"Geriatric Workforce- Who is going to take care of me when I get old?"

Lalith Kumar K. Solai, MD
Service Chief and Medical Director
Geriatric Psychiatry
University of Pittsburgh Medical Center

Acknowledgments

1) Stephen J. Bartels and John A. Naslund: The Underside of the Silver Tsunami – Older Adults and Mental Health Care, New England Journal of Medicine 368;6, February 7, 2013


Disclosures (past 5 years)

Health Resources and Services Administration
Geriatric Workforce Enhancement Program
John A. Hartford Foundation
Mental Illness and Substance Use Disorders in Older Adults

- 5.6 million to 8 million Americans 65 years of age and older have mental health or substance use disorders.
- 10.1 million to 14.4 million by 2030 (IoM, 2012)

Greater disability, poorer health outcomes, higher rates of hospitalization and emergency department visits

Per person costs 47%-200% higher

Mental health services: only 1% of Medicare expenditures

Geriatric Mental Health Workforce

- fewer than 1,800 geriatric psychiatrists in the US today; only 1,650 by 2030

- more than half the fellowship positions in geriatric medicine or geriatric psychiatry go unfilled each year
Geriatric Mental Health Workforce

- Only 4.2% of psychologists focus on geriatrics in clinical practice.
- Difficult to formulate and implement policies to build workforce: different federal agencies hold responsibility for mental health and aging services.

Medicare Annual Wellness Visit

- Requires screening for depression and for cognitive impairment.
- Does not add resources, trained personnel, or additional reimbursed time.

Potential Solutions

- Training in mental health and substance-use disorders should be provided to all primary care clinicians, nurses, care managers, allied health care professionals, and social service providers.
- Extend clinical capacity by developing a workforce of health coaches trained to provide screening and brief interventions.
“reverse innovation”: adapt solutions (e.g., lay health counselors) from resource poor countries to compensate for US workforce shortfall (Patel et al., Lancet, 2007)

like-ethnic peer educators to engage elderly people from ethnic and racial minority groups — the fastest growing group of US seniors and one less likely than white seniors to seek care from conventional mental health providers

Potential Solutions

capitalize on older adults increasing use of internet-base and mobile health technologies

Orphan Status: In Whose Hands?

no single government agency is accountable for this vulnerable, high-cost, rapidly growing population

workforce development falls into a crack between agencies responsible for mental health and substance use and those responsible for aging

perpetuating the “evidence-free” practice of geriatrics: the NIH allows the exclusion of participants over 65 in federally funded research involving adults but requires detailed justification for excluding women, minorities, or children
Shirley A. Conway, MSN, MBA, RN-BC, LNHA and Michael Tarmey, MS, RN will highlight the collaboration between NICHE and AAGP in a Geriatric Psychiatry Unit.

I will come back to highlight strategies undertaken to address this workforce issue.

---

Next Presentation

Making the Case: Why is Geriatric Psychiatry & Mental Health So Important?

- Michael Tarmey, MS, RN, Director Clinical Operations Inpatient Behavioral Health, Addison Gilbert, Beverly & BayRidge Hospitals, Members of Lahey Health

- Shirley Conway, MSN, MBA, RN-BC, LNHA, Director Geriatric Initiatives, Addison Gilbert, Beverly & BayRidge Hospitals

State of Affairs: Projection of Impact

- Geriatric Population
- Chronic Illness
  - Most common chronic condition: experienced by adults is mult morbidity: Almost 3 out of every 4 elders
  - Account for 2/3 of healthcare spending
  - PLWMCC: New Acronyms: Persons Living with Multiple Chronic Conditions
What is a Chronic Illness?
CMS Prevalence Chronic Conditions 2014: Top 15

- HTN
- Hyperlipidemia
- Arthritis
- Ischemic Heart Disease
- Diabetes
- CKD
- Heart Failure
- Depression
- Alzheimer’s Disease/Dementia
- COPD
- Afib
- Cancer
- Osteoporosis
- Asthma
- Stroke

https://www.cms.gov/Research-Statistics-Data

Relationship Between: Mental Health & Physical Health

What Came First? For Example:
Depression or Physical Illness & Pain?

Bi-Directional Relationship:
Depression & Chronic Medical Disorders

- The adverse health risk behaviors and psychobiological changes associated with depression increase the risk for chronic medical disorders, and biological changes and complications associated with chronic medical disorders may precipitate depressive episodes.

Bi-Directional Relationship: Depression & Chronic Medical Disorders

- Comorbid depression is associated with increased medical symptom burden, functional impairment, medical costs, poor adherence to self-care regimens, and increased risk of morbidity and mortality in patients with chronic medical disorders.


Bi-Directional Relationship: Depression & Pain

- Comorbidity between Major Depressive Disorder (MDD) & pain is common and the 2 conditions exhibit substantial epidemiological, clinical, and neurobiological overlap.
- They also appear to facilitate development of each other & chronic pain is a strong predictor of subsequent onset of MDD (and vice versa).

Current Psychiatry Feb 2016 Maletic & DeMuri

Depression

- Rate of depression in older adults ranges from 7% to 36% in medical outpatient clinics - and increases to 40% in the hospitalized elderly.
- Comorbidities & Depression common: highest rates of depression are found in those with strokes (30% to 60%), coronary artery disease (up to 44%), cancer (up to 40%), Parkinson's disease (40%), and Alzheimer's disease (20% to 40%). Recurrence rate high at 40%.
- Physical Illness & functional impairment common stressors in older adults who commit Suicide.

(nursing textbooks)
Geriatric Syndromes

- Sensory Impairment
- Malnutrition
- Substance Abuse
- Sleep Disturbance
- Falls & Skin Breakdown
- Functional Decline

Functional Decline

- Loss
- Financial Constraints
- Loneliness & Isolation
- Environmental Barriers
- Transportation
- Depression

Chronic Disease

- Pain
- Long-Term Mental Illness
- COPD & Diabetes
- Cardiac Dysfunction
- Failure to Thrive

nicheprogram.org • 2016 Annual NICHE Conference • Care Across the Continuum
Leading to Disability and Premature Death

Nicetiches Syndromes
- Chronic Illness
- Geriatric Failure to Thrive
- Functional Decline

NICHE Principles
- The mission of NICHE is to provide principles and tools to stimulate a change in the culture of healthcare facilities.
- Provision of Evidenced-Based Nursing Geriatric Care.
- Achievement of patient/person centered care for older adults:
  - Person and Family Centered Care: Emotional Care
    - Putting the patient and the family at the heart of every decision and empowering them to be genuine partners in their care.
    - Individuals’ values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals.
    - Always Events® are those aspects of the patient experience that are so important to patients and families that health care providers must aim to perform them consistently and reliably for every patient, every time.
NICHE Goals

- NICHE:
  - Prevention of Geriatric Syndromes
  - Provision of Evidenced-Based Geriatric Care
  - Holistic: Physical & Emotional Well Being
  - Providing a "tool box" and common language for care

Addressing Mental Health Issues In Your Practice:

- Assessment: Geriatric Depression Scale & Substance Abuse
- Prevention & Treatment of Geriatric Syndromes
- Owning the Patient: Wherever you are providing care:
  - Collaborate
  - Advocate
  - Educate and...
  - Ambulate!

Taking the Stigma Out of it:

- Utilize Psychiatry More: Psychiatric Consults
- Making your framework of care truly head to toe
- You need not be a "Psych Nurse" to provide mental healthcare
- Geriatric Nurses make great Psychiatric Nurses!
- Unit-based: Senior Adult Unit at Addison Gilbert
  - 14 bed Gero-Psych-Med "Acute Care for the Elderly"
  - Founding System-wide NICHE Program since 2007
  - Interprofessional Team providing true Holistic care
Taking the Stigma Out of it:

- Unit-based: Senior Adult Unit at Addison Gilbert
  - No "Psychiatric" in name
  - 14 bed Gero-Psych-Med "Acute Care for the Elderly"
  - Founding System-wide NICHE Program since 2007
  - Interprofessional Team providing true Holistic care
- NICHE Program:
  - Psych Leadership partnering with M/S Education
  - Geriatric Steering Committee: Truly Interprofessional

NICHE & Mental Health Care & Accountable Care Alignment

- Chronic Care - Care Management now reimbursable
- Depression Treatment is itself a Quality Measure
- Recommendation by US preventative services that all adults be screened for depression.

http://www.uspreventiveservicestaskforce.org
Addressing the Issue

- Nursing Shortage
- Geriatric & Psychiatric Trained Healthcare Workers
- Approach: Care and Prevention of MCC
- Interprofessional & Coordinated

NICHE & AAGP:

- Utilizing NICHE as a Framework for Care: Presentation at 2015 AAGP Meeting on:
  "Successful Interprofessional Team Model for Unit-based and System-wide Treatment of the Elderly":

  – Team Presentation: Steven Gillespie, MD, Board Certified Geriatric Psychiatry & Hospice and Palliative Care Medicine
  – Our NICHE Program Medical Director

NICHE Resources Available

- GRN Education: The 3 "D's"
  – Delirium
  – Dementia
  – Depression
  – The 4th D: Drinking & Drugs
- NICHE Education Briefs: Self Neglect
- Try This on Consult Geri RN - Hartford Institute for Geri Nursing
NICHE & AAGP: Future

- NICHE Presentation at AAGP Conference 2016
- NICHE representation at annual meetings
- More to come!

Acknowledgments

Mary Anne Hall
Tanya Fabian
Denise Korzon
Elizabeth Mulvaney
Jennifer Lingler
Charles Reynolds
Juleen Rodakowski
Daniel Rosen
Elizabeth Skidmore
Kathy Slomka
Disclosures (past 5 years)

- Health Resources and Services Administration
- Geriatric Workforce Enhancement Program
- John A. Hartford Foundation

Geriatric Mental Health Mini-Fellowship

- An inter-professional training on GMH for a week
- Nurses
- Rehabilitation staff
- Pharmacy
- Social Work
- Family Medicine
- 2 years of training
- More than 50 people trained
- Replicate this model of training at other sites

Geriatric Mental Health Mini-Fellowship

- The members of the committee met every other week to identify potential training needs and the content/speakers for the program
- Decided based on scheduling conflicts to start with a 3 day program for the first year
- Each day focused on one topic: delirium, depression or dementia
Geriatric Mental Health Mini-Fellowship

Talks were given by faculty from each discipline in the morning and case discussion with faculty happened during late afternoon.

- Delirium: An overview of the current field. LALITHKUMAR SOKAL (MD)
- Delirium: Impact of delirium on patients. BETTY ROBISON (Nurse)
- Strategies for early detection/treatment of delirium. FRED RUBIN (MD)
- Pharmacy review of Delirium: JOSEPH HANLON (PharmD)
- Case presentation and Discussion of Delirium with panel of experts (Social Work, Physical Therapy, Psychiatry, Pharmacist and Nursing)

Geriatric Mental Health Mini-Fellowship

Feedback Comments 2014

- “I will definitely look to other disciplines to share the expertise I am now more familiar with. I also now feel more confident when speaking in a multi-disciplinary group.”
- “This fellowship has definitely increased my understanding of other professions and improved my ability to care for geriatric patients”
- “The interaction with teams was key, was stimulating and engaging. The time spent with my own specialty was less stimulating and less engaging”
- “Focus on the disciplines and what they actually do, the first activity on the first day should have been about this. I feel other disciplines still do not have an understanding of what advanced nurse/practitioner does, do a survey to see what each discipline thinks of others and then have a discussion”

Based on Feedback 2015 the Mini-Fellowship was extended to 5 days.

- One day for Normal Aging and roles of each disciplines
- 3 days for Delirium, Depression and Dementia
- Last day on Palliative care
- The daily format was almost the same
Geriatric Mental Health Mini-Fellowship

<table>
<thead>
<tr>
<th>Questions</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am satisfied with the overall program</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>There was an appropriate mix of lecture/panel discussion/class discussion</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>There was an appropriate amount of hands-on/interactive class activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>The reading materials were useful</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>There were enough breaks throughout the day</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>I am satisfied with the overall objective of bringing multidisciplinary trainees together</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>Trainees will be able to identify strengths of each disciplinary in training</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Trainees will be able to identify ways to improve teamwork</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Trainees will have a better understanding of the three common syndromes in geriatric mental health from a multidisciplinary perspective</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td>Learning from faculty from other disciplines was useful</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>The content was relevant to my practice</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>15</td>
</tr>
</tbody>
</table>


Feedback Comments 2015

“I really enjoyed hearing the numerous perspectives of different healthcare professionals; this helped put all of our practices together to show each profession what we can bring to the patient situation”

“Extremely relevant. Living and practicing medicine. I work with pharmacists, RNs, therapists and PAs on a daily basis. Learned how to better understand motivations of my other team members and how to break down barriers and the importance of good communication”

“As a physician that will practice in geriatric medicine the content in this fellowship is very relevant and it learn about interdisciplinary approach and resource certainly has broadened my knowledge”

“I loved the case studies and the discussions. I thought all activities were very useful. I enjoyed the icebreakers. I appreciated faculty’s push to get out of comfort zone and force us to switch seats and sit with someone new (Thank You!). I am really happy about the lectures and access to their PowerPoints and recommended readings. I intend to use all materials and resources in my clinical practice”

What next?

- Potential Next steps
  - Replicate this program at another site
  - Start this program for practicing clinicians for a fee and offer CEU credits
  - Start this program web based
  - Present to AAGP leaders to seek support and guidance
Geriatric Workforce Enhancement Program

- This is a HRSA program to train Primary care workforce in geriatrics
- We have a 3 year grant to train 3-4 PCP clinics on Geriatric Mental Health topics
- Part of an integrated clinic model of care
- Colleagues have funding to train on dementia care in nursing home

Annual Inter Professional Geriatric Course

- Weeklong exposure to geriatric topics
- Medical Students Year 2
- Exposure includes
  - Nursing home
  - Outpatient
  - Inpatient
  - Mental Health
  - In home services
  - Rehabilitation units

Important Next Steps: Connecting the Dots

- Create a dedicated federal office responsible for overseeing funding and coordination across the different agencies responsible for aging, mental health, and substance-use disorders
- Mandate inclusion of older adults in federally funded research
- Restore the SAMHSA program supporting the implementation of geriatric community mental health and substance abuse programs
- Accountable care organizations to integrate geriatric mental health and substance abuse expertise as components of health coaching and chronic disease management