

Geriatric Mental Health Testimony

**NYS Assembly Standing Committee on Mental Health, Mental Retardation and
Developmental Disabilities**

NYS Assembly Standing Committee on Aging

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My name is Dr. Ron Adelman. I am a geriatrician and Co-Chief of the Division of Geriatrics and Gerontology at the New York-Presbyterian Hospital and Weill Cornell Medical College. I am testifying today with Risa Breckman, LCSW, Director of Social Work Programs and Education with our Division. Thank you for this opportunity to testify on behalf of the Division of Geriatrics. We are going to focus our comments today on the experiences we've had implementing our New York State Office of Mental Health funded demonstration project entitled, *Geriatric Mental Health Integration Into Primary Practice*, for which I am the Principal Investigator and Ms. Breckman is the Project Director. We will also touch on some barriers to service provision and the needs of medical providers in delivering needed geriatric mental health services.

The mission of our Division is to improve the quality of life for older people through the integration of high quality clinical care, the teaching of geriatric medicine to clinical trainees and the advancing of knowledge through scientific research. To serve this mission, in 1998, we opened The Irving Sherwood Wright Medical Center on Aging. The Wright Center is a geriatric ambulatory care practice on First Avenue and 77th Street. Our 16 physicians provide comprehensive outpatient primary medical care in varying number of sessions per week. Our patient population that is primarily Medicare-insured—more than 60% of our approximately 3000 patients are over the age of 75—and are ethnically, racially and socio-economically mixed. We also have a small house call program for homebound patients.

The mental health problems experienced by Wright Center patients encompass the full spectrum—from affective and anxiety disorders to chronic schizophrenia to personality disorders. We care for many patients with dementia, many of whom

experience psychotic agitation. The following brief case example illustrates these problems:

Mr. Smith is an 83-year old retired salesman residing in New York City. Between the expense of living alone in Manhattan and paying for the medications and co-payments for medical visits to manage his diabetes and emphysema, he just barely meets his monthly expenses. Married for over 50 years, his wife died 6 months ago. Now, without other family or friends, he feels helpless to check his own blood sugars, follow his prescribed diet or go for walks as he did with her. Each night, alone in the quiet of his kitchen, he slowly drinks a bottle of wine and ponders the value of his life, wondering if it is even worth living.

What does this case describe? Grief from loss. Excruciating loneliness. Debilitating depression. Suicidal ideation. Alcohol abuse. This scenario, or something resembling it, occurs commonly in the lives of many older adults. Mental health problems among older adults are significant, under-diagnosed and poorly treated. These adversities have a direct impact on the course of acute and chronic illnesses in older adults jeopardizing their overall physical health, well-being and cherished independence. For example, the spectrum of depressive disorders known as affective disorders in psychiatry can lead to non-adherence with medical treatments, interfere with self-care, and cause individuals to disengage from work, volunteer activities, pleasurable pursuits, and withdraw from family and friends. Some older adults eventually become homebound.

Because of Mr. Smith's isolation, it is clear that the one person with any hope of noticing Mr. Smith's distress is his health care provider. It is also evident that a health care provider cannot successfully help Mr. Smith manage his diabetes without addressing

his depression, his losses and loneliness, his alcohol abuse and suicidal ideation. These problems are intertwined.

But there are formidable barriers preventing attentive physicians from screening for and treating psychosocial problems during medical visits. One obstacle is limited time: The average medical visit for those 65 and over is only 18 minutes. During this time the physician must address the chronic medical illnesses and acute problems superimposed on the chronic ones; evaluate new complaints; reconcile medications; and attempt to address psychosocial issues. Another problem is the lack of physician training on how to screen, diagnose, treat and develop a care plan for mental health concerns. Then there is the stigma many patients feel about mental health problems which inhibits disclosure. Compounding these problems is the fact that mental health services are often not conveniently located, causing some already ambivalent patients to forego treatment. And even when physicians do treat patients for mental health problems, another barrier is that they may not do this properly. For example, they sometimes lose focus on the mental health treatment when other illnesses pull for their attention, or they do not try different medications if the initial medications do not work. As a result, many older people discontinue treatment before they are well, or remain at subtherapeutic levels of medication, or are not told of psychosocial intervention options.

The NYS Office of Mental Health's funding for integrating comprehensive mental health care into the medical setting is vitally important. The grant helps us overcome these barriers by locating mental health screening, assessment, and treatment services within our primary care practice, the Wright Center. The grant pays for a full-time psychiatric nurse practitioner and a part-time geropsychiatrist. As Medical Director, I

have redeployed part of our NYPH–funded social worker’s time to the mental health project as well. The grant also provides a small amount of administrative support.

Co-locating geriatric mental health programs within a medical practice facilitates, improves and humanizes care by viewing the patient as a whole person.

Screening for depression and anxiety can now become a routine part of our medical care and is presented to our patients this way. We utilize brief, evidence-based screening instruments for anxiety and depression. For patients screening positive, our physicians can introduce their patients to our psychiatric nurse practitioner because the mental health team’s offices are adjacent. Physicians can schedule their patients an appointment with the mental health provider within weeks. This ease of access increases the likelihood that patients will engage in the needed treatment. For those patients being diagnosed with anxiety or depression, our psychiatric nurse practitioner conducts a comprehensive screening of a range of psychosocial concerns, such as elder abuse or caregiver stress. Patients’ treatment preferences are solicited and incorporated into care planning. Monitoring care is part of the services provided. In addition, our physicians and nurse practitioners can effortlessly “curbside” our mental health specialists for clinical consultations on medication management or psychosocial intervention information. Also, we all share an electronic medical chart so we can communicate complex care information with each other. Mr. Smith is likely to receive help in this humanized, interdisciplinary team approach to care.

The NYS Office of Mental Health demonstration grant provides essential mental health training of our medical workforce. Our demonstration grant provides us an opportunity to provide in-service training to our clinical staff on a broad spectrum of

mental health problems seen at the Wright Center. Physicians receive little training in psychiatry during medical school and residency. We now have weekly mental health team meetings. Our geropsychiatrist provides presentations on a range of mental health issues including depression, anxiety, schizophrenia, delusional disorders, personality disorders and substance abuse. Our team presents, reviews and discusses mental health cases seen in our practice. These sessions may very well become a model for how to teach physicians and nurse practitioners about geriatric mental health care.

The demonstration grant funds our innovative work in the area of elder abuse and mental health. We provide case consultation and training to staff at the Weinberg Center, a shelter for elder abuse victims at the Hebrew Home at Riverdale. The goal of this collaboration is to increase the shelter's capacity to provide emergency assistance to elder abuse victims with mental illness that may have previously prevented their being admitted. Our Division has recently received funding to collaborate with The Weinberg Center, the New York Elder Abuse Network and other community partners to plan for the development of a *Manhattan Elder Abuse Case Coordination and Review Center*. We aim to make mental health a priority of this effort. There is no question that the NYS OMH grant funding has increased our capacity to focus on this initiative.

The demonstration grant enables us to teach others about geriatric mental health and further this work in NYC. Our team is asked to speak at conferences, to geriatric fellows at other medical schools and to community-based organizations about our program and these complex psychosocial issues. We view this educational work as a way of making our grant dollars reach more people. In addition, we have joined geriatric

mental health committees in New York City to bring our expertise and energy to the collective effort aimed at strengthening NYC's mental health service-delivery network.

One of the critical components of the demonstration projects is to evolve a plan for sustaining the mental health resources through appropriate billing strategies. As our project progresses, we aim to quantify the number of billable mental health care visits our practitioners have and analyze the billing outcomes for staff retention.

In closing, geriatric medicine cannot be practiced correctly without adequate attention and respect for geriatric mental health care. Humanism in medicine cannot occur without proper representation of the mental health disciplines. In addition, trainees in all health professions require comprehensive curricular teaching and supervision of their clinical exposure to proper mental health care practice. This extraordinary demonstration grant enables us to expand in all of these directions and gives us the opportunity to develop sustainable models.

The Geriatric Mental Health Act has been a tangible and meaningful way for the NYS legislature to help older adults achieve health and well-being in their later years. Because of our society's burgeoning aging population, it is imperative that this funding be viewed as just the beginning.

Our medical team and our patients are grateful to you for your efforts.

Thank you.

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My name is Ron Goralewicz and I am a newly hired Psychiatric Nurse Practitioner with the Irving Sherwood Wright Center on Aging, New York-Presbyterian Hospital, Division of Geriatrics and Gerontology. Thank you for the opportunity to submit testimony on the important subject of geriatric mental health and on our geriatric mental health integration demonstration project.

I have worked in home care for the past 17 years providing mental health evaluations and treatment for homebound seniors. Research indicates that there is a higher rate of depression in the elderly than in the general population and that the rate of depression in homebound elderly patients is higher again. Depression is a treatable medical condition, and yet, in this population, it is often simply not addressed.

During my 17 years providing psychiatric home care, there have been numerous occasions when I have had to call a physician in the community to report finding one of their patients in a state of severe depression. Quite often the physician, upon hearing the diagnosis, will say: "Is she depressed, I didn't know". The other common responses have been: "Oh yes, I know...it's a terrible situation", or "Oh yes he/she has been depressed for a long time..." These responses point out several important issues about the identification and treatment of depression in our elderly patients.

First, primary care physicians often do not diagnose depression when their depressed elderly patients come into their offices. This may be due in part to the fact that elderly depressed patients often present with somatic complaints and may even deny feeling depressed. This often results in the patient being started on a medication to address the presenting physical complaint. When the physical complaint does not respond, another medication is often added, again not addressing the real underlying pathology, but contributing to polypharmacy and raising the risks of drug interactions.

I have also found that even when internists do recognize depression in their elderly patients, they often prescribe psychotropic medication at dosages that are too high, resulting in unwanted side effects or at dosages too low to affect any real therapeutic effects. Psychopharmacology with the elderly is as much an art as it is a science. Proper mental health assessment, diagnosis and treatment require a certain level of skill and the time to complete an adequate evaluation. These elements are most often lacking in a busy internal medicine practice.

The other issues these responses from the internists convey are that depression is an acceptable condition in the elderly, and, therefore, not treating this illness is an acceptable choice in medical practice. Nothing could be farther from the truth. Untreated depression adversely affects general physical health, negatively impacts quality of life, slows physical recovery from illness, increases mortality and contributes to poor compliance with treatment that can precipitate a hospitalization. Most importantly, untreated depression is a major contributor to the high suicide rate in the elderly.

The most efficacious way to address these serious gaps in mental health care for the elderly is to: 1) integrate mental health care into primary care; and 2) provide on-going training for physicians about identifying, diagnosing and treating geriatric mental health problems. NYPH's demonstration, *Geriatric Mental Health into Primary Practice* (G-MHIPP) accomplishes both of these goals.

G-MHIPP is located at the Irving Sherwood Wright Medical Center on Aging, NYPH's Division of Geriatrics and Gerontology's geriatric ambulatory care practice in Manhattan. In this integrated model, the primary care physicians screen all of their patients for depression and anxiety using evidence-based tools. Patients screening positive have the opportunity to be treated in a familiar and comfortable environment and with an on-going, multidisciplinary team approach including medicine, psychiatry and social work. As the full time Psychiatric Nurse Practitioner recently hired through the grant, I will be making thorough psychiatric evaluations on all patients screening positive for anxiety and/or depression, assessing for other psychosocial problems, making treatment recommendations, sharing results with the team, monitoring the patient's progress and reporting back to the primary care providers. This service will be available to all patients at the Wright Center as well as to the patients in the home care program, our most frail and vulnerable patients. Weekly mental health team meetings are conducted by our team's geropsychiatrist consisting of case presentations and on-going mental health training.

In sum, this model of integrated care meets the most pressing needs of our elderly patients by providing on-site training for primary care providers, providing mental health treatment from geriatric mental health specialists, reducing stigma by incorporating mental health care into a familiar and caring environment, and providing comprehensive and multidisciplinary treatment in a most caring environment.

Hopefully, the New York State legislature will help make integrated physical and mental health care available to older adults throughout New York State.

Thank you.

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My name is Amy Stern and I am the Senior Social Worker at the Irving Sherwood Wright Center on Aging, the geriatrics ambulatory care practice of New York-Presbyterian/Weill-Cornell Hospital. Thank you for the opportunity to submit testimony on the important topic of geriatric mental health and our geriatric mental health integration demonstration project.

I have worked in the field of geriatric social work for 8 years, both in the medical inpatient and outpatient settings. These experiences have illustrated not only how prevalent mental health issues are among the older adult population, but also how significant the presence of a mental health problem is in treating any medical conditions.

Studies show that depressive disorders in older adults often result in increased visits to physicians, increased health care costs and increased risk for nursing home placement. Depression is associated with significant co-morbidity and may be an independent predictor of mortality and risk for development of Alzheimer's disease.¹

The primary care setting is the ideal setting to identify mental health issues among patients. Due a variety of reasons, including accessibility and stigma, many older adults cannot and do not obtain care in community mental health settings. However, older adults do see their primary care physicians on a regular basis, providing a unique opportunity to address mental health issues as they become evident.

Unfortunately, many physicians are not in a position to thoroughly screen, identify and treat mental illness in their patients. Doctors may be constrained by their lack of education on these issues, or limited by enormous time constraints. On-going teaching to physicians regarding mental health issues is a much needed (and often much appreciated) intervention. And, by including mental health professionals on staff in a medical setting, physicians are then able to appropriately refer their patients to receive the needed treatment all within the confines of an environment comfortable to the patient.

Geriatric Mental Health Integration into Primary Practice (G-MHIPP) is based at the Irving Sherwood Wright Center on Aging. As a result of this demonstration grant, primary care physicians screen all of their patients for depression and anxiety using the PHQ-9 and GAD-7. Patients who screen positive, or for whom physicians believe further exploration of mental health issues is warranted, are referred to the Geriatric Behavioral

¹ Kohn, R and Epstein-Lubow, G. (2006). Course and Outcomes of Depression in the Elderly. *Current Psychiatry Reports*, 8, 34-40.

Health Specialist, a full-time psychiatric nurse practitioner recently hired through this grant. These patients are evaluated further and a treatment plan is developed. Referrals for counseling and/or concrete service implementation are made to me, the social worker in the practice. As this program is rolled-out, it will become available not only at the ambulatory care practice but also to the homebound house-call patients seen by our physicians. In addition, our Geriatric Behavioral Health Specialist will also conduct mental health assessments on certain patients seeking admission to the Weinberg Center shelter program for victims of elder abuse and mistreatment. As these interventions are taking place, our geropsychiatrist has been and will continue to meet weekly with medical staff to provide training on mental health issues.

This model of integrating mental health care into primary care allows for a comprehensive system of care provision that addresses the needs of the whole person in a setting familiar and accessible to the patient. In light of scarce community mental health resources for older adults and the enduring stigma associated with mental illness in our society, the primary care practice is the opportune setting to identify and treat mental health issues.

I hope that the New York State legislature will help make geriatric mental health integration in medical practice available to older adults across the state and for years to come.

Thank you.

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Geriatric Mental Health and Primary Care: A Collaborative Enterprise

Serious psychiatric disorders among older Americans are associated with a markedly lower quality of life, significant functional impairment, and premature death due to suicide or exacerbation of comorbid physical illness. In recent decades evidence has accumulated showing that the failure to address psychiatric disorders among the elderly has contributed to an enormous public health burden.

Yet most elderly Americans who suffer from psychiatric conditions—including, among others, depression and anxiety disorders, bipolar disorder, late life schizophrenia or delusional disorder, and behavioral complications of dementia—still receive no treatment at all. Widespread misconceptions about the nature of mental disorders in the elderly, the social stigmatization of these conditions, and scarcity of specialist services owing to poor Medicare reimbursement, have all been cited as explanations for this abysmal record. Such mental health care to the elderly that is actually delivered is provided mainly by primary care physicians (PCPs). However, the adequacy of psychiatric treatment received by older patients from their PCPs remains generally poor, with only a small proportion achieving resolution of their most troubling symptoms.

A variety of reasons have been invoked to explain the substandard mental health care provided by many PCPs. They include PCPs' lack of skills and knowledge, competing demands for PCPs' attention (e.g., need to address complex multi-system physical problems), lack of time to assess and educate patients, and low frequency of contacts. All of these factors have adverse effects on adequacy and adherence to psychiatric treatment.

However, several important National Institute of Health studies over the past decade (for example, the PROSPECT study—"Prevention of Suicide in Primary Care Collaborative Trial," which was conducted by faculty members at Weill Cornell Medical College, University of Pennsylvania and University of Pittsburgh) have demonstrated that these structural problems can be overcome by the implementation of a "Collaborative Care Model." In the Collaborative Care Model, patients are managed by their PCPs in close collaboration with a psychiatrist or a behavioral health specialist (BHS)—ideally both—as a way to extend the reach of mental health services in the primary care setting. PROSPECT in particular established that the adequacy of antidepressant prescriptions and patients' adherence to them were both vastly improved with the use of this model.

With funding from the New York State Office of Mental Health, The Wright Center on Aging is now preparing to take the PROSPECT Collaborative Care Model to the next level, by emphasizing the physical proximity, or co-location of medical and mental health personnel.

The Wright Center on Aging at New York Presbyterian Hospital in Manhattan is a geriatric medical group practice which has, since its inception, created a warm and welcoming ambiance for elderly patients. With support from the NYS Office of Mental Health (via the Geriatric Mental Health Act), we have laid the groundwork and set up the necessary infrastructure to place mental health care directly in this setting. With a part-time geriatric psychiatrist and a full time nurse-practitioner Behavioral Health Specialist in place, we are now establishing a geropsychiatric service insinuated within the folds of a primary medical practice. Our goal is to offer our patients a full range of mental health services—screening, diagnostic assessment, crisis management, psychopharmacological interventions, and psychotherapy as needed—all under one roof, in a geriatric-friendly place where they receive their medical care. We are already beginning to observe the destigmatizing effect of the co-location concept—i.e., those patients who might have been reluctant to seek needed mental health care if only handed a referral slip and a telephone number are more likely to keep their appointments and express satisfaction with the mental health care they receive at the Wright Center. Care can also be offered in a more timely way. The new program will thus provide mental health services that are “on-time, on-target, and in-situ.”

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