

A Glimpse of GEMM:
“GEriatric Medical and Mental Health Care”

Ben Chapman, Ph.D.
Deborah King, Ph.D.

[The Partnership]

Jewish Senior Life of Rochester

- Brian Heppard, MD, Bernard Shore, MD, Lisa Vargish, MD, Elaine Gardiner, RN

Jewish Family Service of Rochester, Inc.

- Kimberly D. Kalish, Ph.D., Leslie Friedman LCSW, Roseann Kraus, MSW & Janet Sunkin, LMSW

URMC Geriatric Psychiatry

- Ben Chapman, Ph.D, Katherine Duffy, MD, Deborah King, Ph.D., JoAnn Romano-Egan, PNP

[Our goals today...]

- To share a glimpse of ‘real world,’ messy data (and how Ben deals with it!)
- To prepare a helpful report for NYS OMH in their efforts to advocate for funding for integrated care
- To discuss possibilities for future quantitative or qualitative analyses with this sample??

[In the beginning...]

In 2005, NYS enacted Geriatric Mental Health Act which authorized:

- Geriatric MH and CD Planning Council
- OMH to establish Geriatric MH Demos
- Annual reports to governor and legislature

[The “GEMM Care Program”]

- “Geriatric Medical and Mental Health Care”
- Links **home-based geriatric primary care practice** (JSL House Calls Program) with a **university mental health program** dedicated to older adults (UR Geriatric Psychiatry Program, Older Adults Service) and **community-based counseling and care management services** (Jewish Family Service)

[GEMM Mission...]

“To deliver integrated physical and mental health assessment and treatment to homebound and mobility-challenged older adults.”

[Core Program Elements]

- **Interdisciplinary training & team building**
- **In-home assessment and treatment**
- **Case management services**
- **Ongoing interdisciplinary monitoring, case consultation**

GEMM Care Protocol

- **RN conducts first phone screen**
 - including demographics, contact info, emergency contact, referral info, method of co-pay, eligibility criteria
- **MD conducts first medical home visit**
 - Determine safety of home
 - Conduct physical exam
 - Conduct initial mental health screens
 - Develop tentative list of medical and mental health problems
 - Consider whether to initiate mental health involvement

GEMM Care Protocol - 2

- **If indicated, mental health care manager (“GEMM Care Advocate”) or psych NP makes 2nd visit**
 - **Complete mental health and caregiver burden assessments**
 - **Assure that patient/caregivers understand nature of service**
- **Interdisciplinary team meetings twice monthly**
 - **to review initial visit/screening results**
OF ALL NEW CASES
 - **to discuss ongoing treatment issues**
OF ALL CASES

Measures

- PHQ-2: Depression screen (f/u with PHQ-9)
- GAD-2: Anxiety screen (f/u with GAD-7)
- Mini-Cog: Cognitive functioning
- CAGE: Alcohol Abuse
- Zarit Burden Interview

Participant enters
“House Calls” program
and is screened for
mental health and cognitive needs

(-) Score: Receive home-based
physical care services only

(+) Score: Mental health assessment is
completed, Integrated Care Plan (ICP) developed

Potential avenues for further care:

- 1-3 home based mental health treatment sessions – NOT HAPPENING
- Referral to office-based treatment (Older Adults Mental Health Service)
- Referral to other UR service (e.g., inpatient or Alzheimer’s services)
- If treatment refused, plan made for continued follow-up & consultation

Care management services
available to all participants as needed

GEMM Consumers: Homebound, Mobility-Challenged Older Adults

- Ray: 92 yo widowed WWII vet with complex medical co-morbidities (CHF), hx untreated depression & anxiety, adult offspring in conflict about his care
- Katherine: 81 yo retired Kodak employee, multiple CVAs, glaucoma, severe osteoporosis, living w/ depressed caregiving husband in two-room apt
- Frank: 86 yo, late-stage AD, agitation/behavioral issues, family hx suicide (brother), frequent falls/hip fracture, caregiving wife and daughters fiercely protective (fired three nursing aides and one SW prior to GEMM)

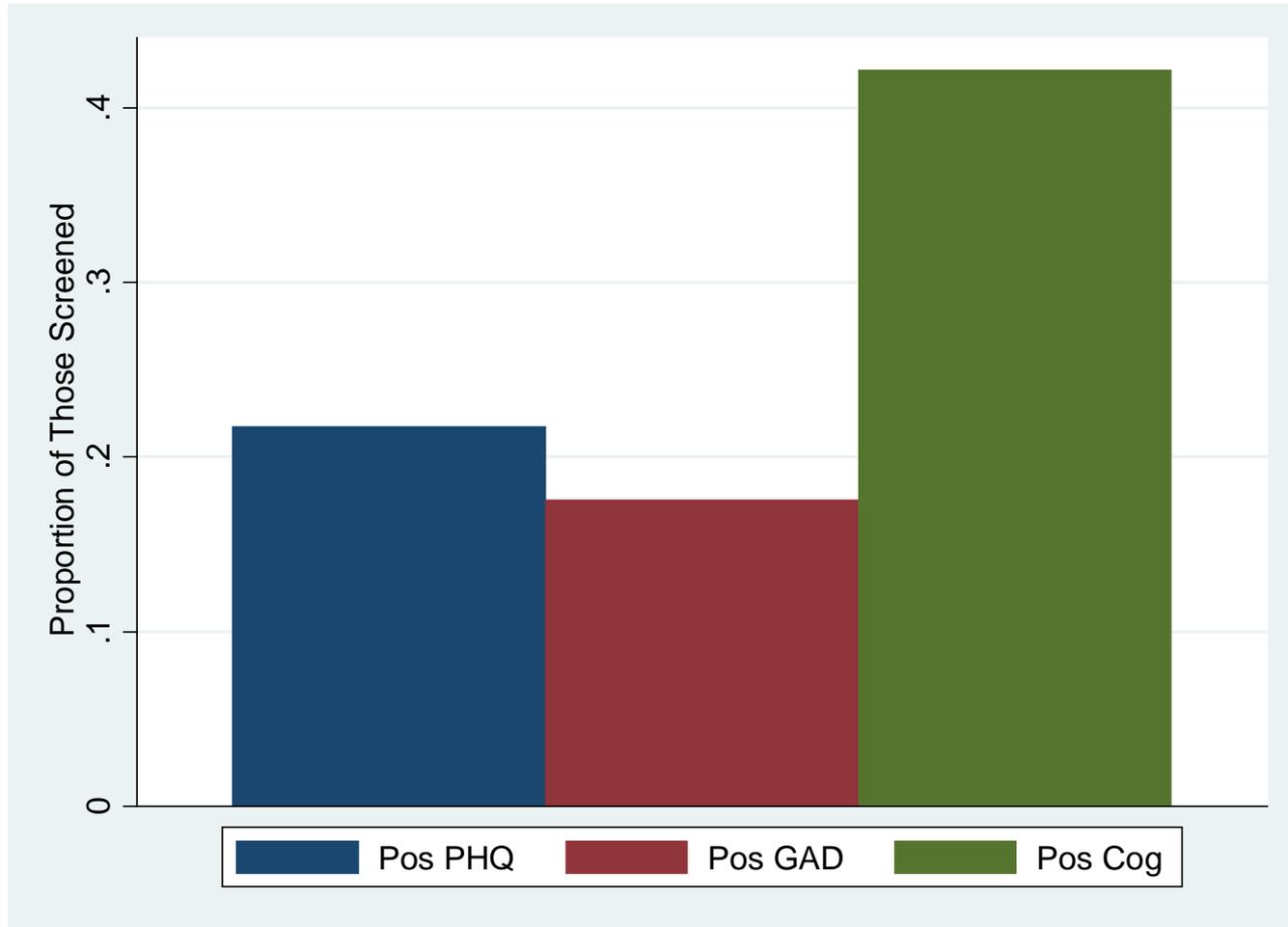
[Baseline Sample (n=152)]

- Mean (SD) age = 83.9 (10.7)
- 70% female
- 98% white
- Varied living situations (most in private residence alone or with partner, minority in assisted living or comfort care home)

Initial Positive Screens

- PHQ-2 ≥ 3 or PhQ-9 ≥ 5
 - 25/115 = 21.7%
- GAD-2 ≥ 3 or GAD-7 ≥ 5
 - 20 / 114 = 17.5%
- Mini Cog positive < 3 or MMSE ≤ 20
 - 43/102 = 42.2%

Percentage of Positive Screens



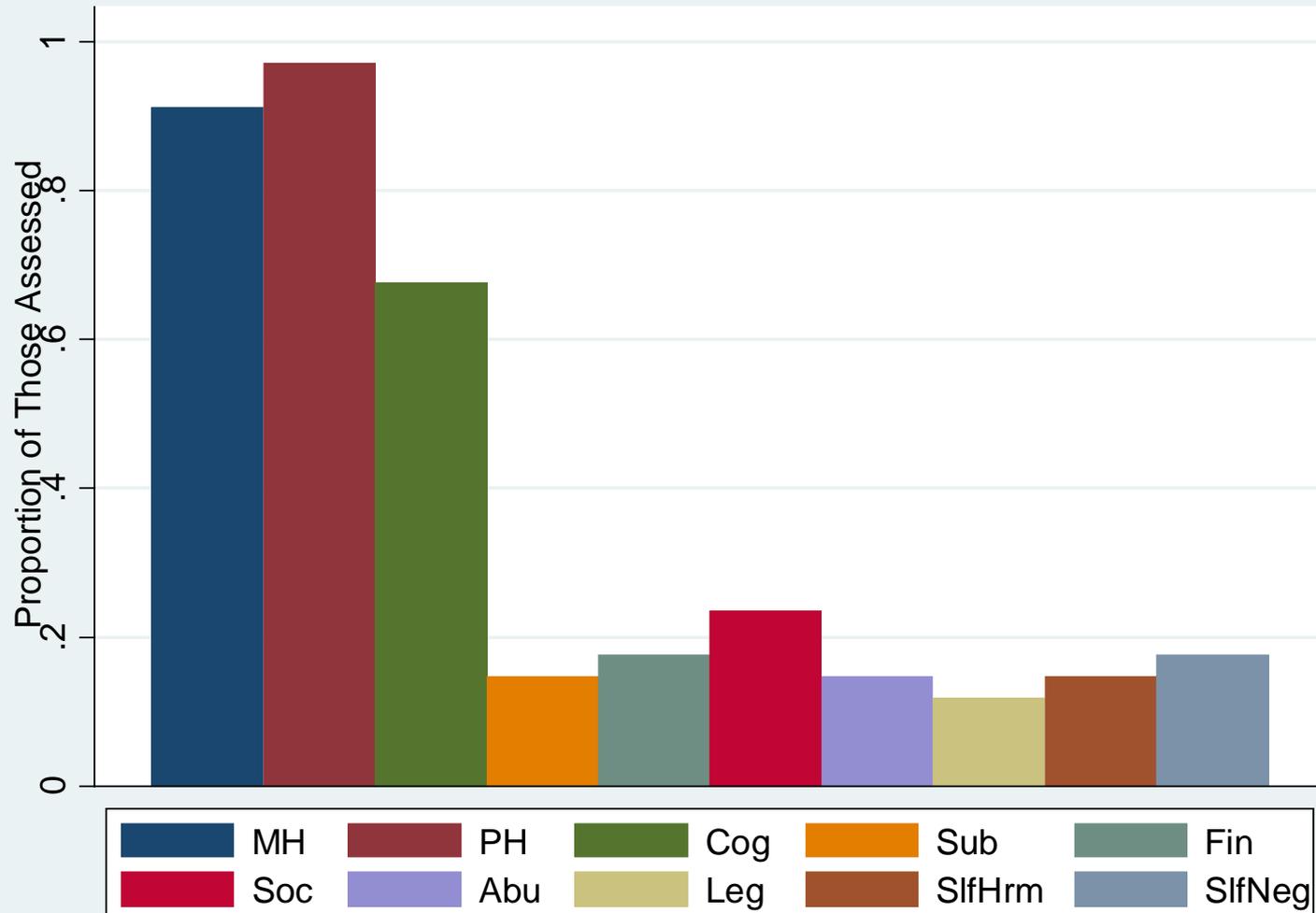
Assessment Needs in Baseline Sample (N = 152)

- No need for assessment = 97 (63.8%)
 - Needs assessment/agreed = 47 (30.9%)
 - Needs assessment/refused = 8 (5.3%)
- Negative GAD 4 times MORE likely to refuse ($p = .10$), negative PHQ 3.2 times MORE likely to refuse ($p = .11$) than accept needed assessment

Proportion Assessed with Identified Issues

- Physical health 97%
- Mental health 91%
- Cognitive 68%
- Social 24%
- Self neglect 18%
- Abuse issue 15%
- Financial 18%
- Substance 15%
- Legal 12%
- Self harm 15%

Proportion with Identified Issues



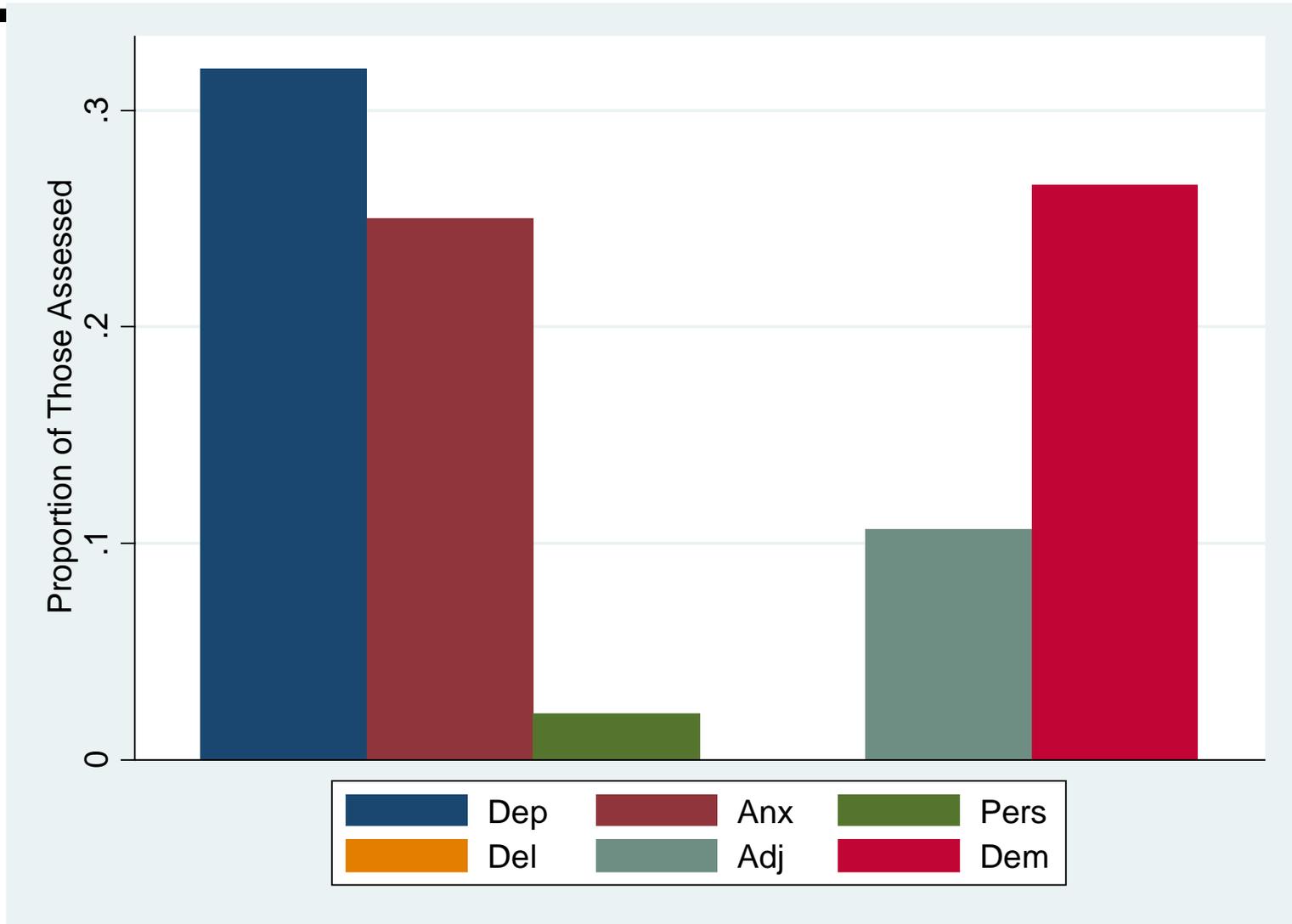
[Problem Co-occurrence]

- 90% Have physical and mental health comorbidity
- 67% Have mental health and cognitive comorbidity
- 67% Have 3 or more problems

[Assessment Diagnoses]

- Depression 32%
- Anxiety 25%
- Dementia 27%
- Personality d/o 2%
- Delusional d/o 2%

Assessment Diagnoses



[Diagnostic Comorbidity]

- Of those diagnosed with depression,
 - 33% also had an anxiety d/o
 - 87% had at least one other dx
- Of those diagnosed with anxiety,
 - 91% had at least one other dx

Outcomes Analysis

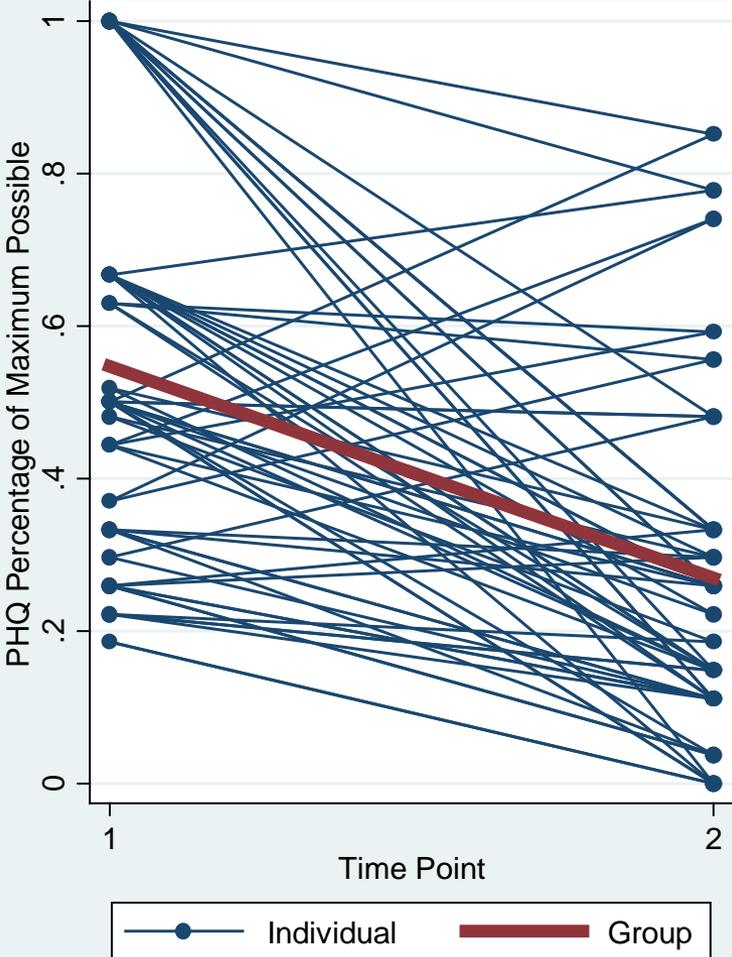
- Measured in percentage of maximum possible (POMP) scores on PHQ and GAD
- Allows analysis across both versions of the instrument (2/9) (2/7)
- Inherently meaningful metric as percentage reduction in symptom severity

PHQ Change, Baseline to First Follow-Up (~ 3 months)

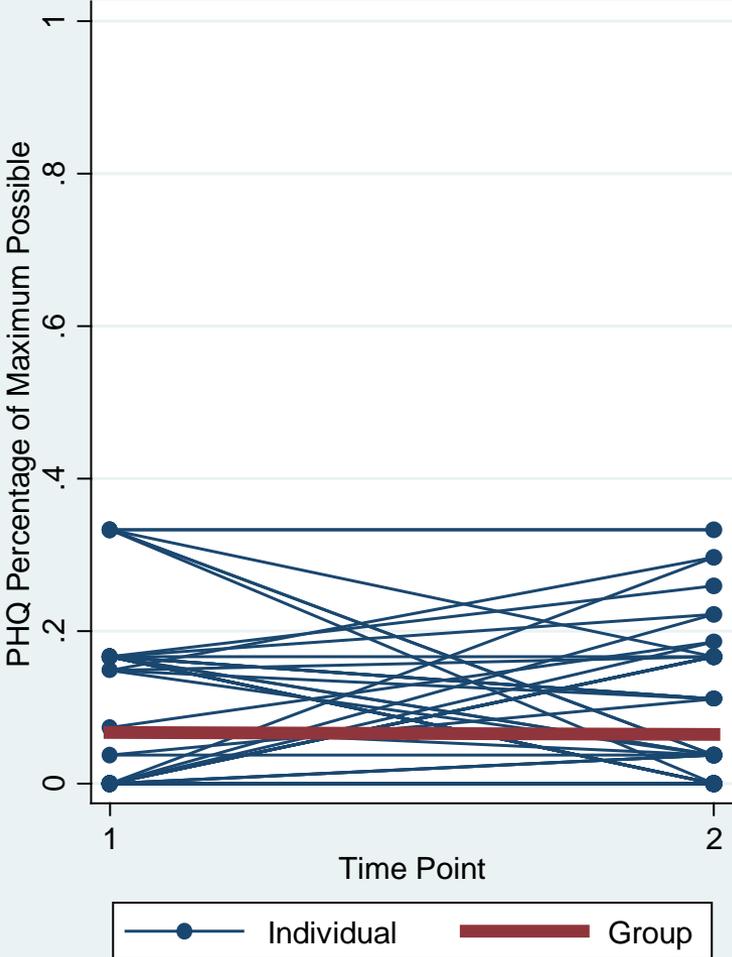
- Among those w/ pos PHQ, 28% reduction in symptom severity ($p < .001$)
- Among those w/ pos GAD, 35% reduction in symptom severity ($p < .001$)
- Similar results when restricting to those with initial mental health problem identified or initial dep/anx dx

Individual and Overall Group Trajectories for PHQ POMP

PHQ POMP Change, Initial Positive Screens

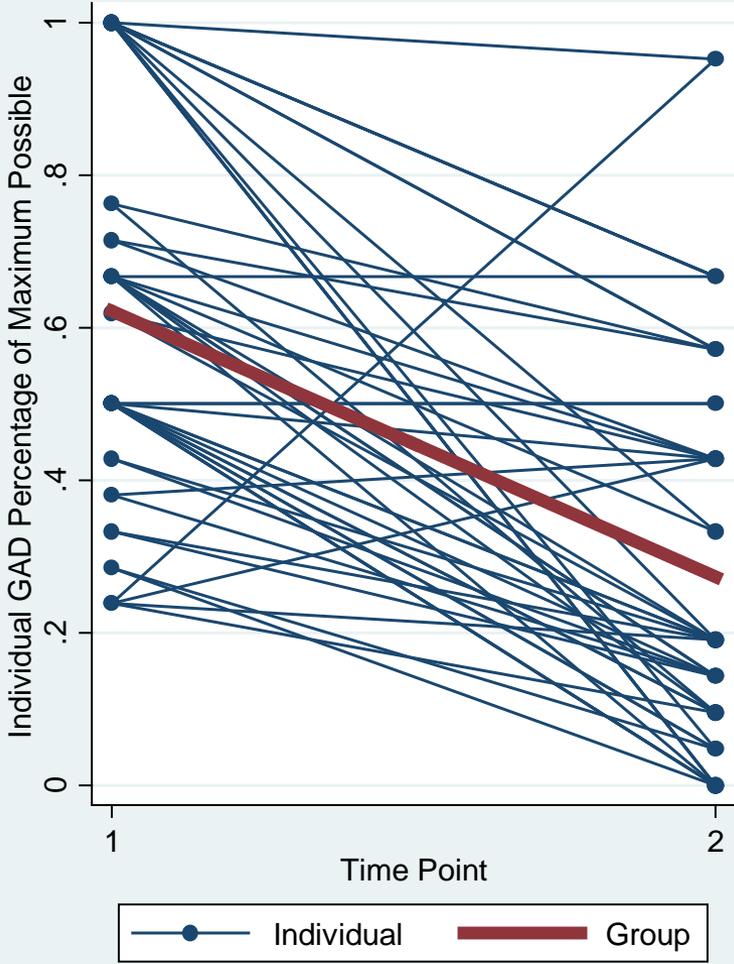


PHQ POMP Change, Initial Negative Screens

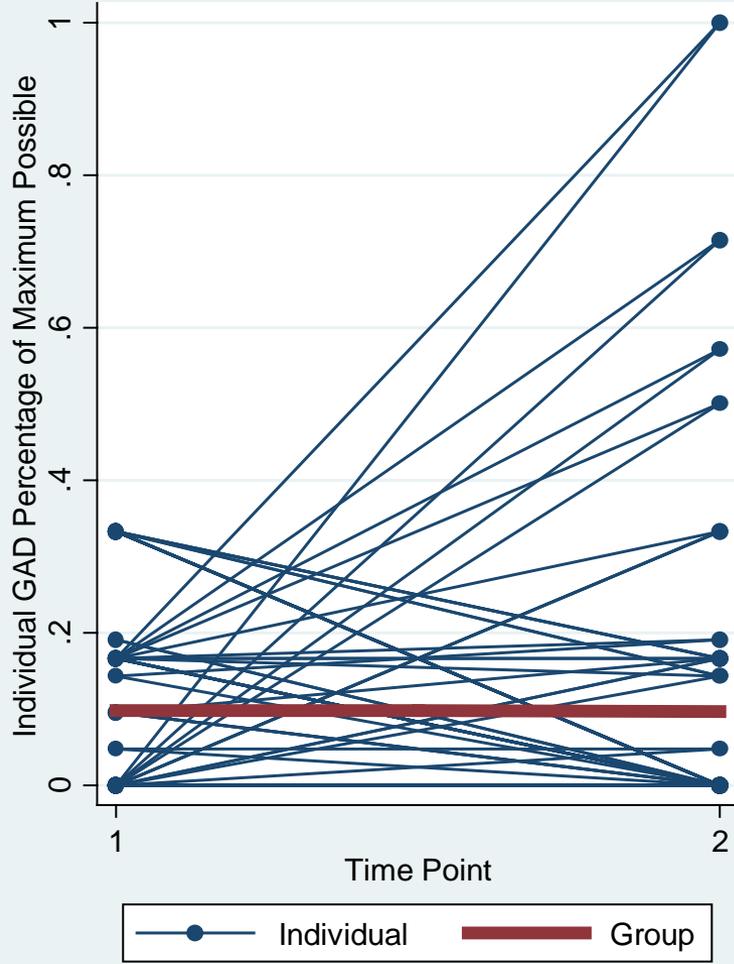


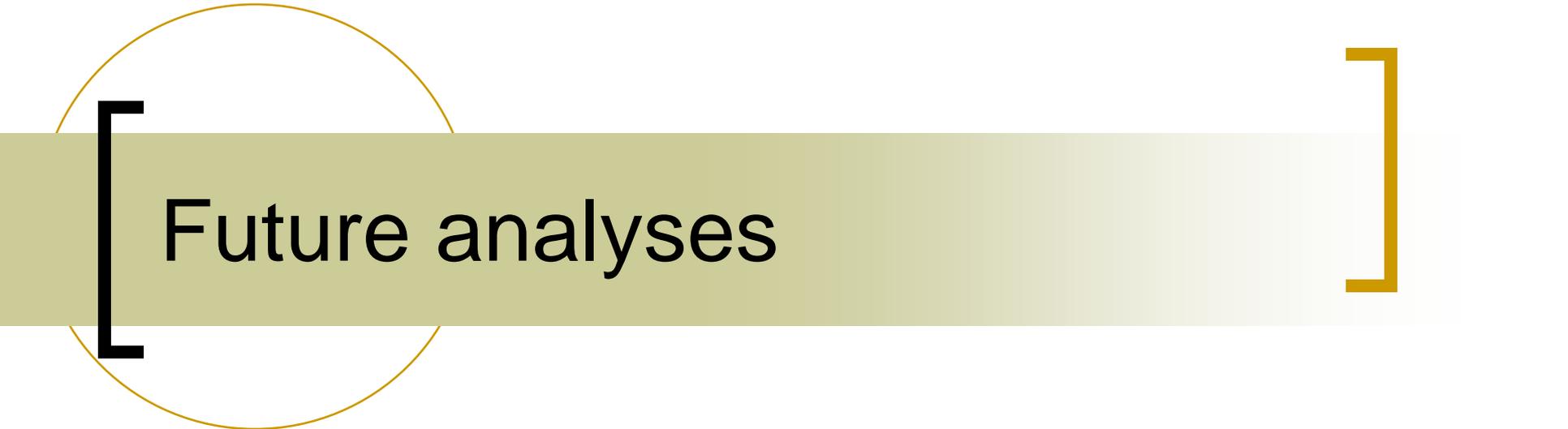
Individual and Overall Group Trajectories for GAD POMP

GAD POMP Change, Initial Positive Screens



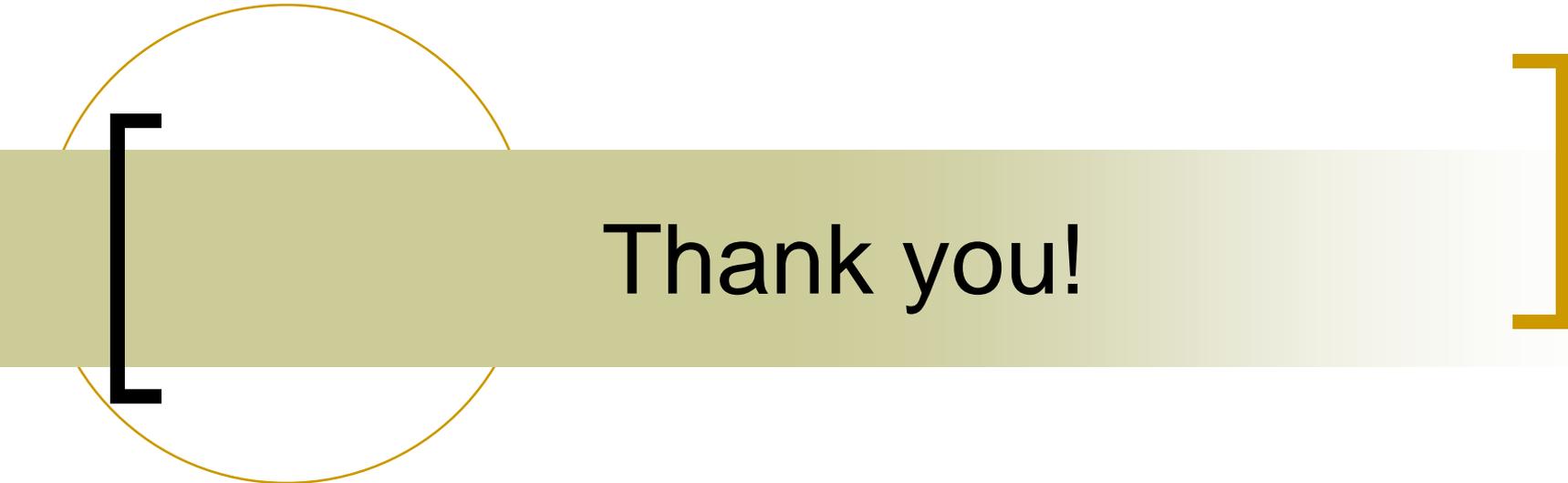
GAD POMP Change, Initial Negative Screens





Future analyses

...will continue to identify predictors of positive response in order to identify those for whom this model is most effective.



Thank you!

deborah_king@urmc.rochester.edu