatric certification (AFAR, 2002). There is also a need for a large number of social workers with geriatric competency. It has been suggested that 60,000 to 70,000 full time social workers will be needed by 2010 to serve the needs of older adults. Sixty-two percent of social workers who are affiliated with the National Association of Social Workers report that they require geriatric knowledge; however, less than 3% of students pursuing a master's degree in social work specialize in aging, and less than 2% of other social work students pursue graduate coursework in gerontology (Browne, et al., 2002, CSWE, 2001).

Addressing the Workforce Shortage

Workforce estimates from five major health care disciplines show large shortages in the number of health care providers with specialized training in the care of older adults. Even fewer health care providers have specialized training in late-life mental illness. Anticipating the growing demand for geriatric mental health services will require building an adequate infrastructure by training clinicians to provide the services that will be demanded by older consumers with mental health problems

(Abramson & Halpain, 2002, Halpain, et al., 1999, Jeste, et al., 1999). However, such efforts have been limited to small capacity training programs. Developing an initiative to address the projected shortfall in trained providers constitutes a major health policy priority.

Strategies to address the current and future shortfall in providers who are trained in geriatrics and mental health include: 1) evaluating future workforce needs for health care providers in geriatric psychiatry and in allied health professions and identifying factors to improve recruitment into geriatric specialty training programs; 2) exploring incentive programs, including loan repayment programs and increased authorization of graduate medical education (GME) payments; 3) expanding required training in geriatrics to long-term care nurses, certified nursing assistants, and other allied professionals in addressing psychiatric disorders and behavioral symptoms of dementia; and 4) developing approaches to increasing the number of providers with geriatric mental health training including early educational awareness of geriatrics as a potential health care career path; development of multidisciplinary training environments for aging and mental health; increasing provider competencies through information-technology mechanisms; and increasing the proportion of educational programs with training in the identification, assessment, and management of late-life mental disorders (Bartels, 2003).

The Mission for Geriatric Care Managers: Addressing Mental Disorders of Aging in the Community—Stone Soup

Despite national efforts to increase the number of geriatric providers, the shortage of geriatric specialists with expertise in mental health will continue. The challenge is not unlike the fable of the resourceful French soldiers who created a large kettle of soup with enough to feed an entire town by soliciting small contributions from multiple sources under the pretence of adding flavor to a "soup" that began with stones and water. The shortfall in health care providers with advanced expertise in mental health and aging will inevitably continue, despite modest improvements produced by health policy initiatives addressing the public health need (Bartels, 2003). The challenge for the PGCM is to assemble a team of appropriate providers who will be able to provide a network of community services and supports uniquely tailored to the specialized needs of the older adult with psychiatric illness.

The geriatric care manager must develop innovative strategies to best serve older adults using available resources. Two prominent service models are well suited to utilizing native resources, including multidisciplinary treatment teams and outreach to older adults in their homes and communities. The following programs provide examples of these models. The PATCH program (Psychogeriatric Assessment and Treatment in City Housing) trains "gatekeepers", or non-traditional referral sources, in congregate public housing to identify older adults who need mental health or substance abuse treatment. Following identification, the older adult is referred to a psychiatric nurse who visits and assesses the older adult within their apartment, and provides brief on-site treatment in consultation with a physician or, when necessary, refers the individual for more intensive treatment (Rabins, et al., 2000). The model of Wrap Around Services for Older Adults offers the most adaptable approach for geriatric care managers. This model is built around three core values: (1) services

TABLE 1

Existing Resources to Coordinate in Caring for Older Adults with Mental Illness

Formal Resources

- Area Agencies on Aging
- Mental Health Centers
- Nursing Homes
- Visiting Nurse Associations
- Home Health Agencies
- Residential Care Facilities
- Health and Primary Care Clinics

Potential Informal Resources

- Family Caregivers
- Senior Centers
- Family Members (spouse, partner, children)
- Friends
- Spiritual Leaders
- Other Social Support Networks

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must be client-centered, family-focused, and individually tailored; (2) when possible, services should be community-based and provided in the least restrictive setting using natural supports, as opposed to institutional care; and (3) services should be providing in a context of cultural competence (Stroul & Friedman, 1986). Wraparound teams are designed to foster collaborative care between consumers and a variety of service agencies. Agencies addressing issues of housing, mental health, home health, medical needs, and recreational needs should be involved in serving older adults with serious mental illnesses and efforts to diminish service fragmentation and to improve communication among these agencies is necessary. Finally, input from stakeholders such as the older adult's mature children, spouses/partners, friends, counselors, medical staff, and home care workers can offer valuable insight into providing appropriate health care to older persons with mental illness. (See Table 1 for a list of potential resources to call upon in providing comprehensive care.)

Older adults with mental illness have complicated service needs, and are often dependent upon multiple agencies to meet these needs. Current systems of care are ill-equipped to provide or coordinate the necessary array of services to accommodate projected future service needs (Bartels, et al., 1998) outside of intensive, institution-based care settings. As such, there is an urgent need for geriatric care managers to use existing resources to provide the highest level of care possible for older adults with severe mental illness. The programs described above offer potential methods of action for geriatric care managers to both identify and refer older adults to mental health service providers or to coordinate a health care and support team with access to a team leader or consultant with geriatric expertise.

Conclusion

The impact of the national workforce shortage is felt by every older American who cannot access or has delayed access to a health care provider. It is felt by every older American who is treated by a physician who does not understand the different metabolic, social, and psychological changes between the middle-aged adult and the older adult. Moreover, it is felt by members of the health care community who strive to care for the older person under increasing workload pressures. However, the workforce shortage presents geriatric care managers with an opportunity to address appropriate care of older adults. As fragmentation across health care disciplines increases, geriatric care managers play an increasingly important role in coordinating the delivery of health care. The core actions of care managers including systematic assessment, planning, service coordination or referral, and monitoring are essential for meeting the multiple service needs of older adults, especially those with mental illness. Geriatric care managers will be increasingly challenged to coordinate appropriately trained teams to provide health care services to their clients. In a workforce that has few providers with geriatric training, care managers will need to be ever resourceful in assembling teams of providers that meets their clients' needs for appropriate care. In establishing the health care team, it will be important to identify at least one person with geriatric experience to help promote effective service models and interventions (Kovner, et al., 2002). Geriatric care managers are in a special position that allows them to decrease the negative impact of fragmented service delivery by coordinating a multidisciplinary team of providers, with access to geriatric expertise.

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Founded in 1978, the AAGP provides psychiatrists with a special interest in mental health care for the elderly exceptional professional benefits through educational, informational, and interactive programs for its members. The membership committee will review this application and present it to the Executive Committee, which meets bi-monthly.

MEMBERSHIP CRITERIA

A physician who is currently a psychiatry resident may apply as a Member-in-Training.

1. The applicant must have completed a residency in psychiatry approved by the AMA, ACGME or be certified in psychiatry by the American Board of Psychiatry and Neurology.

2. The applicant must have been or must be actively in the practice of geriatric psychiatry.

3. The applicant must have a major professional interest in the mental health care of the elderly, or devote substantial professional time in connection with the public mental health care delivery systems for the elderly.

4. Annual dues: $195 General, $65 Member-in-Training.

Please include payment and send to AAGP, PO Box 85080, Richmond, VA 23285-4133

Accepted: ☐ Checks or ☐ Credit Card _____ exp. date _____

GENERAL INFORMATION

Full Name _____ **Degree(s)** _____

Preferred Mailing Address *(Check Appropriate Category: Business or Home)*

Phone _____ Fax _____ Email _____

Second Address *(Check Appropriate Category: Business or Home)*

Phone _____ Fax _____

EDUCATION

My American Board of Psychiatry and Neurology certification in psychiatry is: # _____ date _____

My added qualifications in Geriatric Psychiatry certificate is: # _____ date _____

My medical degree was received at _____ date _____

My medical license number is: # _____ date _____

My residency training in psychiatry was received at _____ date _____

My Geriatric Psychiatry Fellowship was received at _____ date _____

Have you ever had your medical license revoked in any jurisdiction: ☐ Yes ☐ No

If yes, where? _____ *Please explain* _____

PROFESSIONAL BACKGROUND

Please indicate the organizations of which you are a member:

☐ APA ☐ IPA ☐ AGS ☐ GSA ☐ AMA ☐ ASA ☐ CPA ☐ AMDA

Do you accept referrals? ☐ Yes ☐ No

Please indicate if you are an employee of the: ☐ Local ☐ State ☐ Federal Government

Please indicate the most applicable category: ☐ Practicing Psychiatrist ☐ Fellow (PGY5) ☐ Resident (PGY 1-4)

How would you describe yourself and your work? ☐ Clinician ☐ Researcher ☐ Student/Fellow

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AAGP Membership Application *(continued from front)*

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1. **What percentage of time in each work setting do you work?**

   ☐ Nursing Home ☐ Assisted Living ☐ HMO/PPO ☐ Private Practice ☐ University ☐ Other _____

2. **Please provide the name and location of the institution(s) where you work** (i.e. nursing home name, university, etc.)

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Filling out this section is optional, however, information provided by potential members enables AAGP to respond to inquiries primarily from our members about diversity in the field and membership.

Gender ☐ Male ☐ Female

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Country of origin _____ Date of Birth _____

REFERENCES

Please list the names, work addresses and phone numbers of two psychiatrists whom we can contact as professional references. AAGP members are preferred.

1. Full Name and Degree _____ Phone Number _____

2. Full Name and Degree _____ Phone Number _____

I affirm that all information provided is correct to the best of my knowledge.

Signature _____ Date _____

If you were referred by an AAGP Member, please list the name here _____