

# BLUEPRINT FOR CHANGE

ACHIEVING INTEGRATED HEALTH CARE FOR AN AGING POPULATION



REPORT OF THE APA PRESIDENTIAL TASK FORCE ON INTEGRATED HEALTH CARE  
SHARON STEPHENS BREHM, PHD | PRESIDENT | 2007



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# **BLUEPRINT FOR CHANGE: ACHIEVING INTEGRATED HEALTH CARE FOR AN AGING POPULATION**

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A copy of the report is available online at: <http://www.apa.org/pi/aging/blueprint.html>.

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**PREFACE**  
**Sharon Stephens Brehm, PhD**  
**President, American Psychological Association, 2007**

One of the most interesting aspects of the American Psychological Association is that every year it organizes a large number of task forces (i.e., small groups, usually around 6 – 8 participants) that address a wide range of topics of interest to both psychologists and, often, the general public as well. Having served on the Finance Committee for two terms, I knew something about the task force system, since the funding for each of them is included in the APA budget. Nevertheless, when I was a candidate for the APA presidency, I was not aware that every president is provided sufficient funds to establish 3 presidential task forces during his or her presidency, should he or she wish to do so. What startles me now is that during my two years of campaigning for the presidency, I never had a single thought about these task forces.

But my ignorance ceased quite quickly the moment I was notified that I had been elected. Suddenly it seemed like everyone in APA, staff and members alike, was asking me what my presidential task forces would be doing. And everyone seemed to assume that I had a ready-made answer. When I said, “Well, I haven’t decided yet,” people usually looked puzzled -- or dismayed. So, I started thinking -- quickly -- about what just my task forces should focus on.

Fortunately, the topic of this task force, which was my first one, came to me very quickly. As a presidential candidate, I was already making speeches about the impact that the “aging of the boomers” would have on healthcare services and on our society (as well as on other countries experiencing a similar phenomenon). I was also intrigued by the concept of “integrated healthcare,” that is, the understanding that mind and body are interactive and the practice that combines a focus on both physical and psychological factors.

Obviously, all of these factors are interrelated. The combination of a spike in population and individuals living longer will produce an exceedingly large percentage of older adults. The first baby boomer cohort turned 60 in 2006, while the last cohort will turn 60 in 2024. During this period, the United States and other countries with a similar demographic pattern will confront the greatest incidence of age-related health problems, including dementia, in human history. I am absolutely convinced that the duration of the baby boom phenomenon and the magnitude of the resulting healthcare needs (psychological and physical) will cause a significant restructuring of the healthcare system in the US. I also believe that integrated healthcare, which will benefit enormously from advances in information technology, will become the standard approach to healthcare diagnosis and delivery.

But the single most important factor that led me to develop my first presidential taskforce was my family history. In 1978, my mother was diagnosed as having Alzheimer’s disease. Initially, my sister, who was our mother’s major caretaker, was concerned about our mother’s emotional state, thinking that our mother might be depressed because of our grandmother’s recent illness and death. When the family’s primary care physician examined our mother, he referred her to a neurologist to sort out whether our mother’s condition was psychological or physical. The neurologist determined that our mother had Alzheimer’s. A few years later, our mother

developed Parkinson-like muscle rigidity. Although medicine reduced the muscle rigidity, it also increased our mother's sleeping – to the point that she was sleeping far too much. Efforts to find a balance between the two was a continuing challenge.

Mother's illness and her needs for care had profound effects on my sister and her husband, who were in their mid-twenties when mother's condition was diagnosed. It was both a very sad and a very stressful time. Some of this stress was created by the difficulty of managing the care of a person with a chronic, incurable illness. Additional stress was created when not all medical personnel were as sensitive and helpful as they could have been. Indeed, my sister has likened her experience during our mother's five-year illness as "akin to post traumatic stress syndrome." And this stress continued right up to the end. When mother's physical condition worsened, she was admitted into the hospital. After it was clear that she was dying, my sister wanted to take her home, but the doctor would not approve. Ironically, mother's care (six weeks in a hospital, in a single room, all paid by insurance) seems quite extraordinary now. Based on her experience with our mother's illness, my sister emphasizes the need for better coordination of care and for treating people with Alzheimer's as individuals, not as a disease.

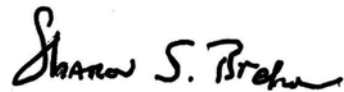
Overall, then, the idea for this presidential task force developed from personal experiences, demographic forecasts, and insights by both individuals and organizations that a piecemeal, uncoordinated approach to healthcare for older adults simply does not work. But the ideas and experiences that sparked the creation of the Integrated Healthcare for an Aging Population Presidential Task Force are only the beginning. The next step was to try to convince some extremely respected and busy individuals that it was worthwhile to participate in this effort to address the challenge of developing a more effective model for meeting the needs of our older adults now and in the future.

As I attended both of the two-and-a-half-day meetings of the Integrated Healthcare for an Aging Population Presidential Task Force and read the participants' steady stream of listserv emails, I have been awed by the expertise and dedication of all those who have participated in this endeavor. Antonette Zeiss, PhD, and Toni Antonucci, PhD, have been the world's best co-chairs. They have worked together with great skill and tremendous understanding of the many issues the Task Force has considered. The other members of the Task Force -- Gregory Hinrichsen, PhD, Deborah King, PhD, Peter Lichtenberg, PhD, ABPP, Martita Lopez, PhD, and Jennifer Manly, PhD – all have extensive and highly sophisticated knowledge about both the science and practice of integrated healthcare for an aging population, and their specific areas of expertise combine to complement each other very effectively. In addition, I, as well as all of the task force members, are most grateful for the outstanding work of Deborah DiGilio, Director of the APA Office of Aging, who served as the APA Staff Liaison and was a full partner in all of the Task Force's activities.

Not only has this task force been an inspiration to all those who have participated on it, but those who have learned about it have also been extremely interested in this endeavor. Whenever I describe the IHAP Task Force to various groups in APA and other organizations, the reaction is always one of full attention. It seems as though all of us are concerned about our own aging and the aging of those we care about, but we just haven't yet had the opportunity to speak freely. The

findings of the IHAP Task Force can help all of us articulate our concerns and cope more effectively with the actuality we face.

Based on this interest in and the quality of the task force's work, I believe that this task force will make a significant contribution to helping our country (and perhaps other countries as well) respond more wisely, effectively, and compassionately to what is clearly a major healthcare crisis. Usually, when you wade out into the ocean, you don't know exactly when a wave will roll in, and it's often hard to estimate, from a distance, how large a wave is coming at you. But in this case, we know when and where this wave will hit the shore, and our projections of its size are likely to be reasonably accurate. The IHAP Task Force Report has sounded the depths and it brings back vital knowledge for use in meeting the needs ahead. Let us hope that our colleagues, our fellow citizens, and our leaders will listen.

A handwritten signature in black ink, reading "Sharon S. Brahm". The signature is written in a cursive, flowing style.

## **Executive Summary**

The Blueprint for Change: Achieving Integrative Health Care for an Aging Population is the product of Dr. Sharon Brehm's 2007 APA Presidential Task Force which was created to address the challenge of how health care can best be planned and delivered for older adults. Our simple answer is: through integrated health care. This report outlines the challenges to providing integrated health care as well as some proposed solutions. The report also reviews both theoretical and practical issues. It ends with an appendix of additional resources and how to access them.

**Chapter 1: Overview.** This chapter begins by highlighting the demographic imperative facing the United States. The number and proportion of older adults are growing rapidly. Older adults are and will increasingly be from diverse populations and life circumstances. Our current health care model does not adequately address the needs of older people. Unless we are creative about how we meet these needs, older individuals and their families will be underserved, poorly cared for, and at risk of increased and unnecessary health care problems. The Blueprint is designed for psychologists in practice, training, research, and policy. We believe the Blueprint is also useful for non- psychologists.

**Chapter 2: The Broken Healthcare System for Older Adults.** Our health care system is predominantly individualistic and individual provider-patient based. There are many problems with this approach but it especially puts older people at risk. In a hierarchical resource-limited system, older people are disadvantaged by care which is not sensitive to multiple morbidities, life span experiences, fragmented care, marginalization, ageism and stigma as well as unique characteristics such as age, gender, class, race, religion and ethnicity.

**Chapter 3: A Basic Model of Integrated, Interdisciplinary Health Care.** The integrated health care model is presented in this chapter. Core concepts include the usual characteristics of care, i.e., individual assessments and individual delivery of care. What is unique about the Integrated Care Model is the sharing among team members of information and team goals, as well as team development of an intervention plan, strategies of care, and implementation. This interdisciplinary team should have team membership that includes the professionals identified as appropriate for specific circumstances. Teams may have problems of territoriality to overcome but when handled well, this leads to an integrated, shared approach to planning and decision-making.

**Chapter 4: Knowledge and Skills that Psychologists Contribute to Integrated Health Care.** Each team member will make unique and sometimes overlapping contributions. In this chapter we focus on psychologists who contribute their knowledge of aging and adult development to clinical issues. This knowledge will be especially useful in the differentiation of normal from pathological changes associated with aging. Further, geropsychological acumen is useful in clarifying which clinical problems may be reversible such as those caused by other treatments or medications. Psychologists can conduct cognitive, capacity, diagnostic, and personality assessments. Psychologists can assess other problems seen in older adults such as mood or anxiety disorders, suicide, and psychotic symptoms. As part of the team, psychologists should be proficient in adapting assessment methods and interventions to fit the setting. It is most useful if



psychologists are familiar with a variety of intervention approaches and are knowledgeable about the most successful treatments of both physical and mental disorders. As members of an integrated health care team, psychologists are encouraged to offer consultation to family members, significant other close relations, and to other professionals. And, finally, psychologists should be sensitive to individual and community characteristics, and whenever possible apply up-to-date research findings and evaluation techniques to the problems at hand.

Chapter 5: Principles of Integrated Health Care. The eight basic principles of integrated health care are presented. These include: sensitivity to ageism; familiarity with the roles of other health care team members; respect for differences in health care processes and beliefs among team members; awareness and productive treatment of conflict among team members; use of conflict resolution skills; receptivity to increasingly diverse forms of communication (e.g. virtual teams) within health care teams; sensitivity to issues of multicultural diversity and marginalization; and the need to offer ongoing assessment of treatment and treatment outcomes.

Chapter 6: Interdisciplinary Collaboration in Diverse Sites of Care. Health care delivery often occurs in multiple settings. It is likely that the health care team will function differently according to the site, although mutual respect and communication are critical in all sites. Examples of different settings include primary care, specialized medical settings such as rehabilitation units, cardiology or surgical centers; long term care settings and community oriented social service settings. Opportunities for selective and universal prevention should be a goal of all interdisciplinary health care teams.

Chapter 7: The Older Consumer's Perspective on Health Care. This chapter takes the older health consumer's perspective on health care. Health literacy is highlighted since it is clear that there is great variation in how much older people understand their health problems and the health care delivery system. The importance of attending to issues of patient satisfaction with and expectations about health care is noted, as is the likelihood that there may be large differences in each older persons' preferences for care. Since marginalization may be more prevalent among older people than other age groups, attention should be given to disparities in health as well as preferences for and access to care. Several suggestions are offered for how to improve older adults' knowledge of and access to health care.

Recommendations: This final section offers recommendations for future APA action. Over forty recommendations are identified within five subgroups: research; education and training; practice; public policy; public education and awareness. Recommendations are not prioritized since each recommendation has merit. Priorities will vary in different contexts for those supporting, providing, or receiving health care. Nonetheless, we believe all recommendations need to be implemented. Given the limited life of President Brehm's Task Force, we are pleased that the APA Continuing Committee on Aging has agreed to assume the responsibility for exploring how best to encourage the implementation of these recommendations.

## Chapter 1

### Overview

We face a demographic imperative: the population of the United States is aging, and the proportion of older adults is growing rapidly. This is not a bad thing - people living longer is a good thing. However, it does pose challenges. This Task Force was created to address one such challenge: how can health care best be planned and delivered for older adults? Our answer is to advocate for integrated health care. Integrated health care refers to an approach in which older adults' needs are treated holistically. Multiple professional disciplines collaborate actively with each other as well as with the patient and the family in assessing each patient and then planning and delivering coordinated care.

Advocating for integrated health care is a complex task. Clearly, other professions need to be involved in many ways and at many stages for developing models for such care. However, since this Task Force is created as part of an APA Presidential initiative, we decided to start the complex process of working toward collaborative care by creating the *Blueprint for Change: Achieving Integrative Health Care for an Aging Population* for psychologists. We have many goals for this *Blueprint*. We want to speak to an audience of psychologists first and foremost, and to help them begin to think about how their work could be informed by the integrative care ideas laid out in this report. We believe this report is relevant for all psychologists, i.e., those who are researchers and academics as well as those who are clinicians and service providers. We believe all psychologists have a critical role to play in the achievement of integrated care for an aging population. While we address many issues, we also recognize that there are multiple follow-up tasks that flow from this report, but are beyond the scope of a one-year Task Force.

Support for the concepts of integrated health care and interdisciplinary teams is not new to APA. Most recently in 1998, the Education Directorate prepared a report, *Interprofessional health care services in primary care settings: Implications for the education and training of psychologists*, for the Substance Abuse and Mental Health Resources and Services Administration and Health Resources and Services Administration. As noted in the report, one theme that emerged was that “considerations about professional education, training, and practice in primary care roles and settings must be framed by a collaborative interprofessional model of service.” In 2001, in acknowledgment of the inextricable relationship between mental health and physical health, the APA mission statement was amended to include health, and currently reads: “The objects of the American Psychological Association shall be to advance psychology as a science and profession and as a means of promoting health, education, and human welfare...” In 2005, Council adopted the Health Care for the Whole Person Statement of Vision and Principles, a product of the Health Care for the Whole Person (HCWP) presidential initiative of Ronald F. Levant, EdD, ABPP. The Statement notes: “There is abundant scientific evidence that behavioral, psychological, spiritual and psychosocial factors are significant determinants of health status, healing and health care utilization for all ages, including older adults.”

The *Blueprint for Change: Achieving Integrative Health Care for an Aging Population* was informed by and builds upon this history to propose a model that represents the best care for older adults and to describe psychology's role in that care. Our fundamental task is to lay out a model that represents the best care for older adults and to describe psychology's role in that care.

This will be an aspirational model, and it is presented clearly as such. There are many challenges that make it difficult to provide such care to all older adults, given the current status of health care in the United States. However, this model has been attained in many settings: in various care sites for the Department of Veterans Affairs, in many long term care settings, in many geriatric primary care sites, in rehabilitation settings, and others.

In addition, there is good news on the horizon that will make it easier to implement an integrated care model in many sites. Until recently, Medicare did not allow psychologists to be reimbursed for many of the activities that are necessary for interdisciplinary, integrated care, such as team discussion time for development of a treatment plan and following up with other health care providers about a medical problem found in the course of psychological care. However, there are new team conference CPT codes that will be available for use as of January 1, 2008, that will allow non-physicians, including clinical psychologists, to bill for these types of services. The two new codes can be used for team conference services when to capture participation of healthcare providers, in meetings at least 30 minutes long, that involve interdisciplinary professionals from at least three disciplines, and in which there is discussion to assess a patient's care plan and progress. The new team conference codes, 99366 and 99368, are meant to be used by non-physician practitioners. Similar CPT codes have been available, but could be used only by physicians.

Thus, while we recognize and will address, to some extent, challenges faced by psychologists who want to provide their services in an integrated care context, we believe that presenting a model that pushes beyond standard care, but has been accomplished and could be expanded, is the appropriate goal for this report. We encourage readers of the report to think about how the approach described could expand and improve their work with older adults and other disciplines that are also involved in the care and treatment of our nation's older adults. We encourage readers to think about how they could change their approach to practice, training, research, and policy in their organizations, or other professional activities, to support implementation of this integrated care model.

The intent of the *Blueprint* is to provide guidance for psychologists to be effective in contributing to, joining, and creating integrated care teams. To do that, we first describe the problems in current care for older adults: fragmented care; care that is not available at all for many older adults (let alone in optimal form); care that is not adequately sensitive to diversity in older adults; and a lack of sharing and understanding across the professions whose mutual skills, interests, and abilities are essential for holistic care. We then describe a basic model for providing integrated care that is simple, but can be elaborated to fit diverse contexts. Further chapters lay out the skills that psychologists bring to integrated care, and how the basic model of integrated care can be applied in a variety of specific health care settings. We also explore how this model of care builds upon the accumulating empirical evidence provided by research in this field as well as how it fits with the expectations for care of older adults. We further describe how the model can be used to empower older adults and support them in demanding improved health care.

This is not a "how to" manual, with specific, step-by-step detail on developing or improving integrated care. Its goal is to encourage readers to think about their possible role and

contributions to integrated health care for older adults. Exactly as the title suggests, it is a “blue print”; it provides a clear drawing of the house that could be built and the amenities it would contain, but a contractor would need much greater detail to order the materials and adapt the blueprint to a specific site. Readers will be directed to other “how-to” resources for additional information.

We recognize that readers will have varying levels of expertise in working with older adults and in working collaboratively with other health professions. Some readers will find that this report simply confirms what they already knew about optimal care for older adults; other readers will have experience with aspects of the report, but find new concepts they can apply. We also hope and expect that some readers will find themselves drawn to a model of care that is new and different for them, to conduct research that addresses the specific issues raised by this model, and to work with a different population than they have previously. We hope this *Blueprint* can speak to all these groups.

As suggested above, this *Blueprint* is designed to have relevance for psychologists in practice, training, research, and policy. We consider the multiple ways within psychology of approaching integrated health care for older adults. Thus, professional practice will be a major focus. Changing care to prepare psychologists for work in integrated health care settings, rather than in more isolated practice primarily with other psychologists, suggests important challenges to training models for professional psychology. In addition, recognizing that it is essential to prepare for the rapidly burgeoning population of older adults directly challenges many current training settings to include more content on aging. The approach presented also offers important research opportunities. While there is already much research to support this approach, there are many unanswered questions and many findings, both basic and applied, that invite further exploration. Finally, psychologists in policy contexts should be an important audience for this report. Change requires advocates at many levels. Psychologists can work in many contexts to promote change. They can work at their academic settings to promote changes in training; they can work in public health care settings to advocate for better, more integrated care; they can work with the political process locally or nationally, independently or in concert with APA.

We hope this *Blueprint* will also have personal value to psychologists. Many of us, and family members of all of us, are part of the growing population of older adults. We hope that the model of care we present will be valuable to psychologists on this personal level, as they become members of the aging population and as they find themselves the caregivers or significant others of close family and friends who would benefit from integrated health care. Psychologists need to expect and demand to receive effective health care themselves, as well as for their patients. That care will best be provided by a system that is holistic and integrated, rather than isolated and fragmented. Entering the care system as a patient is difficult – one is vulnerable at the time, and the system is set up to function without asking what the patient wants. It takes great assertiveness and a clear vision of the care that should be offered to speak out and become an active participant in one’s care, rather than a passive recipient. We hope that this *Blueprint* can help develop that vision and lend strength and courage to psychologists as they and their aging family members need health care.

While we strive to accomplish a great deal with the *Blueprint*, we also believe that we will be starting a process, rather than completing every possible task in promoting integrated care. In many ways we hope to be sowing the seeds of a health care revolution. Specifically, there will be many other possible products and activities to support integrated care for older adults that are not part of the *Blueprint*. Work on these additional products and activities can follow and expand on the work in this Task Force report. Some of these are suggested below; we hope that readers will have additional ideas.

Many of our ideas for future efforts are specifically for psychology. These include development of a Fact Sheet for psychology faculty and training directors on integrative care models and opportunities that include suggestions for training. Similarly, a fact sheet for students in professional psychology could provide guidance on how to shape and develop a career that would emphasize care in integrated settings. Psychologists could develop a research agenda of the most important issues about which we need empirical evidence, that could emphasize the importance of thinking through the application of basic research findings for improving the health care of the aging population, and promote activities that would expand our knowledge of the impact of integrated care as well as the processes that lead to best clinical outcomes.

There are important other audiences that psychology could serve as well. Fact sheets for consumers on how to better navigate the current health care system and create one's own integrated team could be invaluable. Fact sheets could be developed for caregivers on the importance of integrated care for their care recipients and offering steps to work with health care providers to better integrate care for their loved one. A briefing sheet for policy makers on integrated care and the importance of psychologists as part of the interdisciplinary team could be developed and serve advocacy roles effectively.

Finally, returning to our opening point, psychology cannot single-handedly create integrated care. We on the Task Force have reached out to other professions and have encouraged them to comment on our work and to coordinate our work with their own efforts to promote integrated care. As an example, there is currently a strong movement and support for interdisciplinary research with a recognition that such integrated efforts are often more fruitful than isolated or single-disciplined ones. Such efforts must continue and be expanded. Psychology can work with other professions in integrated care to develop fact sheets for a variety of disciplines. These could include what benefits they would experience from becoming involved in an integrated care model, evidence of improved care for their patients when utilizing an integrated care model, and how to use effectively the expertise of psychologists as team members. In addition, we have much to learn from other professions, about their roles in health care, for example, about their understanding and misunderstanding of what psychologists offer, about their research on older adults, and about the challenges they face in trying move to a more effective system of providing care.

We turn now to laying out the *Blueprint*; we hope it will offer new ideas and stimulate new directions for psychology. As you read, if you find that there are actions or ideas we do not fully cover, we invite you to become a part of the ongoing efforts we hope this Task Force report will stimulate.

## **Chapter 2**

### **The Broken Healthcare System for Older Adults**

The current health care system in the United States presents multiple limitations in providing quality care for older people. Despite the fact that 36% of all expenditures are for people age 65 and older (Keehan, Lazenby, Zezza, & Catlin, 2004), the quality of care provided to older adults for many medical conditions is poor (Wenger et al., 2003b). Research has revealed low-quality care among elders for conditions such as cardiovascular conditions, pneumonia, cancer, and diabetes, but also cognitive impairment, falls, urinary incontinence, end-of-life care (Wenger et al., 2003a), and mental illness (Bartels, 2003). There are significant disparities in access to care and quality of care based on income, race/ethnicity, and insurance status (Gauthier & Serber, 2005).

Our individualistic, physician-patient based health care (Harris, Jr., 1996) exacerbates the many ways in which older people are vulnerable to a fragmented system. Health care professionals with paternalistic orientations and competing demands on their time, outdated systems of manual record-keeping, and the increasing burden of chronic and acute medical conditions in old age all combine and lead to learned helplessness and disempowerment in the health care system (McWilliam, Brown, Carmichael, & Lehman, 1994). Healthcare is often provided in isolated settings, and is reactive rather than focused on prevention and promotion of wellbeing (Epstein & Sherwood, 1996).

The broken system is especially evident when examining mental health services for older adults. There is increasing evidence of bidirectional causality in the influences of psychological and medical processes (Speer & Schneider, 2003) and older adults are more likely than younger adults to have comorbid physical illness and mental disorders (Lebowitz & Niederehe, 1992). However, older adults do not seek out mental health services, especially services available in traditional mental health settings such as mental health hospitals or clinics, counselors, and private offices (Demmler, 1998). Instead, they typically seek treatment for mental health issues from primary care physicians (e.g., Burns & Taube, 1990). Evidence suggests that coordinated care which integrates psychologists and other mental health providers within primary care settings can enhance access to services, quality of care, and lower overall healthcare expenditures (Katzelnick, Kobak, Greist, Jefferson, & Henk, 1997; Katzelnick et al., 2000; Strain et al., 1991). Despite their demonstrated efficacy, Medicare financing and other billing policies do not support such integrative care practices (National Council for Community Behavioral Healthcare, 2006), although, as noted in Chapter 1, some more promising policies will soon be available.

Also, as noted in Chapter 1, the United States faces an unprecedented aging population. The United States is familiar with an older population that belongs to a mainstream culture and is English-speaking, with immigrants primarily from European countries. In the near future, however, we will face an older population of immigrants from Middle Eastern, Latin American, and Asian countries whose diverse language proficiencies may not include English and whose life experiences, beliefs, family function, traditions, and reactions to the traditional healthcare system may differ from the mainstream. Diversity of the older population will not be limited to

cultural background; we must be prepared for heterogeneity in a number of critical areas, including health status, sexual orientation, gender identity, gender expression, disability, availability and involvement of family members as partners in care, physical activity, occupational status, educational background, financial resources, knowledge about technology, and trust of mental health professionals. These older people will have significantly different life span and life course experiences. Health care providers must understand and competently manage these rich cohort differences. For example, “familial support” in a context of heterogeneity includes “families of choice,” which are often used in lieu of family of origin for many older gay and lesbian adults. Further, for many minority groups, familial support extends beyond the immediate family system. When working with minority families in integrated care, it is important that providers be as inclusive of the extended family system as possible.

One purpose of this Blueprint is to suggest how psychologists on integrated teams can facilitate and optimize the health care received by this extraordinarily diverse and growing population of older adults. In order to more fully contextualize the issues that frame this discussion, three brief case examples are presented of the broken system for older adults and the difficulty older adults and their families have in negotiation and navigating this non-system. These case examples are very brief illustrations and not exhaustive. Other case examples will be presented in subsequent chapters. The cases combine aspects of real cases, and the names and some other personal information are fictional. Nonetheless, Task Force members concur that the cases presented are exemplary of the complex situations presented by older adults who would be best served by an integrated health care system, rather than the typical care described below. Examples in later chapters will provide a picture of how care can be improved when health care professionals work in an integrated way.

### **Case Example 1**

Mrs. Garcia is a 54-year-old monolingual Spanish-speaking woman who completed 6 years of school in the Dominican Republic, where she was born and raised. She immigrated to the United States in 1985 at age thirty-seven. She was divorced from her husband five years ago, has three adult children and five grandchildren, and lives alone in a one-bedroom apartment in the Washington Heights section of Northern Manhattan. She is currently on disability from her job as a home health care attendant. She has been diagnosed with diabetes, glaucoma, nephropathy, and hypercholesterolemia and she takes medications for these conditions. Mrs. Garcia leaves her apartment at least three times a week, on Monday, Wednesday, and Friday, to eat lunch at a congregate meal program at her church, which is two blocks away.

Over the last several months, the attendants at the congregate lunch noticed that Mrs. Garcia attended less frequently, and when she appeared, she was uncharacteristically disheveled. On two occasions, she stumbled while navigating the lunch tables, reporting that she was dizzy and her vision was blurred. The attendants suggested that she visit her primary care physician, but Mrs. Garcia replied that the office was on the East side, too far away from her apartment. The attendants asked that Mrs. Garcia return on the day that nurses conduct “Health Maintenance Clinic” for people attending congregate meals (the first Tuesday of every month). However, Mrs. Garcia “forgot to come” on the first Tuesday of the month for two months in a row. Mrs. Garcia did not seem concerned about the missed appointments, reporting that she had sought out a

*curandera* who lived in her neighborhood, who used herbs to “cleanse” her of illness. The meal program coordinator called Mrs. Garcia’s daughter, who was listed as her primary contact.

The daughter translated for her mother during visits with the nurse, then her primary care physician, and finally a neurologist, but none of these providers had access to the records of the others. All of the visits revealed changes in Ms. Garcia’s ability to keep track of her medications and control her glucose levels, causing hyperglycemia and other complications of her diabetes. The neurologist called the daughter and recommended that Mrs. Garcia have a neuropsychological examination and that she see a psychologist for her anxiety. The bilingual receptionist at the Memory Disorders Clinic attempted to schedule neuropsychological testing with Mrs. Garcia, but her insurance did not cover the testing and the family could not afford to pay out of pocket. One week later, the daughter called the office to report that Mrs. Garcia refused to go to a psychologist because she thinks that only “crazy” people go to these doctors. The daughter tried to convince her to return to the neurologist but she refused, saying “I did not like the way he treated me.”

## **Case Example 2**

Mrs. Ruttger is an 81-year-old non-Hispanic White English-speaking woman who lives alone. She was born and raised in Michigan and lived in a home near Clara City, Minnesota, on the farmland she owned for 35 years. She attended two years of college in Grand Rapids, Michigan, where she met her husband; he died from a heart attack 17 years ago. The couple had no children. After her husband’s death, Mrs. Ruttger arranged a farming partnership with the owners of the adjacent family farm (Judy and Thomas Schatt). Mrs. Ruttger took no medications and was in good physical health, aside from prior surgery for breast cancer at age 69.

After the death of Mrs. Ruttger’s sister, Judy and Thomas noticed that Mrs. Ruttger was not as engaged or outgoing as usual, and that she lost interest in the business operations of the farms. Fearing that Mrs. Ruttger had become depressed, Judy brought her to see her primary care physician (PCP). The PCP referred Mrs. Ruttger to another physician, a “specialist” in the nearest town, for follow-up. When Mrs. Ruttger and Judy later arrived at the specialist’s office, Judy was surprised to learn that the “specialist” was a neurologist and not a psychiatrist. After a full neurological exam and mental status testing, the neurologist diagnosed Mrs. Ruttger with Alzheimer’s disease. The neurologist told Judy that Mrs. Ruttger would probably live only another 5 or 6 years.

Mrs. Ruttger became more passive as her dementia progressed, and soon Judy and Thomas needed someone to attend to Mrs. Ruttger during the day. Neither the primary care physician nor the neurologist knew of resources for them to find home health care, and insurance carriers did not offer home health care for her condition. Judy finally identified home health care providers from the Yellow Pages for a small town about 20 miles away. Mrs. Ruttger developed muscle rigidity during the final years of her life. The neurologist prescribed Cogentin. The home health care provider began to notice that immediately after beginning this medication, Mrs. Ruttger’s condition significantly worsened. Judy called the neurologist’s office and was asked by the receptionist to “write the doctor a letter” about her concerns. Judy was upset by this response and felt that the neurologist had “given up” on Mrs. Ruttger because her condition was not going to



improve, and was not even willing to adjust the dosage of this medication in order to improve Mrs. Ruttger's quality of life.

### **Case Example 3**

Mr. Jewell is a 66-year old African American man with 8 years of education who worked in construction until five years ago. He lives in a condominium with his domestic partner, William, in Long Beach, California. Mr. Jewell has two sons by his previous marriage, and William has a 30-year-old daughter who moved in with the couple a year ago with her newborn daughter. Six years ago, Mr. Jewell was diagnosed with congestive heart failure. He has a history of hypertension (since age 45), had a heart attack at age 52, and had a pacemaker implanted four years ago. William is Mr. Jewell's primary caretaker, which now involves helping Mr. Jewell move safely around the condo and manage his medications. Mr. Jewell's medications are beta-blockers, a diuretic, and digoxin. Mr. Jewell had multiple hospitalizations over the past two years, as well as three emergency room visits in the past two months due to painful swelling in the feet and ankles and shortness of breath.

During the most recent ER visit one month ago, the physician told Mr. Jewell and William that he was in "Stage D" of CHF and was surprised that his regular physician had not prescribed an ACE inhibitor. An ER nurse recommended that it was time for Mr. Jewell and William to consider hospice care, and gave the names and brochures for several palliative care networks. After that ER visit, William and his daughter noticed that Mr. Jewell was frequently tearful and no longer interested in cooking, which was his favorite activity, or playing with his granddaughter. William had regularly taken Mr. Jewell to the Shoreline path and Marina for walks, but now his partner refused to go, saying that he was in too much pain. William noticed that even though he had previously needed to keep close tabs on his partner to try to prevent him from sneaking out to the patio to smoke a cigarette, he was now disinterested even in this long-time addiction.

Four months later, William brought Mr. Jewell in to the ER and reported that his partner had not eaten for four days, had been vomiting, had diarrhea, and was seeing yellow halos around objects. Diagnosed with digoxin toxicity, he was hospitalized and treated with Digibind, which relieved his symptoms. In the hospital cafeteria, William and his daughter spotted the ER nurse who had previously recommended hospice care. William told the nurse that he was worried that he would soon be unable to continue to care for Mr. Jewell on his own and that his partner's spirit seemed to be ebbing. The nurse asked whether they had followed up on the hospice information; William seemed angry, saying, "Why are you people trying to kill him?" William said that it was their wish to continue to care for Mr. Jewell at home, and that they wanted to continue to pursue lifesaving measures, such as heart transplant and life support. The nurse explained that hospice care could take place in the home, and that the goal of palliative care was to relieve pain and suffering, not to hasten death. William said he would discuss it with Mr. Jewell, but ultimately they decided that they would be uncomfortable with a stranger in their home.

### **Summary and Definitions for the Blueprint**

The case examples demonstrate only a small subset of the challenges that face older people as they encounter the current health care system. However, there are some common themes that can help to frame the issues that the following chapters of this Blueprint address.

#### *Older people facing multiple disorders*

Each of the older adults in the case examples faced acute health crisis episodes on top of chronic conditions. This is common among older people, and illustrates the utility of integrated care. In fact, if only one condition were to present itself at a time, integrated care would not be as critical, though for disorders that are chronic or intrinsically complex, it would still be the optimal model of care. However, it is the norm for older people to have comorbid conditions and, as discussed above, for the link between physical function and psychological function to be significant. The concept of *excess disability* is integral to judge the effectiveness of integrated care in improving overall quality of life among older people. Excess disability occurs when older people with severe and persistent medical disorders have worse functional impairment than would be expected given the severity or stage of their illness (US Department of Health and Human Services, 1999). In the case of Mrs. Garcia, her anxiety was interfering with her ability to manage her diabetes medications, causing an overall deterioration in her health and level of independence. Mr. Jewell's depression was a factor in his withdrawal from activities that maintained his function, despite his advanced stage of heart failure.

#### *A fragmented system*

Each case highlights the confusing, segregated, and disconnected array of services and providers involved in health care of older people. Services are available in a dizzying number of settings, such as hospital-based or private primary care offices, emergency rooms, community centers, nursing homes and other long term care settings, in-home care, churches, mental health clinics, and hospice care. There is little communication between providers in order to maximize treatment plans, and there is lack of knowledge about the roles of other potential members of the team. For example, the neurologist treating Mrs. Ruttger was unaware of services that would provide in-home care for Mrs. Ruttger, and once in place, the physician did not effectively participate in the team by attending to the flow of information from the home care provider and modifying his treatment in order to maximize Mrs. Ruttger's quality of life. There is overemphasis on reactively treating the flare-ups of immediate symptoms of an illness, without coordinated efforts to emphasize wellbeing and prevention of disease and disability. In an integrated care setting, Mr. Jewell's frequent emergency room visits may have triggered an interdisciplinary assessment of the issues underlying his rapidly worsening condition. One can also imagine that Mrs. Garcia's crisis may have been entirely preventable had a model emphasizing prevention and the whole person been applied to her diabetes self-care. Many older people and their families, faced with a health crisis and a background of chronic disease, are unable to navigate this system successfully and become frustrated and disempowered (Administration on Aging, 2001).

#### *Diversity interacts with the fragmented system to create marginalization*

Each case provided examples of how culture interacts with a fragmented health care system to create formidable barriers to improving quality of life. All older people possess culture; culture is

not unique to immigrants or ethnic minorities. One critical aspect of culture is age itself. Older adults are not a homogeneous group with similar needs and capacities. Psychologists participating in integrated care must have explicit knowledge about intra-individual differences in aging, including age cohort differences among older adults. Diversity in the aging process itself was exemplified by Mrs. Garcia and Mr. Jewell, who are relatively young, yet have multiple chronic health problems that interfere with their function. Older age does not necessarily coincide with declines in physical and cognitive function, and behavioral and social factors play a part in the relationship between chronological age and biological age (Seeman et al., 1995). It is possible that marginalized groups experience accelerated aging in which biological age is greater than expected at a given chronological age. There also may be unique issues for persons living with a chronic illness who are now approaching the later stages of life, such as persons living successfully into old age with HIV.

An uncoordinated health care system is vulnerable to unnecessary disparities in health among certain social groups based on age, race, ethnicity, culture, socioeconomic status, gender, sexual identification, body shape, immigration, and physical disability (Abramson, Trejo, & Lai, 2002; Banks, Buki, Gallardo, & Yee, 2007). Common barriers were demonstrated in the case of Mr. Jewell, whose family shared fear and misperceptions of hospice care and in the case of Mrs. Garcia, whose care suffered from lack of bilingual and bicultural staff. The perspective of this *Blueprint* is that we cannot assume whether an individual is marginalized in the health care system based on race, gender, poverty status, etc. However, when providers do not communicate, and when the system does not acknowledge the connection between physical and mental health, health disparities will occur. In other words, a fragmented system of health care can exacerbate the association between diversity and marginalization.

#### *A life course perspective is needed*

A life-course perspective illuminates the fact that older adults have been exposed to conditions that will profoundly influence their social, psychological and health statuses from childhood to old age (Baltes, 1987; Barresi, 1987; Jackson & Sellers, 1996). Although older adults may present for acute issues, health care should be organized around the reality that the aging process is dynamic, and it should build in the opportunity to develop long term plans as well as assistance for acute and post-acute stages.

#### *Ageism also contributes to marginalization*

Mrs. Garcia's primary care physician may have assumed that because of her age, disability associated with her diabetes was to be expected, and that interventions to increase her ability to manage her medications would be ineffective. Mrs. Ruttger's neurologist disengaged once the diagnosis of a progressive neurodegenerative disease was made, and he withdrew from the process of improving her quality of life and that of her caregivers when he determined there was "no hope, no cure." Perhaps the assumption that older people will be physically and mentally frail underlies the persistent de-emphasis on prevention of disability that is exacerbated by the structural and financial underpinnings of our health care system.

#### *Stigma associated with mental illness must be considered*

Older adults are less likely than younger persons to self-identify mental health problems or seek specialty mental health services (Mickus, Colenda, & Hogan, 2000). This has multiple environmental influences, as family members and professional providers may share the misperception that mental disorders are a "normal" part of aging (Gallo, Ryan, & Ford, 1999). The stigma associated with receiving mental health services must be balanced with the attempt to provide care for psychological and cognitive disorders within a primary care or community-based setting (US Department of Health and Human Services, 1999).

*Anybody can be a saboteur of integrated care*

The cases also illustrate that any member of the health care team can potentially present barriers to effective collaborative health care. Physicians, nurses, social workers, psychologists, insurance companies, Medicare, the family, and older adults themselves are all possible disconnection points for the flow of information and respect that is the basis of successful integrated care.

### **Selected Definitions for the Blueprint**

**Excess Disability ...**Refers to discrepancy in expected level of functional disability among older people with severe and persistent medical disorders given the severity or stage of their illness.

**Diversity ...** Heterogeneity among people with respect to factors such as age, race, educational background, language, racial socialization, cultural background, socioeconomic status, gender, disability, sexual orientation, religion and spirituality which influences identity. Individuals have multiple identities which interact with each other

**Marginalization.....** The process by which individuals or social groups are overtly or covertly excluded and relegated to a lower social standing

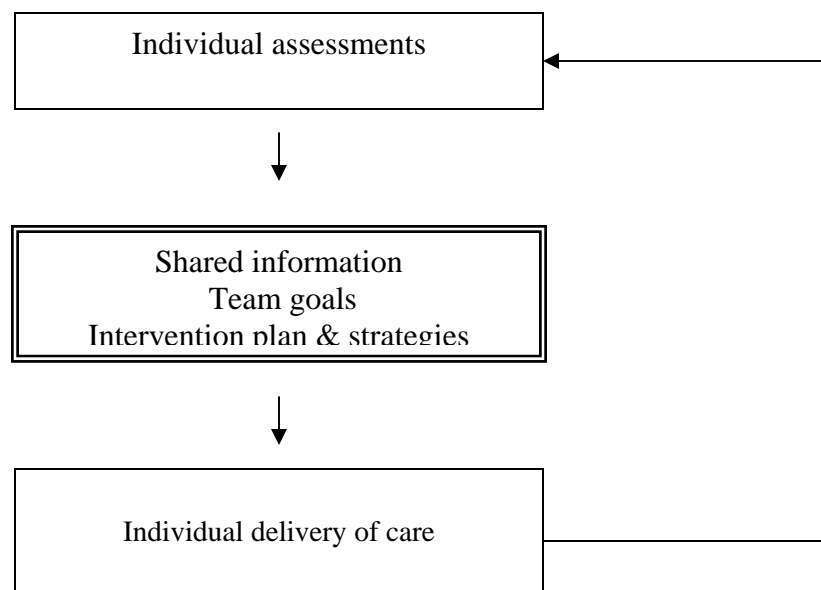
**Stigma.....**A mark, symbol, or other indication of deficiency, disgrace or infamy that identifies a person as having an “undesirable” condition

### Chapter 3

#### A Basic Model of Integrated, Interdisciplinary Health Care

Integrated health care is also often referred to as interdisciplinary health care or interprofessional health care. This approach to care is characterized by a high degree of collaboration across the various health professionals serving patients in assessment, treatment planning, treatment implementation, and outcome evaluation.

A diagram of a basic model of integrated health care follows. It demonstrates the relationships in an integrated health care setting of how individual professionals function and how their efforts fit into the work of the team as a coordinated whole. This is a simple model that can be adapted in more detail to describe how integrated health care might be provided in many specific care settings. Before exploring elaborations of the model for specific care sites, we present this most basic form of the model, to assure that the core concepts of integrated care delivery are clear.



In the model above, the tasks in the boxes surrounded by single lines represent the usual tasks of any health care professional. Individual health care providers conduct assessments of patients who will receive services from the team, from the particular perspective of each team member's profession. Integrated care team members should represent and be able to assess the biological needs of the patient (e.g., a physician), the psychological needs of the patient (e.g., a psychologist), and the social needs of the patient (e.g., a social worker), in order to provide a full "biopsychosocial" assessment. In addition, all team members should be sensitive to the full array of diversity issues – cultural, ethnic, racial, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual, and personal identity – that are represented in each individual receiving health care. These diversity variables affect every component of the biopsychosocial model and should be recognized by each team member in relation to their assessment of the patient.

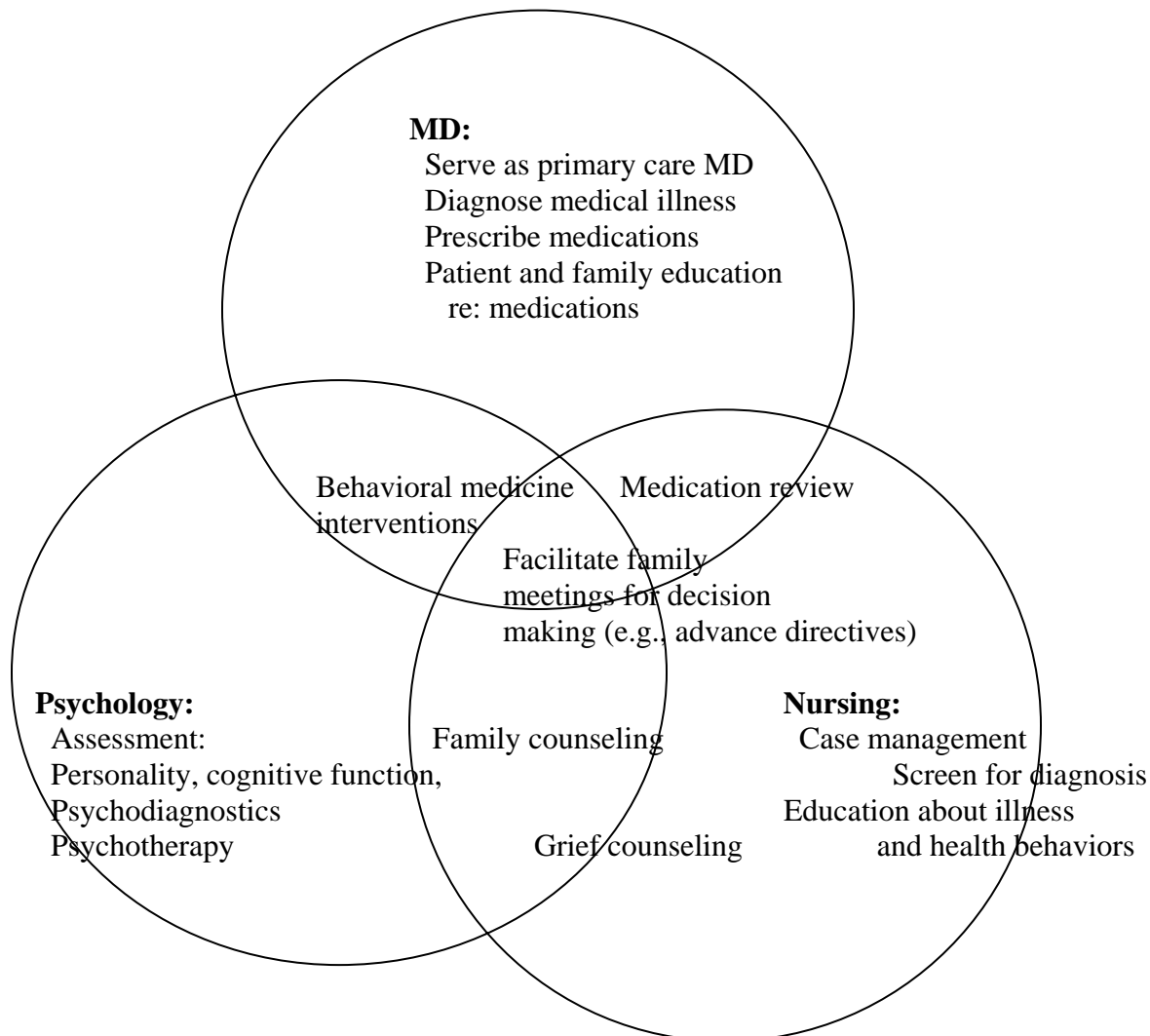
Team members bring their assessments to the team as a whole, where information is shared by all the professions represented. The team uses these multiple perspectives, including a rich appreciation of diversity issues, to develop a full picture of the biopsychosocial needs of the patient and of treatment goals and strategies. This sharing of information and process of integrating all the information, from multiple perspectives, offered by diverse team members is the essence of interdisciplinary, integrated care. Such discussion involves mutual respect, learning from each other, incorporation of divergent information, and consensus development. In the process, a richer, more complete understanding of the patient emerges, and a holistic treatment plan to address the inter-related problems each patient presents can be crafted.

Individual team members then provide the specific health care services needed that are within their profession's scope of practice, informed by an awareness of the patient's identity and recognition of the importance of delivering care in a culturally competent manner. As the team provides services, each team member monitors the patient's response and assesses whether the patient is improving, staying the same, or declining. These assessments are again brought back to the team, and the team makes new decisions about whether to continue with the original plans or to incorporate new information to revise goals and intervention strategies. This iterative, collaborative process continues throughout the time that the team provides health care services to each patient. [For more information, see Zeiss & Steffen, 1996.]

In delivering care, the team needs to recognize both the shared knowledge and skills among the professions represented on the team, as well as the unique knowledge and skills contributed by each profession. The simple diagram below demonstrates how a small team, with a few members, can both share knowledge, skills and related clinical tasks while also respecting the unique contributions of each team member. In the diagram, each member of a Geriatric Primary Care team is shown, with some of their important functions listed. Each profession on the team, Medicine, Psychology, and Nursing, is represented by a circle. The circles overlap, representing areas where skills are shared by two or three team members. Those shared skills are shown in the overlap areas of the diagram. Each professional also has a unique space within their circle that does not overlap with any other team member. Tasks that are unique to each discipline on this particular team are shown in those parts of each profession's circle.

Similar diagrams can be generated for larger teams, showing the interrelationships of team members. Such complex diagrams for larger teams also can outline the full array of treatment options available cumulatively to patients served by the team. Teams vary in different contexts. We explore in a later chapter especially how the setting of care affects team size and membership. In addition, throughout the Blueprint we emphasize that health care teams may differ depending on cultural background. Psychologists should be familiar with the roles of pastors, healers, grandchildren, and others within diverse communities and families, and should consider how each of these, and others, may fit in as an important member of the team.

## Interprofessional Team Role Map – Geriatric Primary Care



Teams can struggle with the areas of shared knowledge and skill. If team members are territorial, there can be “turf battles” about who “owns” particular treatment options, for example, whether psychology or social work offers family counseling. Strong, effective teams let go of such “ownership” issues and support each other; team members and patients benefit from the reality that some team members have shared abilities and can support each other’s efforts.

Delivering care using this model is most effective when the team also takes an integrated, shared approach to planning and decision-making. That approach has been presented previously in descriptions of interdisciplinary (also often referred to as interprofessional) health care teams (Baldwin, 1996; Heinemann & Zeiss, 2002; Lavin, et al., 2001). Interdisciplinary teams are



characterized by shared leadership and shared power in decision making across all the professions involved on the team. Thus, interdisciplinary teams have no specific person designated “the leader” as such, although it is common for one person to have an administrative title, such as “coordinator.” In an interdisciplinary team, any staff member could be assigned that title and role—the psychologist, the physician, the social worker, the advanced practice nurse, and so forth. The decision would be made based on skills, interests, and functional responsibilities, not on hierarchical processes.

This basic model for the development of interdisciplinary care teams, which will be our basis for a more complex exploration of integrated health care of older adults, is the basic care model advocated by the Department of Veterans Affairs. For more than 16 years, the Interprofessional Team Treatment and Development (ITT&D) program served to develop this model and to train teams at different sites around the country in its effective use (Heinemann & Zeiss, 2002). Twelve sites were distributed across the country, designated to be local, regional, and national resources for interprofessional training. Originally, this program functioned specifically in geriatric settings and was known as the Interdisciplinary Team Training in Geriatrics (ITTG) program (Fulmer, Flaherty & Hyer, 2004). However, it soon expanded to work with health care teams throughout the VA system, providing guidance and training to staff and trainees (Lichtenberg, Strzepek & Zeiss, 1990; [http://www.va.gov/oaa/fellowships/Psychiatry\\_Psychology/PsychsocialRehabAnnounce.doc](http://www.va.gov/oaa/fellowships/Psychiatry_Psychology/PsychsocialRehabAnnounce.doc), 2006). Similar models have been promoted by other programs, such as the Geriatric Interdisciplinary Team Training (GITT) program funded in the 1990s by the Hartford Foundation and modeled on the VA ITTG program (Seigler, Hyler, Fulmer & Mezey, 1998).

This Task Force uses the basic core model described above to explore how psychologists can function effectively in integrated care settings serving older adults. Psychology is one of the disciplines that we expect should be involved as a team member in integrated health care for older adults, using the model outlined above. We will identify different sites of care, considering the continuum from the healthiest to the neediest older adults, and discuss how to extend the simple but powerful model described above to these sites of care. We also will identify the skills that psychologists bring to such sites of care, including general psychological skills as well as more specific skills for work with older adults. The latter discussion will use the *Guidelines for Psychological Practice with Older Adults* (APA, 2003, <http://www.apa.org/practice/adult.pdf>). We discuss some obstacles to effective team work, including varying models of care and communication used by different professions. Throughout all discussion, we will suggest how psychologists can and should bring sensitivity to the needs of under-served groups and individuals, such as members of cultural minority groups. Finally, we suggest products that can be used to educate other professions and the public about integrated health care for older adults. We also discuss actions that the APA and individual psychologists can take to promote this model of care, which is a powerful and necessary model for serving the needs of our aging population.

## Chapter 4

### Knowledge and Skills that Psychologists Contribute to Integrated Health Care

While very few psychologists have been trained to work in an integrated health care setting, virtually all have training that would enhance integrated care teams generally, as well as those specifically working with older adults. Basic graduate school courses such as social psychology, developmental psychology, psychophysiology, neuroscience, learning and motivation, personality, and cognitive psychology all provide relevant information. Many psychologists have additional training in subjects more directly related, such as geropsychology, health psychology, neuropsychology, adulthood and aging, diversity and aging, group dynamics, and program design and evaluation. Clinical and counseling psychologists offer assessment and treatment skills as well. Psychologists' research expertise is also useful to the team on multiple dimensions such as knowledge concerning evaluation and assessment, incorporation of the latest basic and applied research findings as well as awareness of current findings regarding clinical intervention, including appropriateness and effectiveness of interventions with diverse populations. Still, for those who wish to extend their work to integrated health care teams focused on older adults, additional training may be required.

Mentioned in the previous chapter, the *Guidelines for Psychological Practice with Older Adults* have been developed and approved as policy of the American Psychological Association (2003). This document was intended to help psychologists in general practice and other settings evaluate their own readiness to work clinically with older adults and to assist with obtaining additional education and training. The guidelines included in the document are meant to facilitate a higher level of professional practice with older adults. The *Guidelines* provide an excellent overview of the knowledge base and the skills needed to work with older adults and their families. This *Blueprint* draws heavily from this excellent compendium as well as from a clinically focused brochure generated by a previous APA Presidential working group, entitled *What Practitioners Should Know About Working with Older Adults* (Abeles et al., 1998, <http://www.apa.org/pi/aging/practitioners.pdf>).

#### Knowledge of Aging and Adult Development

In an integrated setting, psychologists should have a clear sense of their own scope of expertise and competence. Each member of the team has a specific delineated role that may range from narrow, such as testing, to broad, such as assessment and treatment. Because the role is usually known before the psychologist joins the team, the individual has the opportunity to gain the specific skills needed if he or she does not already possess the necessary competencies.

To work in age-related integrated teams, psychologists are urged to recognize their own attitudes and beliefs about aging and about older people (Abeles et al., 1998). It is essential that they try to reduce the ways in which their biases and stereotypes affect their clinical work. Psychologists should seek consultation or further education when indicated. For example, a psychologist who has extensive experience with relatively healthy older adults living in the community may need additional training or consultation if shifting to a practice that emphasizes institutional long term care.

At the most basic level, psychologists have knowledge and training in normal developmental processes in adulthood and aging. A number of publications review recent advances in knowledge of normal aging (e.g., Qualls & Abeles, 2000), as do the APA Division 20 and Office on Aging home pages (see <http://apadiv20.phhp.ufl.edu> and [www.apa.org/pi/aging](http://www.apa.org/pi/aging)). Social and psychological dynamics of the aging process are included in this category, such as adaptation to transitions and stressors like retirement, acute and chronic illness, and widowhood. Older adults are more satisfied with their interpersonal relations, have more positive and less negative relations and report considerable consistency in their convoys of social relations (Antonucci, 2001) although the socioemotional selectivity theory (Carstensen, 1998) argues that, faced with imminent death, older people prefer to focus on those close and important to them. While aging inevitably involves adapting to losses, integrated health teams are poised to capitalize on more positive conceptualizations of the aging experience (e.g., Williamson, 2005). Important aspects of well-being include self-acceptance, autonomy, and a sense of purpose in life (APA, 2003). The large majority of older people maintain positive outlooks and, aside from the dementias, older adults have a lower prevalence of psychological disorders than do younger adults (APA, 2003).

Diversity is broadly defined and includes such factors as age, gender, ethnicity and culture, socioeconomic status, educational status, sexual orientation, disability status, religion, and urban/rural residence. It is also important to recognize that diversity is a fluid concept and diversity is defined by both macro and micro elements of the environment. Thus, an older man refusing to shake a female visitor's hand or be examined by a female geriatrician would be considered rude or abnormal, without the knowledge that his religion forbids him from touching a woman to whom he is not related. Similarly, a woman in jeans and a t-shirt would not be cause for concern, unless you knew that she was from a culture that expected her to be fully covered, i.e. head and body, when in public. In an integrated setting, psychologists should be sensitive to diversity issues and the ways in which diversity may influence both mental and physical health in later life. Psychologists will prove themselves indispensable members of the team if they can provide culture-specific expertise. For example, the psychologist may be able to alert the team that the depressed older man who emigrated from Japan has a higher probability of attempting suicide, as an "honorable" death, but is less likely to discuss suicidal thinking with a health professional, compared to males from a number of other groups. Or that a patient will need special permission from her spiritual leader to not fast during a specific time period, permission which would be readily given in the face of malnutrition or other health concerns.

Older adults are also diverse because of individual differences in the aging process. Counter to common conception, older adults are even more heterogeneous than younger adults (Neugarten, 1974). As discussed in previous chapters, young older adults differ in many ways from the oldest old, because they are from different generations or cohorts. Cultural diversity among older adults is extremely broad. It is very different to be an older second generation Chinese male immigrant than a first generation older woman who recently emigrated from a civil war torn region in Central America. Their mental and physical health vulnerabilities may be different as might be the treatments which are most likely to be successful.

Having knowledge of gender and sexual orientation diversity among older adults is important for psychologists working on integrated care teams. For example, a number of issues

disproportionately affect women, such as caregiving, responsibility for raising grandchildren, caring for adult children with disabilities, violence, being undertreated for treatable conditions, financial limitations, and socioeconomic status. A noteworthy aspect of gender diversity and aging is the preponderance of women surviving to older ages. As a result, the average older adult is likely to be a woman. Interestingly, the gap between male and female mortality has been closing over the past 100 years (Fries, 2005). Discussions of aging often emphasize women's issues, although recently, increased attention is being given to older men's concerns. One example is their reluctance, relative to women, to consult physicians. Issues related to sexual orientation often arise and may, for example, underlie an older adult's reluctance to move into a community or group living situation. He or she may be concerned about having to conceal important personal information like sexual orientation.

As mentioned previously, a rapidly increasing proportion of older persons is from ethnic and racial minority groups. It is crucial that psychologists who work with older adults be prepared for this demographics shift. For example, people from different ethnic groups or older persons of non-White minority heritage may differ from White older persons regarding their expectations about family roles in caregiving, about the importance of inclusion of spirituality in an overall assessment, about the degree to which they will accept treatment from a physician or psychologist, and so on.

It is important for psychologists who work in these settings to be able to differentiate normal physical aging changes from those with other etiologies such as medication side effects or from symptoms of illness and also be familiar with common chronic health conditions. Health psychologists and others who are specifically trained in behavioral medicine, as it relates to older adults, will be particularly welcomed among integrated health care teams. These experts may provide useful input concerning preventive care as well as treatment of conditions with significant behavioral components including pain, incontinence, medication nonadherence, and sleep disorders. Neuropsychologists are also specialists who provide highly relevant services for older adults including in-depth assessment of cognitive functioning as well as assistance and treatment in the emotional and behavioral problems related to cognitive impairment.

### **Knowledge Related to Clinical Issues**

Psychologists who wish to work on integrated health care teams with older adults are encouraged to be knowledgeable about the typically mild cognitive changes associated with normal aging (Abeles et al., 1998) and the effects of sensory deficits, especially vision and hearing, on cognitive functioning. These normative changes can be differentiated from changes associated with a variety of mental and physical pathologies, and with medication side effects. At times, referral to a neuropsychologist is warranted. Advanced age is tied to increased risk of cognitive impairment and different patterns of cognitive impairment are associated with specific disorders. Cognitive impairment may be reversible, especially when triggered by medication side effects, anxiety or depression, or an underlying treatable physical condition.

The *Guidelines for Psychological Practice with Older Adults* emphasize that older adults face many of the same problems of daily living that younger adults do. There are certain factors that are more frequently associated with difficulties in daily life for older adults than for younger

people, such as chronic illness, dementias, sensory deficits, increased dependency, and a declining social support network. These factors impose significant difficulties both on the individual and on family members. Psychologists on integrated health care teams make an effort to attend to caregivers, who are often older adults themselves. They are commonly very stressed both by their concern for the patient and by the strains of caregiving. Caregivers themselves are frequently at increased risk for a variety of psychological and physical disorders. Cultural factors may lead to particular strain for ethnic minorities who feel an older relative should be honored and cared for by the family. Many acculturated immigrants face considerable guilt when older relatives need more extensive care than they can provide. Financial and legal considerations may impose additional difficulties. The team psychologist should have good working knowledge of the Americans with Disabilities Act (ADA), which gives civil rights protections to individuals with disabilities. Other serious issues that may especially affect ethnic minorities and women include poverty, language barriers for immigrant patients, lack of access to health insurance, fraud perpetrated on older adults, severe isolation in their own communities, grandparents raising grandchildren, and elder abuse.

About one-fifth of older adults may meet criteria for having a mental disorder (Administration on Aging, 2001), and psychologists in integrated care settings should be knowledgeable about the types of psychopathology that are prevalent in older adults. These include the dementias due to degenerative brain diseases and stroke, recurrences of disorders they experienced when they were younger, and mental problems comorbid with physical illness and/or precipitated by medications. Anxiety disorders, especially generalized anxiety disorder, are commonly seen in clinical settings, as are depression, substance abuse, and chronic insomnia. Suicide is of particular concern, as suicide rates are higher for older adults, particularly older White men, than for any other age group (McKeown, Cuffe, & Schulz, 2006). The majority of these older men visited a medical provider in the month before the suicidal death (Luoma, Martin, & Pearson, 2002). Older adults may present themselves to health care professionals with physical symptoms when they are actually experiencing an emotional disorder.

An integrated health care team psychologist is encouraged to be familiar with general legal issues and with the ethical issues involved in providing psychological services to older adults. Each professional on the team follows the ethics code of his or her own profession, and each code is different. A case in point is the fact that most professions do not have explicit ethical standards on dual or multiple relationships. For psychologists conducting psychotherapy, these occur when psychologists have other relationships with clients in addition to that of therapist-client. The psychology Code of Ethics has explicit guidelines regarding such relationships, and this is an area in which psychologists can have an impact on team dynamics and culture. All team members should take special care to protect the autonomy of older adults, especially when they are physically frail or cognitively impaired. Obtaining informed consent often becomes an issue when the older adult is cognitively impaired, but it is important to remember that a dementia diagnosis does not automatically denote incapacity (ABA/APA, 2005). Protecting the older adult's confidentiality may become a challenging task, for instance, in residential care settings. Families or other health professionals may feel entitled to information that ethically should not be shared. Conflicts may also arise between family members, health care professionals, and others (e.g., nursing home staff) regarding decision making for the older adult, particularly when his or her cognitive capacity is diminished. Psychologists can help to resolve

conflicts between older adults' rights to maintain autonomy in activity choices including travel and sexuality, and institutional or family needs to provide safety and privacy. In terms of legal issues, psychologists have an ethical responsibility to report elder abuse or neglect and therefore should be knowledgeable about state requirements and resources. End-of-life decisions may also bring up legal and ethical issues for the psychologist and other team members (APA, 2000).

## **Assessment Knowledge and Skills**

Assessment is a primary role for all integrated health care team members. Psychologists typically have some assessment training but often need additional specialized training, e.g. in cognitive and capacity assessment, in personality assessment, and in the assessment and measurement of various psychopathologies, including substance abuse, which may present differently in older adults (e.g., Abeles et al., 1998). Psychologists who wish to work on these teams are encouraged to develop competence in assessing older adults for the presence of mood or anxiety disorders; suicidal thinking, plan, or intent; and psychotic symptoms. Aging is a relatively new field marked by frequent and significant advances. Consequently, psychologists are encouraged to keep up-to-date on aging related developments in theory, research, and practice. Areas developing quickly include various methods of assessment, especially those most appropriate for use with diverse populations of older adults. As with younger people, measures should be reliable and valid for the population with which they are being used, i.e. with older adults from the full spectrum of diverse backgrounds. One excellent resource is the *Geropsychology Assessment Resource Guide* (1996) produced by the Department of Veterans Affairs. Other resources include Strauss, Sherman, and Spren's *A compendium of neuropsychological tests* (2006) and Hunt and Lindley's *Testing older adults* (1990). Many states require annual continuing education for licensed psychologists and this is a good way for those individuals to stay current, but all are encouraged to embrace the goal of life-long learning.

Psychologists should be familiar with the behavioral assessment of a variety of problems and issues likely to be present in the older patient, especially in institutional settings like hospitals. Team psychologists are encouraged to be able to tailor assessments to specific older individuals to assess health behaviors, coping resources, medical regimen adherence, and other important aspects of behavioral health care. When necessary, team psychologists adapt their assessments to meet the specific needs of diverse older adults, such as those with sensory or communication impairment, cognitive impairment or developmental disabilities, and low literacy. They recognize the crucial importance of cultural differences, including fluency in speaking and understanding English, and the special needs of minority older adults. Numerous additional factors are also considered, such as level of pain, medication side effects and substance abuse. Team psychologists also use their assessment skills to plan interventions and to evaluate their effectiveness. Since aging is a dynamic process, psychologists should encourage ongoing and recurrent assessments rather than single, limited ones.

A major role for psychologists on integrated health care teams is their ability to assess cognitive changes via cognitive screenings and functional ability evaluations (e.g., Lichtenberg, 1999). They integrate findings from cognitive measures and a variety of evaluative modalities, and produce practical and feasible recommendations based on the resources available. They often include family members and caregivers in their assessment. In some situations, a

neuropsychologist may be consulted to conduct a comprehensive neuropsychological examination.

Team psychologists should be proficient in adapting the assessment method to fit the setting. For example, a hospital assessment may have to be performed at the bedside with a roommate a few feet away, while an assessment in an independent living facility can typically be conducted privately with the client sitting up in front of a table. While such situations represent the frequent realities of patient care, they can be difficult both for the care provider and for the patient whose cultural, ethnic, or religious sensibilities might be offended.

Some psychologists have expertise in group dynamics and systems, and such knowledge is especially useful for those who wish to be part of an integrated team. Psychologists with this expertise apply systems-oriented thinking to evaluate the overall functioning of settings such as hospital and rehabilitation units, residential facilities, and wellness centers. They can also evaluate and facilitate group processes within the team itself. For example, they may generate strategies for integrating and coordinating the roles of the various team members (Zeiss & Steffen, 1996). As another example, rather than just assessing an older adult who is depressed after entering a nursing home care unit, the psychologist can evaluate the functioning of that unit to determine what aspects of it might be contributing to the depression and amenable to change or what specific needs or interests of the patient, such as others who speak the same language or come from the same background, should be addressed.

### **Intervention Knowledge and Skills**

Once an assessment, or stage of assessment, is completed, psychologists on health care teams working with older adults integrate the results with an individual's functional abilities, emphasizing how disorders may affect daily function. Assessment results are used to plan psychological interventions that will have a positive impact on daily function. These plans are integrated with other team members' recommendations and plans, a process that often requires significant creativity and thinking "outside the box." The ability to adapt traditional intervention methods requires that psychologists be familiar with current theories and research regarding treatment of older adults.

Older adults respond well to a variety of intervention approaches, including behavioral, cognitive behavioral, interpersonal, and psychodynamic therapies; socio-environmental modifications; cognitive rehabilitation; and life review therapy. In terms of the specific problems for which older adults are treated, evidence supports the effectiveness of psychological interventions for traditional psychopathology, such as depression, anxiety disorders, sleep disorders, and alcohol abuse (APA, 2003). Unfortunately, evidence is lacking regarding the effectiveness of these interventions with older adults from ethnic minority groups (Areán, 2003).

Psychologists who wish to work in integrated settings that serve older adults should also be familiar with the common medical disorders of aging and their medical treatments, as mentioned earlier. This knowledge enables them to apply the psychological interventions that are efficacious for a variety of behavioral health problems. For example, behavioral therapy is useful for the treatment of urinary incontinence (Burgio, 1998), insomnia (Lichstein & Morin, 2000),

and chronic pain (Watkins, Shifrin, Park, & Morrell, 1999). Psychological techniques are also helpful for managing dementia, chronic disease, and sexual dysfunction (APA, 2003).

Health care team members are typically sensitive to the well-being of caregivers, many of whom are older themselves. It was previously mentioned that team psychologists should also be knowledgeable about the well-documented physical and emotional stress inherent in caregiving. Psychological interventions provided to caregivers help not only the caregiver but also the person receiving the care, often allowing him or her to remain at home longer. Illustrative of the fast pace at which this field is growing, recent caregiver intervention studies have incorporated the use of technology as a cost-effective strategy to improve caregiver access to informal and formal support services (e.g., Finkel et al., 2007). Team psychologists often work with family members, either individually or in a group, and this work may be psychoeducational or more psychotherapeutically focused.

As mentioned above for assessment, expertise in applying psychological interventions with the full range of diversity found among older adults is essential to the integrated health care team psychologist. He or she should be familiar with modifications of interventions for persons with sensory and communication difficulties, physical disabilities, low education and literacy, and poor or nonexistent English-speaking skills. The psychologist should also be comfortable working with persons with all types of cognitive impairments, such as memory disorders, aphasia, and behavioral disinhibition. Special considerations must often be given to persons of different cultures and ethnic backgrounds, and to older adults who are gay, lesbian, bisexual, or transgender. Cultural competency/and or cultural sensitivity is indispensable when working with older persons from unfamiliar cultures and requires scrupulous self-education, perhaps with help from the older adult and/or his or her family, and through formal training materials. This is another situation in which psychologists have a duty to try to be aware of their biases and stereotypes and how they affect their clinical work.

Occasionally the psychologist may need to use an interpreter in order to work with an older adult. The use of interpreters, while essential at times, is fraught with difficulties and represents another area in which additional training is often necessary for psychologists who work with immigrants or non-English-speaking native Americans, Latinos, etc.

The team psychologist should be able to select (1) interventions that can be implemented most effectively in the specific care setting and (2) adaptations that make older adults safer in their pursuit of preserved independence. For example, a depressed, cognitively impaired older adult in a nursing home may benefit more from socio-environmental modifications than from individual psychotherapy. On the other hand, a high functioning older woman with generalized anxiety disorder who has recently undergone a hip replacement will typically respond best to individual cognitive-behavioral therapy conducted in the rehabilitation facility or the psychologist's office. The psychologist should also be skilled in the application of group, couples, and family modalities, all of which are helpful when working with older adults.

To work in integrated settings, psychologists should also be knowledgeable about primary and secondary prevention and health promotion and be able to apply these skills when appropriate. Primary prevention comprises actions taken to prevent a disorder or injury from occurring and



might include psychoeducation and promotion of improved health habits with a wide population or with at-risk individuals and groups. A variety of risk behaviors can be targeted, such as smoking, physical inactivity, poor nutrition, obesity, and substance abuse. Secondary prevention skills have to do with identifying and treating a disorder early in its course and might incorporate, for example, adherence to treatment regimens and dietary changes. Additional skills involve understanding the strengths and limitations of local community resources, including community and health system barriers (APA, 2003).

Recently, the development of the positive psychology movement has dovetailed with the areas of prevention and health promotion. Positive psychology is a strength-based, preventive approach to interventions and one of its themes is the notion that the experience of adversity can sometimes yield benefits. These benefits, often referred to as psychological thriving or flourishing (O’Leary & Ickovics, 1995), are more likely to occur when the individual who has undergone psychological or physiological adversity demonstrates curiosity, or attraction to novel stimuli, and high levels of perceived control and self-efficacy. Social engagement is also important, as are the abilities to relax and to be positive about one’s situation. Team psychologists can facilitate psychological thriving among older adults by working to enhance these factors when possible. At the same time, one must be careful not to ‘blame the victim’ for the adversities she or he faces.

### **Skills in Consultation, Program Development, and Research**

Psychologists who wish to join integrated care teams are encouraged to offer consultation to family members, significant others, and other professionals. They may be able to provide training and clinical supervision to staff who work with older adults. They can play key roles in helping design and implement new programs, and their research skills are valuable in program evaluation. In these situations, as in the others mentioned above, psychologists strive to be sensitive to ageism, cultural factors and the special needs of older adults from minority groups. For example, a team may wish to expand services to low-income older adults, and therefore may set up an office that is located within a public housing complex. Another example is a team that targets services to African American older adults and thus offers services at a local church primarily attended by African Americans. At the same time, the team should be sensitive to the effects of stigma and the fact that people using team services may be concerned about being visible to others in their community.

Psychologists’ research expertise is valuable to the team in many ways. For example, psychologists’ knowledge of research is useful for evaluating the literature upon which assessments and treatments are based. Psychologists conduct research that can be useful in assessing and treating older people. Knowledge of relevant research can bring to bear important new information in clinical situations. In addition, since it is important for the team to evaluate the interventions being offered, psychologists can advocate for evaluation research and contribute to the design and execution of evaluation studies.

## **Chapter 5**

### **Principles of Integrated Health Care**

Supportive empirical evidence for the use of integrated, interdisciplinary care in treating older adults with chronic disorders such as depression and dementia is rapidly accumulating (Bruce et al., 2004; Callahan et al., 2006; Ciechanowski et al., 2004; Skultety & Zeiss, 2006). Effective treatment for older adults is predicated on health care which is coordinated among various professionals who self-identify as belonging to and working on a health care team. Psychologists have for decades been making major contributions on integrated teams that treat older adults (Lichtenberg, 1994; Zeiss, 2003). This chapter will discuss the core principles of integrated care for older adults, with a focus on the contributions psychologists can make. The care of older adults health is often centered around disorders of a chronic nature for which there are no known cures, and for which there are a number of complicated treatment issues. Alzheimer's disease and depression, two of the more well known and studied age-related disorders, serve as excellent examples of the need for integrated care.

Maurer and colleagues (2006) provided their perspective on the management of Alzheimer's disease over the past 100 years, offering a simple, yet powerful conclusion: the skill of the clinical team attending to the patient was the main determinant of the quality of treatment received. They describe the biopsychosocial model of care given to today's patients with dementia. The importance of pharmacological and nonpharmacological treatments is highlighted, as is the need to link family caregivers to social services. Psychologists clearly play important roles in the detection and assessment of dementia, in the behavioral and nonpharmacological interventions for problems associated with dementia, and for the nonpharmacological interventions and strategies offered to informal caregivers (Lichtenberg, Murman & Mellow, 2003).

The treatment of depression can be similarly conceived. A chronic condition, with high potential for relapse even when immediate treatment is effective, depression in older adults can require both pharmacological and nonpharmacological interventions. These interventions are best coordinated through an integrated healthcare model (Skultety & Zeiss, 2006).

In the treatment both of Alzheimer's disease and of late life depression, a high level of coordination and shared team leadership are required. Age-related disorders require that different members of the team perform different roles, and these roles necessitate shared leadership. If a patient's dementia is being optimally controlled medically, but significant behavioral challenges are apparent, a psychologist's behavioral problem-solving intervention may be the prime emphasis of current treatment. With regard to depression, if a patient prefers cognitive-behavioral psychotherapy to medication, than the psychologist's therapy may be the prime emphasis of current treatment. This chapter will explore the core principles of making integrated healthcare effective.

#### **Basic Principles of Integrated Care**

Eight principles of Integrated Care will be presented. Some of these principles are unique to an integrated model, and others are generalizable to psychological care of older adults.

*Principle 1: Integrated teams are sensitive to ageism and its influence on treatment decisions*

The American Psychological Association adopted the Resolution on Ageism as policy in 2001. Ageism, pervasive discrimination against older adults, is widespread in the United States (Palmore, 1990). Allport used his social categorization theory to describe the basic tenets of discrimination (Allport, 1954). The non-dominant group (older adults in this case) is viewed as homogeneous and portrayed as having a variety of negative characteristics. Older adults are viewed stereotypically as (1) alike; (2) alone and lonely, (3) sick, frail and dependent, (4) depressed, (5) rigid and (6) unable to cope (Hinrichsen, 2006). This pervasive view portrays all older adults in a negative light, ignores the incredible heterogeneity of aging and the strengths and positive attributes of older adults. On an integrated health care team specifically, ageism can translate into feelings of hopelessness, the expectation of poor progress, and a lack of quality care provided by the team. Ageism underlies findings such as the under-utilization of screening for bone density, cognitive and affective functioning and the over-estimation of late life depression by many health providers who work with older adults. Team members, themselves, must be cognizant of their own ageist thoughts and beliefs, and try to minimize these.

*Principle 2: Psychologists become familiar with core roles of other health care team members.*

Psychologists are urged to learn more about the roles all members of the health care team occupy. Psychologists are not typically trained in integrated healthcare teams and may need to learn a variety of new skills relevant to team functioning (Zeiss, 2003). The ability to implement knowledge of team functioning is central to a psychologist's success on an integrated healthcare team. Understanding team functioning requires psychologists to know what different team members' strengths and roles are, and to be familiar with the techniques and interventions of each team member. Often members of different professions have different views of how the team should operate. Some take a hierarchical approach, while others are committed to equity across professions. Differences of opinion and differences in expectations can be extremely detrimental to the functioning of the team and must be recognized and addressed. Care is delivered to older adults by a team of health professionals, even when that team may not be located within the same building, health system, or even the same town. The *Guidelines for Psychological Practice with Older Adults* (APA, 2003) specifically instruct psychologists to be familiar with current information about health-related aspects of aging (Principles 6-10), and with how to be effective in working with other disciplines.

*Principle 3: Models of health care processes and beliefs may differ among team members*

The professional models that team members bring to their work can at times, be at odds, and influence the quality of team functioning. Although both the medical and psychosocial models of care focus on a biopsychosocial approach, professions such as medicine and nursing are more often called on to attend to the biological issues related to patient care, while psychologists and social workers are often called on to attend to the psychological and social issues related to care. These tasks are often quite different along several dimensions. In comparing some medical versus psychological care in geriatrics, for instance, Brown and Zimmer (1982), and later Qualls and Czirr (1988) focused on some of the differences between models of care and the ways in which conflict occurs due to these model differences. Classic differential diagnosis techniques

for acute conditions look to rule out competing hypotheses and lead to a *single* medical diagnosis. A psychosocial model, classically attempts to understand the *variety* of psychological and social conditions that affect chronic disease symptoms and patient functioning. The two models are also distinguished by the pace of action. Medical providers often have very limited time with each patient, and therefore need to make diagnoses quickly.

Although these historical model differences are less pronounced in current care of older adults (Lichtenberg, Murman & Mellow, 2003), they continue to exist and perhaps even exist more so in primary care settings in particular. Much primary care practice is built around the 7-12 minute visit and acute diagnosis approach. The Primary Care visit is based upon the accurate report of problems by the patient. This dependence on self-reported symptoms often leads to delayed detection of mental and physical health problems such as cognitive impairment, alcohol abuse, anxiety, malnutrition, and new onset disability. One drawback of brief primary care visits with many ethnic minority and many poor patients relates to health literacy. Practitioners may describe diseases and treatments in technical language, and handouts are typically written at higher reading levels. It is important to provide 5th grade reading level materials. Geriatricians, in contrast, place their focus on function and quality of life, and the intersection of disease and behavior, and therefore use many techniques consistent with a psychosocial approach such as incremental assessment and a focus on quality of life (Ensberg & Gerstenlauer, 2005). Geriatric primary care is more likely to involve an integrated team, and to use behavioral triggers rather than patient report to enhance early identification of new conditions or disorders.

*Principle 4: Conflict among team members is natural and can lead to a strengthening or weakening of the team*

Roles, power, status and perhaps most importantly, the ability to negotiate conflict represent other areas affecting team functioning. Psychologists have both unique roles and shared professional roles on any given health team for older adults. Are these explicitly delineated? Do psychologists occupy roles that other team members would also like to occupy, or vice versa? How are these desires handled? How do team members work together? Is there an effort to take the knowledge obtained by each team member and integrate it into the comprehensive treatment plan? Disagreement about who occupies which roles and how much a certain team member's work is considered for treatment planning can bring about intense conflict.

Even in well functioning teams, conflict is inevitable. The process by which it is negotiated is key to the future functioning of the team. Zeiss (2003) described Tuckman's 1965 model of team process and the stages of forming, storming, norming and performing. The storming stage of team development often deals with issues such as those described above—who occupies which roles and has influence over the plan of care. But even with explicit role expectations and a “performing” team, conflicts are inevitable. Two major sources of conflict include (1) the model of care—medical v psychosocial; and (2) the influence of strongly held personal values and beliefs that influence care choices. Conflicts can occur between team members when they are not “speaking the same language.” In a long term care setting, for example, the medical model expectation of the care staff may be that behavioral disruption can be treated and eradicated through pharmacological intervention. The psychosocial model may be to investigate how staff and patient can interact so as to maximize function and minimize disruption, emphasizing

significant improvement but not necessarily cure of the underlying disease (i.e. the chronic disease model of care). A second source of conflicts is discrepancies in deeply held personal preferences and beliefs upon which decisions are made. Decisions about the ability to continue driving, return home from hospitalization, or pursue intimate relationships developing among residents of long term care dementia units are but a few examples. Differing value systems may make these differences of opinion about these decisions intense. Although these matters may appear at first glance to be about quite different spheres of life, there are no definitive answers that can be identified for any of these dilemmas. For example, the issue of driving appears to be a legal one, but in fact, there are not standard reporting laws across states, and the loss of a driving privilege as opposed to voluntary restrictions can directly impact an individual's well-being.

*Principle 5: Psychologists benefit from applying conflict resolution skills to team conflicts*

Integrated healthcare teams need to know how to negotiate conflict. Psychologists are often trained to work in settings that do not require extensive team interaction. As a result, seeking and/or receiving training in conflict negotiation is not a high priority. As mentioned above, the ways in which conflict is resolved can either strengthen or weaken team functioning. Training in conflict negotiation can be found in classic texts such as *Getting to Yes* (Fisher & Ury, 1981) and *7 Habits of Highly Effective People* (Covey, 1989). These sources teach people to separate the person from the problem, focus on interests or outcomes versus positions, use brainstorming in determining possible choices, and monitor choices made by some measurable standard. A key to success with these techniques is to learn to minimize "position bargaining." In position bargaining, team members engaged in the conflict seek to "convince" the other side that their own position is correct. Taking the focus away from personal conflicts and from positions stated and refocusing the discussion on goals or interests of the older adult can be effective in resolving conflict. A critical component to conflict resolution is the agreement to monitor and measure the success or lack of success with the treatment choice. The plan resulting from the resolved conflict is not necessarily permanent, nor optimal. An agreed upon set of outcomes should be designated along with the plan. Psychologists may be in a good position to model conflict resolution skills that strengthen the team. Below are two case scenarios that depict the types of conflicts that occur on teams.

**Team Conflict Example 1**

Mrs. Washington, an 83-year-old African American widowed woman who completed high school worked as a secretary for the public schools. She now lives alone and is referred for a cognitive evaluation during an inpatient medical rehabilitation stay. Mrs. Washington has been widowed for 15 years, and has no children. She has lived alone in a two story flat for the past 40 years. The referral is made due to the observation of signs of confusion during rehabilitation for a lower extremity femur fracture. The fracture occurred when Mrs. Washington tripped on the leg of a stool in her kitchen. Mrs. Washington demonstrated in the Occupational Therapy lab that she can perform all of her basic Activities of Daily Living (e.g. bathing, grooming, toileting), whereas a home assessment noted that her apartment was disorganized and she required significant assistance with some key Instrumental Activities of Daily Living (e.g. money management, possibly medication management). The cognitive assessment finds that Mrs. Washington is demonstrating symptoms of mild to moderate dementia with robust memory and

executive dysfunction. Mrs. Washington is able to state that she wants to live alone, but is unable to appreciate the potential risks of doing so (e.g., responding to future falls, emergencies). She is also unaware of her cognitive dysfunction and therefore unwilling to use compensatory strategies. The psychologist has found evidence for significant dementia and impaired decision making. Furthermore, based on the research literature which has found that living alone successfully requires good cognition, the psychologist recommends that Mrs. Washington leave her home to go live in a senior housing facility where formal care help can be provided. The physician, visiting nurse, and occupational therapist all state that in her own environment Mrs. Washington will function satisfactorily and they do not want to impinge on her autonomy. Mrs. Washington states that she wants to return home, but as described above she also demonstrates some significant deficits in decisional abilities. What are some ways the psychologist can avoid “position bargaining” and work with team members to develop a plan that will provide the proper balance between autonomy and structured care? What outcomes should be agreed to and monitored if Mrs. Washington is to remain in her home? For example, will Mrs. Washington allow meals on wheels to come to her home, or a chore provider who assists with home safety and medication management?

## **Team Conflict Example 2**

Mr. Allison, an 83-year old widowed Non-Hispanic White man, a college graduate who was a successful business owner, fell and broke his foot. Mr. Allison has been widowed for 8 months. One month later, Mr. Allison returned to a geriatric primary care clinic complaining of GI distress. Mr. Allison also has diagnoses of hypertension, diabetes, and early peripheral vascular disease. The physician notes that the man’s hypertension is not responding well to treatment, and that the man appears moderately anxious. The man, a highly respected member of the community, has been a patient of this physician for over three decades. When hearing about this case in a team conference, the psychologist suggests that Mr. Allison be referred for psychological assessment. The psychologist states that based on the research literature, Mr. Allison is not only at high risk for an anxiety or depressive disorder, but is also at high risk for problem drinking and perhaps even suicide. The physician states that this man is a pillar in the community who would be averse to being treated for mental health problems. How does the psychologist help the treatment of Mr. Allison? How can the psychologist avoid position bargaining? Does the psychologist insist that his or her skills are uniquely needed in this case, or can the psychologist assist another team member in providing the needed assessment and treatment?

### *Principle 6: Health Care teams communicate in increasingly diverse ways*

Health care teams are ever changing, and are utilizing technology at an increasing rate. Health care teams are becoming more diverse due in part to technology. Telehealth has expanded the way some teams function. In many teams using telehealth, the health care professionals are dispersed geographically. Indeed, the team may be seen as a virtual team, with no consistent structure for team meetings. How are team members to communicate under such circumstances? This is an important question to address for any group working together. Is there a single medical record that can be accessed by all team members? If so, does this record contain all of the relevant clinical information? The movement towards electronic medical records enhances the

likelihood of care being more integrated. Easy access to information on health services by other professionals makes it more likely that new treatments and assessments will be complementary to what is already being done. When using electronic methods for communication, confidentiality issues must be addressed. Patients must understand that their care is provided by the team, not a single provider, and that information will be recorded in ways in which all team members will have access to it. Providing up-front consent to sharing of information may be new for many providers, but it is done successfully in many clinical contexts and can fully meet HIPAA requirements. Providers also must be confident that the shared systems for communication are encrypted and cannot result in unauthorized sharing of information.

Verbal communication is often critically important for healthcare teams to work effectively. Written notes may leave out information, or may not convey information clearly to all who read them. Further, verbal conversation builds a commitment from each team member to follow the agreed upon treatment plan. Team conferences can also be a time to negotiate conflicts about treatment decisions effectively.

Defining the role of the older adult patient and/or informal caregiver may improve care and outcomes. Will the patient and/or caregiver be considered part of the team? Chronic care, especially among older adults, falls to family and other informal caregivers. Caregivers often arrive at their roles without any clinical training or understanding. In some teams, the family caregiver is considered an extension of the team. For example, in many dementia evaluations, the detection and staging of dementia is determined primarily by interview of collaterals, particularly family members. In contrast, an older adult patient with depression may request that most or all of the contents of their psychotherapy sessions never be shared with a family caregiver. Explicit discussion of the role on the team of the patient and caregiver will help the team function.

In their review of depression treatment, Skultety and Zeiss (2006) noted the variety of team approaches in the studies reviewed—from multidisciplinary to some form of integrated care. Psychologists can help the team make explicit decisions about its model of information sharing. The format for recording information (chart notes, formal reports, etc.) should be agreed upon, and in most situations the mental health information obtained should be shared with other team members. Psychologists often believe that the information they acquire needs to be kept private and therefore not shared with team members. An integrated approach recognizes that all patient information is sensitive, and that mental health information, like other health information, should be shared with all team members through notes/reports in the medical record. Whether it be in person or by phone conference, it is often helpful to have regular information sharing in team meetings so that assessment results can be integrated into the treatment planning process. Because psychologists are often involved as consulting experts, it will be important for psychologists to clarify whether they are to occupy other roles on the team or only on certain specific cases.

*Principle 7: Health Care teams are sensitive to issues of multicultural diversity and marginalization*

In *The Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, APA defines “multicultural” narrowly as “referring to the interactions between

individuals from minority ethnic and racial groups in the United States and the dominant European-American culture” (APA, 2002, p. #2). Health care treatments have long been based on studies with Non-Hispanic White males, and diverse groups have historically been under-represented and under-served. These trends continue today, despite ever increasing federal government interest in eliminating racial and ethnic health disparities (Curry and Jackson, 2003). Jackson, Antonucci and Brown (in press) highlight the importance of bringing a cultural component to the biopsychosocial model. They define culture as “a symbolic vehicle of meaning, including beliefs, ritual practices, art forms and ceremonies as well as informal practices such as language, gossip, stories and rituals of daily life.” This definition highlights the many areas in which health care teams will need to be sensitive and the potential for integrating traditional medicine and medical-psychological practices to create care that is guided both by culturally valued practices and by current empirical knowledge. Alternative and complementary health beliefs and practices may be central to some patients’ treatment.

Language and language barriers are increasingly common challenges in health care provider-patient interactions. Literacy generally, and health literacy specifically, greatly impact the effectiveness of engaging patients in self-management of chronic disease. The issues of language, health literacy and cultural differences all can affect willingness to enter into treatment and follow through on the health care team’s recommendations.

The APA recognizes that health care teams and psychologists need to increase their multicultural competency for those with a gay, lesbian or transgender orientation. A related but not redundant issue is that of marginalization (Banks et al., in press). While many under-represented minority groups have limited access to health care, the issue of marginalization is also examined at the intersection of socioeconomic status (particularly poverty), gender and racial/ethnic identities. Rural older adults, for instance, be they non-Hispanic White or African American, may face the same marginalization issues when interacting with the health care system. As with ageism, health care providers themselves must be aware of their own biases and seek to limit the impact of these on patient care.

While our focus here is on cultural diversity among the patient population, it is also worth noting that there is increasing ethnic and cultural diversity among health care providers. Problems sometimes arise if there is a lack of sensitivity on the part of the patient. Sexism, racism, ethnic and cultural insensitivity exhibited by older adults who were socialized under a different set of society norms may require special adaptations and tolerance on the part of the health care team members.

*Principle 8: Assessment of treatment and treatment outcomes should be ongoing*

Treatment outcomes vary greatly. Some reasons for this are known, and relate to issues of comorbidity, frailty or disability, whereas others are not known. Even though treatment is initiated, it may fail to be implemented fully. For instance, although older adults are often treated pharmacologically for mental health problems such as depression, the majority does not get an adequate trial, i.e. reach therapeutic levels. Health services research often points to the trends that across a number of conditions older adults are undertreated or are continued on ineffective treatments despite lack of evidence supporting continuation of the treatment. Psychologists are



well trained to plan and implement careful and accurate assessments of treatments. The timing of these assessments, and the ways in which the results are integrated into further treatment decisions, are matters for the team to consider. In addition, many mental health disorders in late life (e.g. anxiety, depression, substance abuse) have significant relapse rates. Incorporating relapse prevention interventions and early detection of relapse symptoms can benefit older adults and their caregivers.

## **Chapter 6**

### **Interdisciplinary Collaboration in Diverse Sites of Care**

[The Task Force would like to recognize and thank Jennifer S. Funderburk, Ph.D and Yeates Conwell, M.D. of the University of Rochester Medical Center, who collaborated with the Task Force on the development of this chapter.]

In this chapter, we examine the application of the integrated healthcare model to a diverse array of settings in which services are provided to promote the health and well-being of older adults. Psychologists are uniquely qualified to contribute to the design, implementation and evaluation of integrated care models because of their expertise in evidence-based methods of assessment and treatment, their familiarity with organizational dynamics and systems approaches to care, as well as their comprehensive training in research design and methods of program evaluation. Although the primary emphasis to date and the bulk of research evidence has been on integrating mental health into primary care or long term care services, opportunities abound for collaborative, integrated care in other settings frequented by older adults and their families or caregivers. We focus here on three broad categories: health-related sites of care, long term care settings, and community-oriented social service settings. Within health-related settings, we focus at some length on integrated primary care models because of recent research emerging in this area and because of the potential for psychologists to assume more prominence in these collaborative models. However, it is important to note that psychologists are functioning as members of collaborative teams in a broad array of settings dedicated to the care and treatment of older adults experiencing a variety of problems or illnesses. Therefore, our goal is to encourage creative thinking and innovation in the application of these principles to diverse settings and to a range of conditions or problems experienced by older adults. We provide several case examples to illustrate setting-specific variants of the basic integrated care model and to describe the variety of roles that can be assumed by psychologists.

### **Integrated Care in Health-Related Settings**

#### *Primary Care*

Regardless of racial background, ethnicity or socioeconomic status, older adults would rather seek mental healthcare from primary care providers than from specialty mental health clinics or providers (Areán, Alvidrez, Barrera, Robinson, & Hicks, 2002; Davidson & Meltzer-Brody, 2003). Yet a significant proportion of late-life mental health problems go undetected and untreated in primary care settings. Attempts to improve this situation have included providing enhanced mental health training to primary care providers and implementing screening tools to improve detection of depression or other mental health problems. However well designed, these efforts have met with only modest success, causing many to call for a better solution to the problem, namely the integration of mental health services directly into primary care for older adults.

The most common and well studied type of integrated model in the primary care setting is for the treatment of depression (Blanchard, Waterreus, & Mann, 1995; Boulton et al., 2001; Bruce et al., 2004; Burns, Nichols, Martindale-Adams, & Graney, 2000; Toseland et al., 1996; Unutzer et al.,

2002; Williams et al., 2000), although reports of integrated care for disorders such as Alzheimer's disease (Callahan et al., 2006) and panic disorder (Roy-Byrne et al., 2001) also exist. These approaches vary according to the degree of emphasis on psychosocial factors, the extent to which interdisciplinary collaboration is part of the model, and the roles played by psychologists if they are included in the interdisciplinary team (Frank et al., 2004; Haley et al., 1998 Skultety & Zeiss, 2006).

For example, the RESPECT-Depression Three Component Model, developed by the MacArthur Initiative on Depression and Primary Care (Dietrich et al., 2004; MacArthur Initiative, 2004; Oxman, Dietrich, Williams, & Kroenke, 2002) was designed to improve outcomes for depressed patients by using structured, algorithmically defined interactions between the patient and three components of the healthcare team: the primary care clinician, a care manager, and a mental health specialist. The model includes tools for interactive skills training of primary care clinicians to standardize practice with regard to screening and assessment of depression, the use of a reliable and valid scale, the Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001). The primary care clinician is trained to make optimum use of a care manager who serves as a telephone resource to the patient and primary care practice, as well as an interface between the mental health specialist and the primary care clinician. Specifically, the care manager makes regular phone calls to monitor the patient's progress, seeks consultation as needed from a mental health specialist, and gives informed feedback on a regular basis to the primary care provider. A key element of this model is the enhanced communication and feedback provided to the primary care clinician about the depressed patient's condition and possible treatment approaches. Compared to approximately 34% of patients who received usual care, 53% of intervention patients demonstrated a response to treatment at six month follow-up. Moreover, greater numbers of intervention patients achieved remission of their depressive syndrome within six months (approximately 37% compared to approximately 27% of usual care patients). Multiple studies indicate that the provision of this type of support to the primary care provider improves clinical outcomes for depressed patients (Oxman, Dietrich & Schulberg, 2005), although it should be noted that not all focused specifically on older adults and many contained relatively small numbers of ethnic minority participants.

Psychologists, psychiatrists, social workers, family therapists, and nurses have all served as mental health specialists in integrated care models. These professionals may assume a number of roles with varied emphasis across models, depending on the degree to which psychosocial factors are considered in assessment and treatment. For example, the *Prevention of Suicide in Primary Care Elderly: Collaborative Trial* (PROSPECT; Bruce et al., 2004) aimed to improve physicians' treatment of depression and suicidal behavior through the involvement of a depression care manager (a nurse, social worker, or psychologist) who met regularly with the physician and the patient. The depression care manager also provided brief interpersonal psychotherapy if patients requested psychotherapy or if they refused or were not responsive to antidepressant medication. Similar to the outcomes of other collaborative care models for depression, patients in the intervention arm of the study were more likely to achieve a clinically significant improvement.

Another integrated care intervention, the *Improving Mood-Promoting Access to Collaborative Treatment* project (IMPACT; Unutzer et al., 2002), involved a depression care specialist (nurse

or psychologist) who provided psychoeducation and initial evaluation of primary care patients, as well as consultation with the primary care physician and team psychiatrist. Twenty-three percent of the participants were ethnic minority individuals, 90% had insurance coverage for prescription medication, and 77% had Medicare coverage. Using a stepped care approach, the depression care specialists offered patients either antidepressant treatment or brief problem-solving therapy in successive stages, depending on patients' preferences and responses to treatment. Results of this intervention, widely considered the most promising of integrated care models for depression, revealed that half of the intervention patients experienced a 50% reduction in depressive symptoms, although only one quarter became asymptomatic.

Integrated care models are effective in reducing depressive symptoms in older adults (Gilbody, Bower, Fletcher, Richards, & Sutton, 2006; Skultety & Zeiss, 2006), although a significant percentage of individuals either drop out of treatment or fail to maintain substantial improvement. Moreover, the best results are obtained when older adults are offered a choice of treatment approaches (i.e., psychotherapy or medication), when care is truly interdisciplinary (i.e., involving an integrated collaborative approach that facilitates communication between providers), and when the care managers involved have mental health backgrounds.

### **Case Example 1**

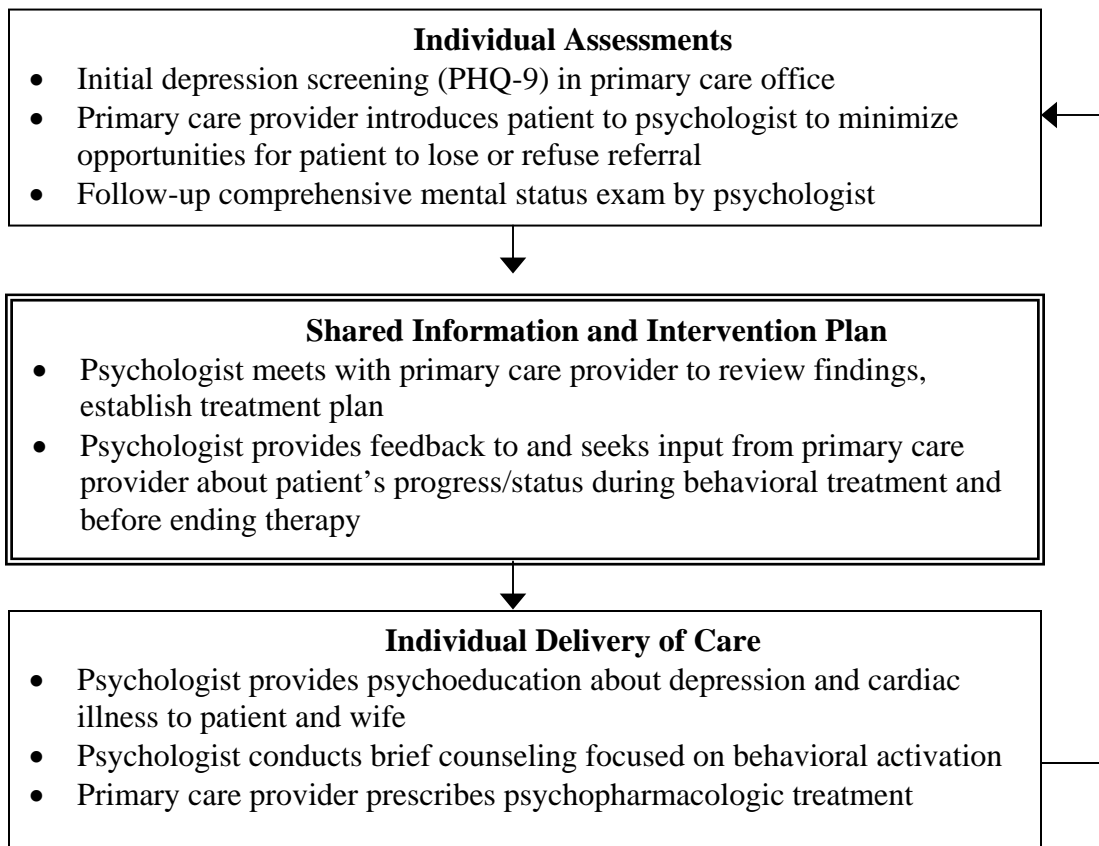
Mr. Howard Thomas is a 72-year-old retired African American veteran living in the rural Midwest with his wife of 46 years. He had triple by-pass surgery three months ago and was seeing his primary care provider, a family physician, for a follow-up visit. He was accompanied by his wife, who shared concerns that he was spending all of his time alone in the den watching TV. Mr. Thomas completed a variety of screening measures given on an annual basis in his primary care clinic. These tools were reviewed by the clinic nurse, who informed the physician that Mr. Thomas scored in the depressed range on the PHQ-9. The physician reviewed Mr. Thomas' health status to assure that new or unresolved medical and neurological issues were not responsible for his depressive syndrome. Additional questions about Mr. Thomas' mood and activities revealed decreased interest in previously pleasurable activities such as reading the newspaper and woodworking. With that information, the physician invited the behavioral health consultant (a psychologist) into the meeting with the explanation that she was a member of the care team who specialized in helping patients cope with medical illnesses and other life stressors. The physician further emphasized his confidence in the consultant's ability to help Mr. Thomas address his recent difficulties.

The psychologist met with Mr. Thomas for 25 minutes, conducting a more thorough evaluation of his mental state, including the nature and extent of his depressive symptoms and a brief cognitive evaluation. Mr. Thomas reluctantly acknowledged that he often thought about his own death, believing that he was no longer useful to his family because of fatigue and shortness of breath related to his cardiac illness and recent surgery. However, he denied experiencing any active suicidal intent or plan. With Mr. Thomas' permission, the psychologist invited Mrs. Thomas back into the room to share the results of the evaluation and confirm the diagnosis of major depression. The psychologist provided psychoeducation about depression, explaining that suicidal feelings were often a serious symptom of depression that warranted careful monitoring. She also described the relationship between cardiac illness and depression, as well as options for

treatment. Although Mr. Thomas appeared agreeable to a trial of antidepressant medication, his wife expressed concerns about her husband taking “yet another medication.” The psychologist listened attentively to her concerns, acknowledged that it was ultimately their decision about the medication, but also provided additional information about antidepressants and how they work. The couple agreed to meet again for additional sessions to discuss ways to help Mr. Thomas cope more effectively with his physical limitations. Next, the psychologist met briefly with the primary care provider to share the results of the meeting and formulate a preliminary treatment plan that included options for antidepressant medication in combination with short-term therapy.

Mr. Thomas and his wife met with the behavioral health consultant for three additional 30-minute sessions in the primary care clinic over the next two months. The sessions focused on helping him cope with his physical limitations and monitoring his suicidal thoughts. As well, the psychologist helped Mr. Thomas consider how he might increase his involvement in pleasant and meaningful activities that were still physically possible, by using the *Pleasant Events Schedule* (MacPhillamy & Lewinsohn, 1982; Gallagher-Thompson, Thompson, & Rider, 2005), a useful tool for helping older adults expand their repertoire of rewarding behaviors. Mrs. Thomas’ involvement in the sessions helped her gain a better appreciation of the challenges her husband faced in adapting to a less physically stressful lifestyle. The conjoint sessions increased her ability to help him make positive changes, including increased involvement with the family. Mrs. Thomas eventually supported her husband’s decision to start a trial of antidepressant medication and agreed to help him remember to take the medication every day. The psychologist was able to help the primary care provider more frequently monitor Mr. Thomas’ response to the antidepressant, thereby helping to monitor any side effects and make sure they were appropriately managed. At six-month follow-up, Mr. Thomas reported a decrease in depressive symptoms on the PHQ-9. He had been doing some woodworking with his grandson and no longer is experiencing thoughts of his own worthlessness or death.

The following figure illustrates the integrated care model in the case of Mr. Thomas.



Although research indicates that the results achieved in primary care settings are generally positive, a significant proportion of participants remain clinically depressed (Unutzer, 2002). Models that effectively utilize screening tools and a staged approach to intervention require the providers to ensure continuity and prevent vulnerable elders from 'falling through the cracks' before they receive treatment. This type of monitoring is difficult in the real world of busy primary care practice, underscoring the need for interdisciplinary care and causing some to argue for more variety in the sites in which that care is conducted.

### *Specialized Medical Settings*

Psychologists can also assume an important role in the delivery of collaborative care in specialized medical settings, including rehabilitation units and medical clinics such as neurology, epilepsy, cardiology, bariatrics, oncology, gynecology, and transplant or cosmetic surgery centers. Typically, the psychologist provides an evaluation of the patient's mental status, including the ability to comprehend the risks and benefits of treatment and/or the ability to follow through with complex or simple prescribed medical regimens, e.g., in the case of liver or heart transplant. In some settings, the psychologist also engages in short-term treatment to support the patient's ability to comply with dietary restrictions, exercise programs or other behavioral requirements. What characterizes this work as *integrated* in nature is the emphasis on interdisciplinary communication to facilitate ongoing, iterative adjustments of the treatment plan,

the consideration of psychosocial as well as biomedical issues affecting the patient, and clear communication about the unique roles played by each collaborator in order to facilitate team functioning and patient-centered care.

At the most seriously ill and medically-intensive end of the continuum, psychologists promote integrated care within acute care hospitals, emergency medical settings, intensive care units and palliative care or hospice services. In these contexts, psychologists are involved in providing mental status evaluations (e.g., of competence to make medical decisions), diagnostic evaluations (e.g., of depression or anxiety associated with medical illness), brief treatment of mental health problems (e.g., psychotherapy for anxiety or depression), treatment of behavioral problems (e.g., cognitive behavioral treatment of pain or sleep disturbance) and family interventions (e.g., to build consensus about treatment decisions or facilitate grieving). Consider the illustrative case of Dr. Martin.

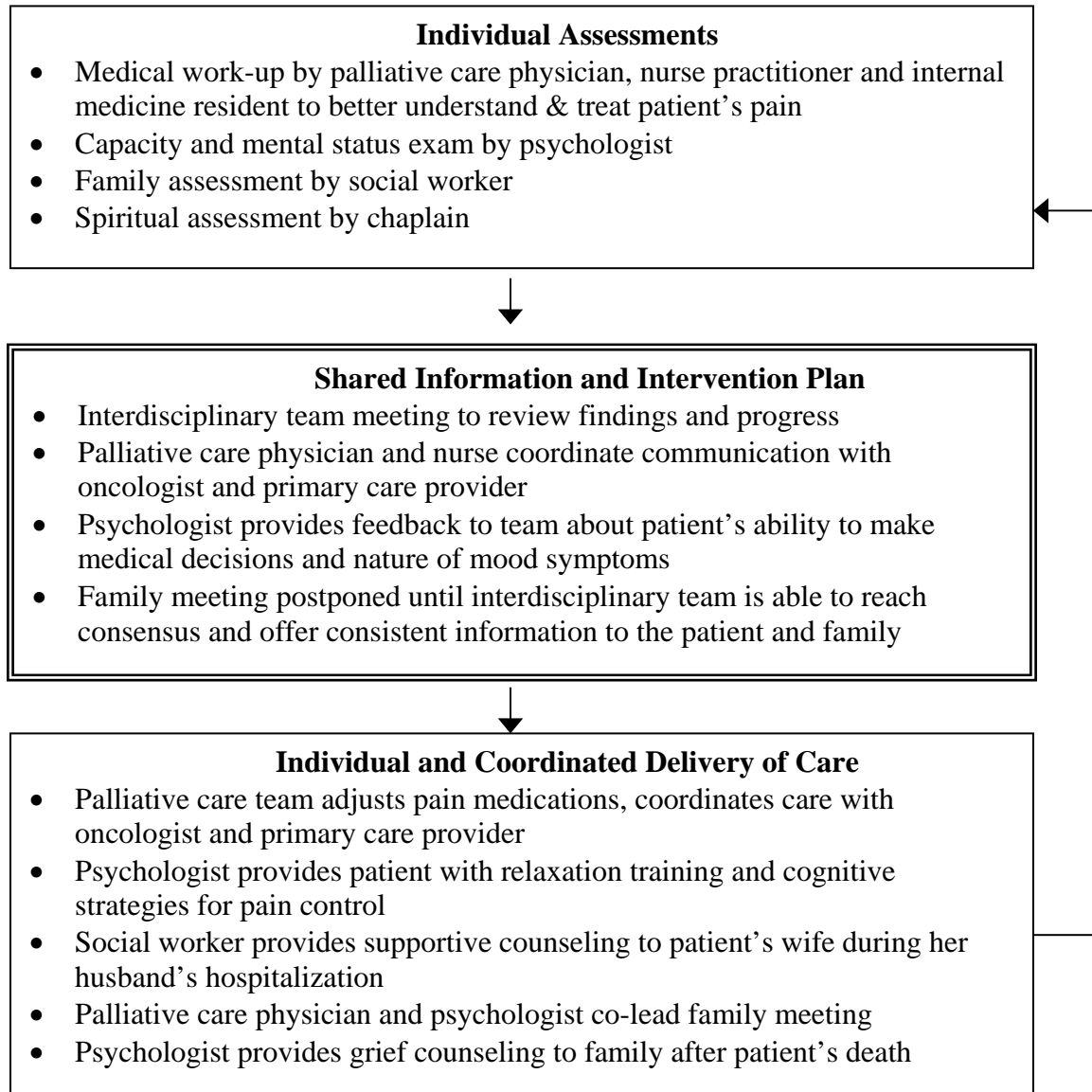
### **Case Example 2**

Dr. Robert Martin was a 69-year-old non-Hispanic White retired history professor who was admitted to the palliative care service of an acute care hospital in a large Northeastern city with multiple medical diagnoses, including advanced metastatic colon cancer and end stage kidney failure. He had recently decided not to pursue further chemotherapy, stating he “had enough.” However, his grief stricken wife of 47 years and two of his four adult children insisted that he pursue one more round of experimental chemotherapy. They noted he was withdrawn and “not himself,” believing that he was incompetent to make such a serious decision. The palliative care team (i.e., physician, nurse practitioner, social worker, psychologist, and chaplain) met briefly to discuss an initial plan of care. They agreed that the psychologist would conduct an evaluation of Dr. Martin’s capacity and general mental state, while the physician and nurse practitioner completed the medical workup and gained further information about treatment options from the patient’s oncologist and primary care physician. The social worker and chaplain collaborated to evaluate the family and determine whether spiritual or religious input was appropriate. All team members documented their assessments in the medical record, with a plan to hold a meeting with the patient and his family the next day to help them reach consensus regarding a plan of care.

The psychologist established that Dr. Martin was competent to make medical decisions although he was having significant anxiety and uncontrolled abdominal pain that were causing him to be moody and withdrawn. The medical team discovered that the oncologist and primary care provider disagreed as to whether the patient should pursue further chemotherapy, a split that mirrored and fueled the disagreement between the patient and his family. The social worker discovered that Mrs. Martin’s grief was especially severe due to the rapid progression of her husband’s illness and her recent loss of a brother to lung cancer. It was also determined that she could benefit from pastoral counseling consistent with her strong Catholic faith. Based on these assessments, the family meeting was postponed until the oncologist and primary care physician could be contacted and encouraged to reach consensus. In the meantime, the nurse practitioner and medical resident conducted a thorough pain assessment and adjusted Dr. Martin’s pain medications, while the psychologist met with him for several brief sessions of relaxation training and cognitive therapy for pain control. Within two days, consensus between the medical providers was established and a family meeting was held. The psychologist and palliative care

physician co-led the meeting in a manner that was sensitive to the family's level of understanding and facilitated the participation of all family members (King & Quill, 2006). Although grief stricken, the family finally was able to accept Dr. Martin's decision to stop chemotherapy and he was discharged to home hospice the next day. Two weeks later, Mrs. Martin phoned the psychologist to report her husband's death and request grief counseling.

The following illustrates an expanded version of the integrated care model in the case of Dr. Martin.



Although collaborative care approaches are designed to address a range of barriers to care at the patient, provider, and service system levels, more refinement is needed. For example, many older adults are uncomfortable presenting emotional difficulties to a healthcare provider. The stigma of receiving either behavioral or psychopharmacological treatment may be greater in



some ethnic minority populations, calling for tailored approaches more consistent with older adults' cultural background and preferences (Ayalon, Areán, & Alvidrez, 2005). Psychologists can play an important role in further development and implementation of modifications to collaborative care models, especially in the delivery of empirically supported, culturally congruent psychosocial interventions (Alvidrez, Areán, & Stewart, 2005) and the management of patient and family attitudinal barriers to care.

### *Long Term Care Settings*

Eight out of every ten nursing home residents have moderate to severe behavioral problems and/or disorders, including agitation, disorientation, forgetfulness, aggression, anxiety, and depression (Rovner, et al., 1990; Swearer, Drachman, O'Donnell & Mitchell, 1998). Characteristics of the long term care environment are known to interact with medical and cognitive illnesses of those admitted to the facilities in a manner that limits residents' personal control over daily routines and reinforces their dependency on others. The call for the use of least restrictive interventions has enhanced awareness of the need for nonpsychopharmacologic, behavioral approaches to the care of chronically ill elders (Cohen-Mansfield, 2003; Teri, Logsdon & McCurry, 1997). Psychologists and other health professionals have been conducting integrated care in nursing homes for decades (Lichtenberg, 1994; Molinari, 2000), formulating principles of interdisciplinary collaboration and designing innovative models of intervention.

One theme repeated across models is that consistent and effective application of behavior management protocols requires the "buy in" of individuals at all levels of the long term care setting, from the nursing assistants (NAs), to the supervising RNs and LPNs, to the primary care providers, to the nursing home administrators. Thus, effective application of the integrated care model in these settings requires incorporation of both resident-focused training in behavioral principles and approaches, and system-focused attention to aspects of team and organizational function. Behavioral analysis and intervention are time-consuming activities, and the psychologist will need to establish trust via long term relationships with staff and administrators to generate sufficient buy-in. Enthusiasm usually increases once a successful intervention is experienced. The systems components used by psychologists in all integrated care settings include establishing common goals and values across team members and disciplines, opening communication within and across all levels of the organizational hierarchy, providing a safe and manageable work environment for the least powerful members of the organization, and establishing an ongoing commitment to a data-driven process of behavioral change by the care team and on the part of the institution's administration.

### **Case Example 3**

Mrs. Maria Santiago is an 84-year-old Puerto Rican widow with moderately severe Alzheimer's disease who was placed in a skilled nursing facility after her husband and primary caretaker died suddenly from stroke. She and her husband had lived independently in a large urban area on the West coast, enjoying frequent visits from their children and grandchildren. Within the first week of admission to a nursing facility in a different state where her oldest daughter lived, she was placed on the list of "problem" residents because of severe agitation, intrusive wandering, and frequent screaming that she believed people were trying to kill her. The primary physician

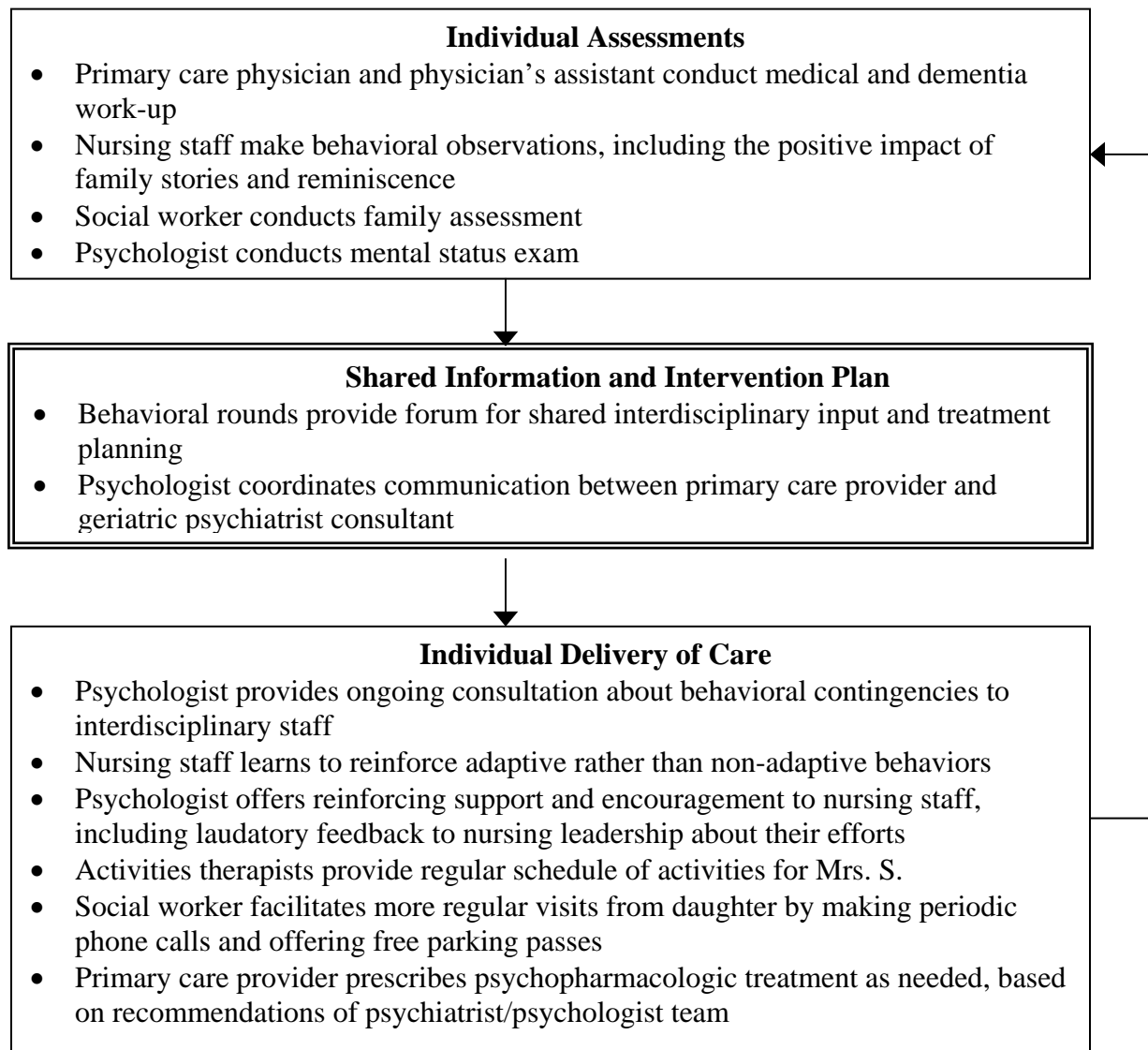
prescribed antipsychotic medication which was quickly discontinued because of motor side effects. The psychologist had a longstanding consultative relationship with the nursing facility, visiting two half days each week in order to participate in weekly interdisciplinary “behavioral rounds” and serve as a liaison between the medical team and a collaborating geriatric psychiatrist. The behavioral rounds provided a critical forum for training and interdisciplinary communication about late-life mental and cognitive disorders, as well as principles of behavioral management.

In discussing Mrs. Santiago’s management, the primary care physician focused on recommendations for another antipsychotic medication to better control her agitation and “paranoid delusions.” The psychologist agreed to address this possibility with the collaborating psychiatrist, but asked first that lab work be completed to rule out reversible causes of dementia. She also discussed the need for baseline neuropsychological testing in order to confirm the nature and extent of her cognitive deficits if Mrs. Santiago was able to comply and if potential language barriers could be addressed. The physician agreed to this plan, after which the psychologist met with nursing staff to gather their behavioral observations. One of the nursing assistants observed that Mrs. Santiago seemed particularly agitated after being alone in her room for extended periods of time. Another Spanish speaking assistant noted that Mrs. Santiago seemed to calm down when re-directed to talk about her children and grandchildren.

The social worker on the team confirmed that Mrs. Santiago had a history of strong and abiding connections to her intergenerational family. After the loss of her husband she was moved to a neighboring state so that her oldest daughter could look after her. Unfortunately, this resulted in the loss of regular support and caring she had become accustomed to from the rest of the family. Motivated by this new perspective on their “problem resident,” the team agreed to engage in further behavioral assessment. First, the nursing staff recorded the antecedents and consequences of target behaviors using a behavior problem checklist. They confirmed that episodes of agitation typically followed periods of isolation in her room. Moreover, they observed that Mrs. Santiago became frightened when seeing her own reflection in the mirror, mistaking her own image for that of a dangerous intruder. Team discussion further revealed that they had been inadvertently reinforcing her negative behaviors by bringing her to the nurse’s station to socialize whenever she became highly agitated.

The following week the physician’s assistant reported that Mrs. Santiago had a urinary tract infection that may have been contributing to her cognitive and behavioral difficulties. Neuropsychological testing was deferred until after treatment of the infection. A treatment plan was established involving: 1) a daily schedule of activities, 2) brief social “check ins” at regular intervals by nursing staff if Mrs. Santiago was calm and not screaming, 3) mirrors were removed from her room, and 4) she was scheduled for an eye exam. After implementing the behavioral plan, the team documented a decrease in Mrs. Santiago’s screaming and an increase in appropriate social behaviors. Although subsequent neuropsychological testing confirmed the dementia diagnosis, she was moved off the list of “problem residents” and transferred to a less restrictive unit that allowed her to be close to another Spanish speaking resident. In response to the nursing assistants’ extraordinary observations and efforts on behalf of Mrs. Santiago, the psychologist wrote a brief note of praise to the Director of Nursing to be placed in their personnel files.

The following figure illustrates the application of the integrated care model to the case of Mrs. Santiago.



Although innovative interdisciplinary care models have been well-described in long term care settings for some time (cf. Lichtenberg, Kimbarow, MacKinnon, Morris & Bush, 1995; Molinari, 2000), much of the existing literature is descriptive and case based. However, randomized controlled trials of collaborative care are now underway using manualized treatment approaches for depression that teach nursing home staff to understand and manage behavioral problems, and increase residents' engagement in pleasant events (Meeks, Teri, Van Haltsma, & Looney, 2006; Meeks, Looney, Van Haltsma, & Teri, in press). These preliminary reports underline the importance of systematic follow-up efforts to maintain treatment gains beyond the initial period of intervention. For example, multiple staff members should be involved in the training to provide consistency through shift changes and periods of staff turnover. Additionally, the nursing home administration must establish sustained incentives for staff participation in behavioral

programming and mental health consultants should participate periodically in ongoing treatment planning meetings to stimulate continued support and reinforcement of behavioral programming efforts.

### ***Community-Oriented Social Service Settings***

Social factors such as isolation, financial difficulties, disability, and family stress play a major role in the pathogenesis, course and outcome of late-life mental disorders. Social service agencies offer important opportunities for integrated care because they afford access to a population of underserved seniors at risk for mental health problems and they employ professionals who have the expertise necessary to address difficult social circumstances. Moreover, aging services workers ‘infiltrate’ a variety of settings inhabited by socioeconomically disadvantaged elders who otherwise would not receive care, including nutrition centers, private homes, subsidized seniors housing, and faith-based health ministries. Psychologists are well qualified to develop, help implement, and evaluate collaborative care models in these settings. Psychologists can also create bridges between social services and healthcare systems at multiple levels, including the level of the individual older adult, his or her family, and the larger healthcare delivery system.

The extent and structure of community-oriented aging services varies widely across geographic regions. Many communities have networks of agencies providing care management (of financial and other psychosocial issues), legal assistance, nutrition services, assistance with transportation, and evaluation and referral in instances of elder abuse or neglect. Integrated care is facilitated in some aging services networks by shared web-based information systems that support electronic client records and facilitate both inter-agency and inter-professional communication and referral. Regardless of the level of coordination of services and databases, however, most communities have aging services agencies (such as Area Agencies on Aging) that are well positioned and financed by the Older Americans Act to address the needs of vulnerable elders with financial, social and disability issues.

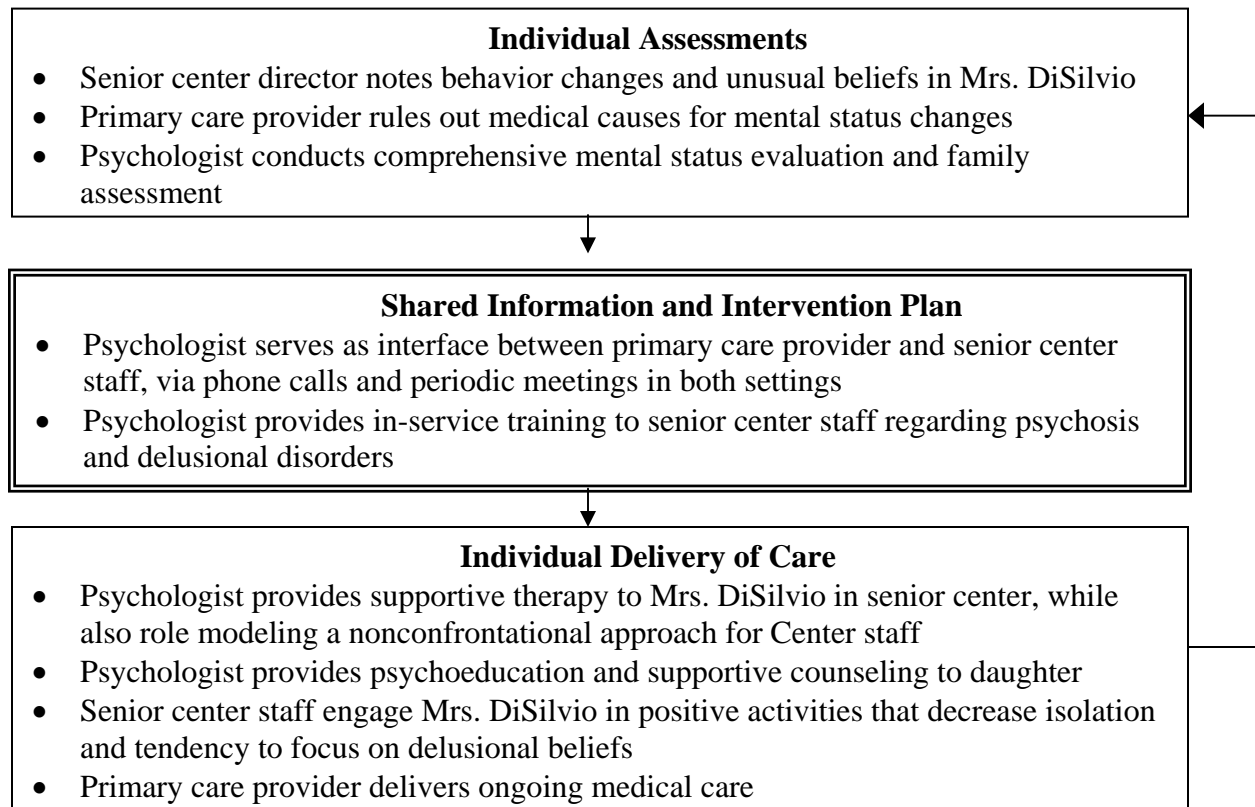
### **Case Example 4**

Mrs. Evelyn DiSilvio is an 81-year-old widowed Italian-American mother of two grown daughters, living alone but regularly eating lunch at a seniors’ nutrition center in an urban area of a large Northeastern city. The center director became concerned after Mrs. DiSilvio appeared increasingly disheveled and depressed over a span of three months. Her concerns deepened when Mrs. DiSilvio confided that she was under government surveillance. The center director consulted a psychologist working with a local aging services agency to see whether some type of evaluation could be provided. Because Mrs. DiSilvio refused to see any mental health professional in an office-based setting, the psychologist began seeing her twice a month at the senior center for assessment and subsequent supportive psychotherapy. As part of the assessment, she worked with Mrs. DiSilvio’s primary care provider to confirm that medical causes for her condition had been ruled out. A dual diagnosis of delusional disorder and minor depression was established after cognitive testing ruled out dementia and other cognitive disorders.

As the psychologist worked with Mrs. DiSilvio in the senior center, she also provided two brief in-service sessions to center staff about delusions and how to respond to elders who report unusual beliefs. Moreover, she served as an interface between the center staff and the primary care office, providing phone consultations to providers in both settings as needed. These educational consultations reduced the tendency for center staff to avoid Mrs. DiSilvio, endorse her unusual beliefs, or give her additional fictional explanations for the unusual occurrences she perceived in her surroundings. Due to Mrs. DiSilvio's relatively high level of functional independence, the benign nature of her delusions, and the fact that senior center staff could regularly monitor her status, the team agreed to work together in the community setting to help her decrease her depressive symptoms and maintain her independence.

Mrs. DiSilvio also reported strained relationships with both of her daughters, which directly influenced her mood. Therefore, the psychologist worked to establish a collaborative relationship with the daughter living locally. This process was complicated by the daughter's longstanding anger about her mother's refusal to accept treatment. The daughter had little understanding of mental illness, so the psychologist educated her about delusional disorder, its manifestations, and how to respond when her mother reported unusual beliefs or events. Eventually, the daughter was able to attribute her mother's problematic behaviors to an illness rather than to an intentional effort to be strange or difficult. Although their relationship remained somewhat strained, the daughter arranged for regular visits to help her mother with shopping. After one year, Mrs. DiSilvio continued to exhibit delusional thoughts, but she was less depressed and continued to live independently.

Application of the integrated care model to the case of Mrs. DiSilvio is illustrated below.



Evidence regarding the effectiveness of community-oriented integrated care has only recently begun to emerge. For example, the *Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)*; Ciechanowski et al., 2004) was a community-integrated intervention for detecting and managing minor depression that targeted individuals receiving aging services or living in senior public housing. Seventy-nine percent of the sample was female, 42% belonged to a racial or ethnic minority (primarily African American) and 58% had a yearly income below \$10,000. The participants were screened for depressive symptoms by social workers, who provided brief problem-solving therapy (PST), as well as social and physical activation. Using a stepped-care approach, the study psychiatrist consulted with primary care providers as needed regarding antidepressant medication if psychotherapy was ineffective. Compared to the usual care group, elders who received the intervention were more likely to have at least a 50% reduction in symptoms, to achieve a complete remission from depression, and to experience greater improvements in functional and emotional well-being. However, only a third of participants experienced full remission. Although encouraging, these results suggest that there is still much work to be done if integrated models are to address effectively the problems of a majority of vulnerable elders receiving social services.

### **Future Directions: Opportunities for Selective and Universal Prevention**

There is no end to the number of potentially rewarding settings in which innovative psychologists can apply the integrated care model to promote the health and well-being of older adults. At the healthiest and least medically-intense end of the continuum, psychologists may provide services or collaborate with other professionals in health clubs and wellness centers designed specifically to address the needs of the aging population. For example, psychologists can take the lead in the development, implementation, and evaluation of mental health screening and referral sessions in fitness centers serving relatively healthy older adults. Alternatively, psychologists may conduct these activities in community centers, faith-based health ministries, or senior nutrition centers in order selectively to focus on more socially vulnerable elders. Psychologists also may play a role in training community “gatekeepers” such as care managers, home health aides, nurses and other health or lay persons who lead formal health ministry programs, or meals-on-wheels volunteers to identify and refer older adults at risk for depression or other problems. For example, one such project involved training care managers in the “Question-Persuade-Refer” method of suicide prevention (Quinnett, 1995). Findings from this pilot study suggested that care managers gained confidence in their ability to talk to at-risk older adults about depression and suicide (Von Bergen, Podgorski, King, & Conwell, 2007).

The Administration on Aging has partnered with public agencies and private foundations to fund evidence-based prevention programs to train community service workers to deliver interventions proven to reduce the risk of age-related disease and disability ([www.aoa.gov/prof/evidence/asp](http://www.aoa.gov/prof/evidence/asp)). As part of this effort, the National Council on Aging Center for Healthy Aging ([www.healthyagingprograms.com/index.asp](http://www.healthyagingprograms.com/index.asp)) has served as a resource center to help community sites adapt structured research interventions to traditionally underserved settings and develop toolkits to help aging service providers bring model health and wellness programs to their communities. These interventions are focused on prevention rather than treatment, and on populations rather than individuals. Nevertheless, they can be enhanced by the application of integrated care principles, such as interdisciplinary planning and implementation, and an

emphasis on psychosocial factors that contribute to health and wellness. Psychologists can make vital contributions by bringing a more sophisticated understanding of the principles of behavior change (and the maintenance of behavior change) to the design and implementation of health promotion programs.

Other rich opportunities to engage in selective prevention occur within Geriatric Research, Education, and Clinical Centers (GRECC) of the Veteran's Health Administration. As part of a strategy to focus attention on the aging veteran population, the VA established GRECCs as "centers of geriatric excellence" to foster the integration of research, education, and clinical achievements. These Centers focus interdisciplinary efforts on translating clinical research into education and practice, thereby improving the quality of life of older veterans. For example, one GRECC in Durham, NC has focused on the MOVE program (Managing Overweight/Obesity in Veterans Everywhere). Other GRECC efforts include the development of new models for improving the quality of dementia care in long term care units. More information on the GRECC model can be found on the VA website: [www.va.gov/grecc](http://www.va.gov/grecc).

Psychologists also are uniquely suited to make important administrative contributions to the overall design and evaluation of integrated care models. As the current healthcare climate demands more evidence of the efficiency and effectiveness of services, psychologists can utilize their expertise in research design and statistical methods to inform a range of quality improvement efforts. For example, Callahan (2003) demonstrated how statistical process control techniques could be used to analyze and improve treatment outcomes in an emergency medicine setting. By taking the lead in these efforts, psychologists are promoting empirically supported methods of quality assurance, contributing to large-scale improvements in healthcare outcomes, as well as helping to provide evidence of the cost-effective nature of integrated health care.

Recent advances in the management of chronic medical illness may also afford new opportunities for psychologists to engage creatively in selective prevention efforts. The chronic care model described by Bodenheimer and colleagues (2002) underlines six key elements of optimum chronic care: 1) linkage with community resources, 2) healthcare organizations that value and support increased attention to chronic conditions, 3) support of patients and families to acquire the skills and confidence necessary to manage their own chronic conditions, 4) healthcare delivery redesign to include interdisciplinary teams of professionals focused on preventive, patient-centered management of chronic conditions, 5) evidence-based clinical practice guidelines, and 6) computerized clinical information systems to prompt providers to follow practice guidelines and to provide performance feedback regarding patient outcomes. Many psychologists have the behavioral, community, family systems and research expertise to make important contributions to all six areas of the chronic care model.

In this chapter, we have only 'scratched the surface' in terms of illustrating the range of settings where integrated care may be applied. For example, space has not allowed full consideration of the range of potential residential sites of integrated care, including naturally occurring retirement communities (NORCs) or assisted living centers. Moreover, there was only a very modest evidence base to guide our exploration of integrated care models beyond the bounds of primary care and long term care settings. It is imperative that psychologists address this gap by creating and evaluating innovative, community-oriented approaches to the care of socially vulnerable

elders at risk for health and mental health problems. Finally, at a policy level, psychologists must play an active role in advocating for legislative and regulatory change if quality mental health services are to become available to all older adults (Elmore, 2007; Karlin & Duffy, 2004; Pruchno & Smyer, 2007).



## **Chapter 7**

### **The Older Consumer's Perspective on Health Care**

#### **Health Literacy**

“Health literacy” among older adults is low. Health literacy is the ability to make reasonable health care decisions based on the individual’s capacity to obtain, analyze, and understand basic health care information and available services (Hibbard, Greene, & Tusler, 2005). Those with lower health literacy have less knowledge about health, receive less preventive care, exhibit worse control of chronic illness, and have more emergency room visits and hospitalizations than those with greater health literacy (Greene, Hibbard, & Tusler, 2005).

One obstacle to health literacy is basic literacy. A national survey of adult literacy found that over two-fifths of older adults can only read at a basic reading level which does not equip them to function adequately in society (Kirsch, Jungeblut, Jenkins, & Kolstad, 1993). Some older adults have considerable difficulty understanding basic information about health plan options. In one study, older adult Medicare recipients made almost three times as many errors on a measure of ability accurately to interpret information about different health plans as younger persons (Hibbard, Slovic, Peters, Finucane, & Tusler, 2001). Among Medicare recipients, poorer health and less education were associated with poorer health literacy. Based on their findings from this study, the authors estimated that over half of older Americans have significant problems in the interpretation of health care options. Health literacy is further complicated for older adults who lack English language proficiency.

In one large study, researchers administered a test of functional health literacy to a group of older adults (Gazmararian et al., 1999). The test ascertained the respondents’ ability to read and understand basic health information, including medication instructions. One-third of English speaking and over half of Spanish speaking older adults had inadequate or marginal health literacy. Factors associated with poor health literacy included being Black, older, having few years of completed school, and having been a blue collar worker. Those with poorer health literacy are often ashamed and hesitant to ask questions that may reveal lack of knowledge, which further erodes access to health information (Parikh, Parker, Nurss, Baker, & Williams, 1996).

#### **Patient Satisfaction with and Expectations about Medical Care**

There is a large literature on patient (dis)satisfaction with health care (Cleary & McNeil, 1988), including satisfaction with health care among minority individuals (Dayton, Zhan, Sangl, Darby, & Moy, 2006). Relative to other countries, consumers of health care in the United States are generally dissatisfied with the care that they receive. A Commonwealth Fund study of patient satisfaction with received health care in six nations (Australia, Canada, Germany, New Zealand, United Kingdom, and the United States) found that the United States had the lowest overall rankings among those nations (Davis et al., 2006). The study used the Institute of Medicine’s (2001) framework for assessing health quality, including patient safety, patient-centeredness,

efficiency (and coordination of care), equity, effectiveness, and timeliness. The United States had the lowest ranking among nations on the first four of these indicators.

Recently researchers have argued for a more complex understanding of the experience and views of health care consumers beyond simple satisfaction indices. Some researchers have found that a patient's unmet expectations of health care providers are associated with less satisfaction with care, weaker intentions to adhere to medical directives, and less improvement in health.

Physicians treating patients with unmet expectations are themselves less satisfied with the patient encounter and find that it requires greater effort to deliver care to these patients (Bell, Kravitz, Thorn, Krupat, & Azari, 2002). Younger patients are more likely to report unmet expectations than older patients. There is a much smaller literature on older patients' satisfaction with and expectations about health care, despite the fact that this age group consumes the lion's share of health care services (Scotti, 2005).

Interestingly, studies have found that older patients generally have higher levels of satisfaction with health care than younger patients (Owens & Batchelor, 1996). One explanation is that older people have different or lower expectations for care than younger adults or see poor health as normative. Older adults may have few expectations on which to judge adequately the health care that they receive (Owens & Batchelor, 1996). Some researchers have suggested that most studies of satisfaction with health care use short time frames to judge consumer satisfaction, rather than episodes of care which may include multiple encounters with health care providers and services that are often neither well coordinated nor integrated (Cleary & Edgman-Levitan, 1997).

Other work has found considerable heterogeneity of views among older adults about health care. Adults 80 years of age and older, as well as those with multiple disabilities, are less satisfied with the care they receive than other older adults. Consistent with this finding, older adults with high levels of morbidity in fact receive poorer quality of primary care than those with fewer medical problems (Shadmi et al., 2006). One likely reason for poorer care is inadequate coordination of care among medical care providers of persons with multiple medical problems. Other studies have found that older Medicare and/or Medicaid recipients express dissatisfaction with information that is available to them for choosing among different health care plans or providers (Edgman-Levitan & Cleary, 1996).

### **Older Patient Preferences for Mental Health Care**

Studies of the general public and adult patients in primary care settings have found that most patients believe that depression requires professional attention (Brody, Khaliq, & Thompson, 1997). Older adults prefer to receive treatment for depression in primary care settings, despite the fact that many depressed older and younger adults seen by primary care physicians are neither diagnosed nor treated for depression (Davidson & Meltzer-Brody, 1999). Like younger adults, more older people prefer to receive psychosocial services for treatment of depression than psychotropic medications, and counseling is preferred as a treatment modality more often than medication (Areán, Alvidrez, Barrera, Robinson, & Hicks, 2002; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000; Landreville, Landry, Baillargeon, Guerette, & Matteau, 2001; Unutzer, et al., 2002). What is also sorely lacking are efforts to improve older persons' understanding of mental health issues, ways to access mental health care, methods for bringing mental health

issues to the attention of primary care physicians, and the means by which mental health care issues can be addressed within an integrated system of health care.

Older people with mental health problems hesitate to or do not receive mental health services because of associated stigma (De Mendonca Lima, 2004). The World Health Organization has, in fact, produced a consensus statement on reducing stigma and discrimination against persons with mental disorders (Graham, et al., 2003). Aged persons with severe mental health problems feel they are stigmatized because of them (Depla, deGraaf, van Weeghel, & Heeren, 2005). Bereaved older adults who view mental health services as stigmatizing are less likely to access them (Bambauer & Prigerson, 2006). Older adults who reveal higher levels of perceived stigma about the receipt of mental health services are less likely to continue treatment than older adults having lower levels of perceived stigma (Sirey, et al., 2001).

Finally, one report from the large Primary Care Research in Substance Abuse and Mental Health for the Elderly study (PRISM-E) is of particular relevance to integrated care for older adults (Bartels, et al., 2004; Bruce et al., 2004). The study found that older adult primary care patients preferred receiving mental health services through an integrated care model, where mental health services were received on-site in the primary care setting rather than referral to an off-premises mental health specialist (Chen, et al., 2006).

### **Issues for Marginalized Older Health Care Consumers**

In view of disparities in health and access to care between marginalized and majority adults, including older adults, we would expect that the views of marginalized adults regarding health care would differ from those of majority adults (Institute of Medicine, 2001). Studies of adults reveal mixed results, with some marginalized people reporting less or equivalent satisfaction with health care (and related indicators) compared with majority adults (see Dayton, Zhan, Sangl, Darby, & Moy, 2006). In a recent study of a mixed age group of respondents, Dayton et al. (2006) found that despite receiving worse care than Whites, Black respondents had higher levels of satisfaction. Some explanations for this paradox include problems in the measurement of health care satisfaction, lower expectations for care by minority groups, and cultural and historical experiences that influence beliefs and attitudes in complex ways. Health literacy is lower in minority compared with majority older adults. One large study found the following rates of “inadequate” health literacy in Medicare enrollees in a managed health care organization: White, 18.2%; Hispanic-English Speaking, 29.5%; Hispanic-Spanish Speaking, 34.3%; Black, 52.1% (Gazmararian et al., 1999). Socioeconomic status is strongly tied to health literacy; and historically older minority adults have had much less access to education and employment opportunities than majority older adults (Hibbard, Green, & Tusler, 2005; Hibbard, Jewett, Engelmann, & Tusler, 1998).

We know little about the views and preferences of older ethnic and racial minority group members about mental health services. However, in a sample of primary care older patients who were predominantly minority group members, Areán and colleagues (Areán, Alvidrez, Barrera, Robinson, & Hicks, 2002) found that both distressed (i.e., those who had notable psychological symptoms) and nondistressed older patients indicated a willingness to use psychological services and preferred individual counseling or psychoeducational classes over other psychosocial modalities. Another study found older African Americans preferred to receive mental health

services in their doctor's or clergy's office whereas White older Americans preferred a professional service provider's office (Dupree, Watson, & Schneider, 2005). A related investigation of mental health treatment attitudes of low-income older adults (the majority of whom were African American and Hispanic) found that psychotherapy was preferred to antidepressant medication in the treatment of depression (Choi & Morrow-Howell, 2007).

### **Ways to Improve Older Adult Knowledge of and Access to Health Care**

Although integrated health care offers numerous advantages to older adults who typically have multiple health conditions, multiple providers, and multiple sites for accessing care, we believe that few older health care consumers are even aware of integrated systems of care. As noted, some authors believe that older adults have little basis on which to shape expectations about care (Owen & Batchelor, 1996). Some older persons – particularly minority and marginalized older adults – have problems even accessing health care, much less nesting their health care in an integrated system of care. Nonetheless, individually and collectively older persons can have an impact on the health care system by voicing concerns – and expectations -- to individual health care providers, insurance entities, and state and local representatives. The American Psychological Association and other organizations concerned with health care could take steps to help shape expectations by letting older health care consumers know what a good system of health care would look like. The content of communications to older adults about how their health care could be better could include:

- (1) The message, “You have a right to better health care through integrated systems of care.”
- (2) Guidance to older health care consumers on how they can best navigate the health care system, with special attention to the needs of older adults who are members of minority and marginalized groups, those with concurrent health and mental health problems, and those of advanced age who typically have multiple health problems.
- (3) Examples of common problems in coordination of care with which older persons must contend.
- (4) Examples of integrated health care systems that work.
- (5) Information about the link between physical and mental health in older adults.
- (6) Ways for older adults to advocate for a better health care system.

Strategies to provide such communication, with the goals of improving health in older adults, by improving health literacy and access to coordinated care, must take into account the diversity of this age group and the generally low levels of health literacy (Hibbard et al., 2001; Kirsch et al., 1993). Hibbard recommended simplification of the tasks that are required of Medicare beneficiaries to choose health plan options, development of more accessible and understandable information including non-print approaches, and identification of those individuals most in need of assistance with making health care plan decisions including use of health literacy screening tools (Hibbard et al., 2001). Similarly, others have recommended that “high risk” older adults (i.e., those who are least able to understand health-related information) need to be targeted for educational interventions that might include audio/videotaped instructions of medical information and use of visual cues vs. written instructions. Language barriers present additional challenges to health literacy and need to be addressed.

These efforts could be coordinated with professional organizations, community groups, health care delivery organizations, pharmacists, and others (Gazmararian et al., 1999). Older minority health care consumers, in particular, should be targeted for interventions given the lower levels of education generally evident in this subgroup of older adults. Health education must be shaped by an understanding of how health information can be best understood by minority older adults that takes advantage of local community resources (Cleary & Edgman-Levitan, 1997). For example, one effort to improve health insurance knowledge among Medicare beneficiaries by using written materials with varying degree of complexity resulted in modest improvement of knowledge (McCormack et al., 2002). Ongoing, multiple messages are tied to improved health care knowledge.

Other approaches include educational materials to guide the patient-consumer in how to organize the health care encounter with the physician. Typical recommendations include preparation for the health visit, written questions for the health care provider, summaries of current medication and medical problems, accompaniment by a friend or family member, encouragement to ask questions, and review and clarification of the health recommendations. A recent issue of *Consumer Reports* (2007; “Get better care from your doctor”) is a good example of such recommendations. Some organizations have prepared guidelines for improving patient-physician communication for older persons that contain similar information. (See Additional Resources for links to consumer materials in English and Spanish).

What is lacking in most patient educational materials is guidance for patients on how to improve coordination of care among health care professionals. As discussed earlier in this document, many older adults have multiple health care providers and coordination of care is often inadequate. Few older consumers are aware of the existence of and the many advantages of integrated health care.

## Recommendations for Future APA Action

The original idea for this presidential task force was laid out in Dr. Brehm's Preface. She created the task force because of her insight that an integrated approach to health care is needed, now more than ever. This was based on her personal experiences, demographic forecasts regarding the aging of the Boomer generation, and mounting evidence that a piecemeal, uncoordinated approach to healthcare for older adults does not work. We have explored all of these issues in this report. The ultimate goal, we argue, is to advocate for integrated health care as a right and need for all older adults. Some of that advocacy will require collaborative efforts with other professions. However, the first step is to educate psychologists about this model of care, the critical need for its availability, and how psychologists can prepare themselves to work in collaborative care environments. This *Blueprint for Change: Achieving Integrative Health Care for an Aging Population* is intended to do exactly that. We have laid out the evidence for the model and the contributions that psychologists can make. We now turn to specific recommendations intended to guide the process of actually implementing the ideas in this report.

The Integrative Health Care for an Aging Population Presidential Task Force offers the following recommendations for consideration by APA governance, divisions, other constituent groups, and members. The Task Force recognizes that it offers a large number of recommendations but believes the process of prioritizing the recommendations and developing an implementation plan are beyond the scope of a time-limited Presidential Task Force. Our intent is to spur future action by outlining the multitude of actions that could be taken to promote integrated health care for older adults, not to lay out the specific path to be taken. Rather, the APA Committee on Aging (CONA), at its fall 2007 meeting, reaffirmed its commitment to taking responsibility for the continuation of the work begun by the Task Force and to develop an implementation plan to promote the translation of these ideals into effective practice.

The Task Force encourages other APA governance and constituent groups to consider providing their continued expertise to CONA in promoting integrated health care for older adults. We also encourage *all* psychologists to review these recommendations and think about how they could best change their approach to practice, training, research, and policy in their organizations, or other professional activities, to support implementation of this integrated care model. In addition, CONA will seek and welcome collaboration with other professional groups in implementing recommendations.

### Research

- Disseminate the *Blueprint for Change: Achieving Integrative Health Care for an Aging Population* to researchers in order to inform their research efforts regarding integrated health care and older adults.
- Develop a research agenda to promote the expansion of the scientific knowledge base regarding the impact and effectiveness of integrated care, the processes that lead to best clinical outcomes, and the contributions of psychologists as members of these teams.
- Encourage research on and use of best practices of integrated health care among culturally and linguistically diverse people

- Encourage research on how factors of diversity, including age, race/ethnicity, gender, sexual orientation, disability, socioeconomic status, family structure, and immigration status affect access to and utilization of integrated health care services.
- Encourage the incorporation of the following data points in ongoing efforts related to psychology workforce analysis:
  - ◊ the number of psychologists who provide services to older adults, including those with specialized training in geropsychology;
  - ◊ the primary geriatric settings in which psychologists work;
  - ◊ the number of psychologists providing services to older adults who work as part of an interdisciplinary team, and what disciplines make up that team;
  - ◊ the number of faculty members who provide training/education in geropsychology; and
  - ◊ the projected need for psychologists who are qualified to address the growing demand for service provision to older adults.
- Encourage psychologists to share their research expertise as members of an integrated health care team.
- Support partnerships between researchers and clinicians that creatively adapt the model of practice described in the *Blueprint for Change: Achieving Integrative Health Care for an Aging Population* in diverse sites of care that serve diverse populations of older adults and their families.
- Foster the dissemination and application of basic research findings for use in clinical practice to improve the health care of the aging population.
- Establish an ongoing mechanism to disseminate scientific findings regarding the benefits and application of integrative health care as the knowledge base continues to develop including mechanisms to assure their distribution to ethnically and linguistically diverse audiences.

## **Education and Training**

- Encourage use of the *Blueprint for Change: Achieving Integrative Health Care for an Aging Population* to guide educational efforts of all offices across APA directorates.
- Encourage APA Offices, Boards, Committees, and Divisions to educate their members on the availability and utility of the *Blueprint for Change: Achieving Integrative Health Care for an Aging Population*, with particular attention to older women; ethnic minorities; individuals with disabilities and chronic health conditions, including HIV/AIDS; those near end-of-life; intergenerational families; gay, lesbian, bisexual and transgender persons; and those of low socioeconomic status.
- Support the development of psychology graduate curricula on integrated health care for older adults.

- Promote clinical training opportunities in integrated health care settings at all levels of training to prepare psychologists for work in integrated health care teams.
- Support the development of education and training opportunities in integrated health care for students and health care professionals across disciplines and at all levels of professional development.
- Collaborate with interdisciplinary colleagues to provide educational opportunities on the need and the value of integrated care (e.g., Gerontological Society of America annual meetings).
- Offer continuing professional education programming on the roles of psychologists in initiating and facilitating the development of and participating as members of integrated health care teams for older adults.
- Work with other professional organizations to develop fact sheets for a variety of disciplines that highlight the benefits of integrated models of health care and how to use effectively the expertise of psychologists and other health care professionals as team members.
- Encourage members of the IHAP Technical Advisory Panel to assist in the development of the above listed fact sheets and to share the message of the *Blueprint for Change: Achieving Integrative Health Care for an Aging Population* via their organizational media outlets.
- Continue ongoing efforts to expand the behavioral geriatric mental health workforce, including geropsychologists, geriatric psychiatrists, and geriatric clinical social workers, to work as members of integrated health care teams for the growing population of older adults.

## Practice

- Encourage all APA entities, including state and regional affiliates and divisions, to incorporate the information from the *Blueprint for Change: Achieving Integrative Health Care for an Aging Population*, particularly models of practice appropriate for older adults in diverse sites of care and with diverse populations of older adults, including those of low socioeconomic status, in continuing education and promotional activities.
- Encourage the utilization of the integrated models of health care reviewed in this report in public practice in mental health, primary care, and educational settings.
- Continue ongoing efforts to educate psychologists regarding existing Medicare CPT codes for the appropriate treatment of the health and behavioral disorders of older adults, and the new team conference Medicare CPT codes which would allow for reimbursement of team discussions leading to treatment planning, which plays an essential role in integrated health care efforts.
- Deliver care in a family-focused, culturally competent manner that encompasses older adult preferences and values in health care decision making.
- Identify and disseminate optimal strategies for encouraging health care providers to participate in interdisciplinary, integrated health care teams and models.



## Public Policy

- Consider the information presented on the importance of integrated health care for older adults contained in the *Blueprint for Change: Achieving Integrative Health Care for an Aging Population* in the public policy efforts of all APA directorates.
- Support efforts to draft an APA resolution on integrated health care for older adults.
- Advocate in support of both federal and private research funding related to integrated health care for older adults.
- Continue to train psychologists as policy advocates and facilitate opportunities for participation in APA policy efforts related to health and aging issues, including supporting integrated health care for older adults (e.g., Positive Aging Act) and increased education and training opportunities for psychologists working as members of integrated health care teams for older adults (e.g., Graduate Psychology Education Program, Title VII of the Public Health Service Act).
- Continue to advocate for public policies that facilitate and promote integrated health care for older adults (e.g., Medicare CPT codes, Positive Aging Act, increased Medicaid funding for mental health services, utilization of electronic medical records, licensing portability, telehealth, health record privacy).
- Encourage psychologists in all settings (e.g., clinical, research, academic, policy) to advocate for practices and policies that support integrated health care for older adults at the local, state, and national level.
- Develop and disseminate briefing materials, in collaboration with other professional groups who support integrated care, for policy makers on integrated health care including information on the importance of psychologists as part of the interdisciplinary team.

## Public Education and Awareness

- Consider the inclusion of messages within existing and future APA Public Education campaigns on the key issues described in the *Blueprint for Change: Achieving Integrative Health Care for an Aging Population*.
- Develop educational materials for older adults, their families, and caregivers that include information on mental health issues, ways to access mental health care, methods for bringing mental health issues to the attention of primary care providers, strategies for improving coordination of care among their care providers, and benefits resulting from inclusion of psychologists as members of interdisciplinary health care teams.
- Promote and disseminate the *Blueprint for Change: Achieving Integrative Health Care for an Aging Population* to diverse media outlets, including both majority and minority media outlets, and those with audiences across the socioeconomic spectrum.
- Encourage all APA entities to share the *Blueprint for Change: Achieving Integrative Health Care for an Aging Population* with other relevant stakeholder organizations, including aging consumer and caregiver groups, aging services networks, health care providers and

administrators, mental health and aging coalitions (e.g., National Coalition on Mental Health and Aging), federal agencies, private foundations, health care industry leaders and insurers, and policy makers. These efforts would be aimed at increasing awareness among these groups about the value of integrated health care, psychology's role in integrated health care teams, and the development of partnerships to promote integrated health care.

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## Additional Resources

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