Selecting relevant and important indicators specific to older adults

The project team, including our two consultants, has completed a thorough review of relevant literature as indicated above to identify candidate indicators. Reports and literature were reviewed to identify quality indicator thresholds and appropriate population-specific goals for effective systems of mental health care as well as methods/approaches in performance monitoring that are adaptable to changing needs of diverse populations. Reports and literature were also reviewed for limitations of mental health care performance monitoring and methods for appropriately interpreting indicators as they relate to intended outcomes.

Candidate measures represent processes and outcomes that are relevant to older adult mental health. Each of the indicators recommended are critically important to older adult mental health, representing highly prevalent or predictive health concerns, as noted for each below.

**Suicide Prevention**

The incidence of suicide is particularly high among older, white males (30.3 suicides per 100,000). Notably, the rate of suicide in the oldest group of white males (ages 85+) is over four times higher than the nation’s overall rate of suicide. Suicide attempts are often more lethal in older adults than in younger adults. Older people who attempt suicide are often more frail, more isolated, more likely to have a plan, and are more determined than younger adults. These factors suggest that older adults are less likely to be rescued, and are more likely to die from a suicide attempt than younger adults. Firearms are the most common means of suicide in older adults (67%), followed by poisoning (14%) and suffocation (12%). Of note, older adults are
nearly twice as likely to use firearms as a means of suicide than are people under age 60. The lethality of older adult suicide attempts suggests that interventions must be aggressive and that multiple prevention methods should be used.

**Affective Disorders**

*Depression.* Depression is not a normal part of life or aging. Depression occurs across the life course in all races, genders, and ages. Depression is, however, the most common mental illness in late life and decreases quality of life.

A review of the epidemiology of depression reports that 8 percent to 16 percent of community-dwelling older adults have depressive symptoms, the prevalence of depression is substantially higher in older adults with medical illnesses, and in those who receive services from aging service providers. For instance, a recent study found that more than one-quarter (27%) of older adults assessed by aging service providers met criteria for having current major depression and nearly one-third (31%) had clinically significant depressive symptoms. Depression is often under-recognized and under-treated in older adults.

*Anxiety.* Three to 14% of older adults meet the diagnostic criteria for an anxiety disorder, however a greater percent of older adults have clinically significant symptoms of anxiety that impact their functioning. For instance, a recent study found that more than one-quarter (27%) of aging service network care management clients have clinically significant anxiety.

Like depression, anxiety disorders are often unrecognized and undertreated in older adults. The detection and diagnosis of anxiety disorders in late life is complicated by medical comorbidity, cognitive decline, changes in life circumstances, and changes in the way that older adults report anxiety symptoms.

**Cognitive Health**

The Alzheimer’s Association reports that in 2014, 5.2 million Americans of all ages had Alzheimer’s disease, and Alzheimer’s disease accounts for an estimated 60% to 80% of all cases of dementia. Based on these figures, one could estimate that in 2014 there were 6.5 million to 8.7 million Americans with dementia.

The Patient Protection and Affordable Care Act (ACA) of 2010 established the Annual Wellness Visit (AWV) as a new Part B benefit for Medicare beneficiaries. Regulations to implement the new AWV benefit define *detection of any cognitive impairment* as “assessment of an individual’s cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers or others.” The benefit of improved diagnostic processes and accompanying quality measures cannot be realized if the first step along that pathway (i.e., detection) is not addressed in a timely manner.
**Alcohol and Substance Abuse/Misuse**
Several recent community surveys have estimated that as much as 16 percent of older adults are at-risk or problem drinkers. More than 25 percent of older adults use prescription psychoactive medications that have abuse potential. Substance abuse, particularly of alcohol and prescription drugs, among adults 60 and older is one of the fastest growing health problems facing the country. Problems stemming from alcohol consumption, including interactions of alcohol with prescribed and over-the-counter drugs, far outnumber any other substance abuse problem among older adults. Further complicating treatment of older substance abusers is the fact that they are more likely to have undiagnosed psychiatric and medical comorbidities. According to one study, 30 percent of older alcohol abusers have a primary mood disorder.

**Medication Management.** Prescription medication misuse and abuse are growing public health problems among older adults; these problems are associated with many serious consequences, and often go unrecognized. Medication management programs, including medication review, are key to assisting the older adult to manage their oftentimes complicated medication regimens effectively.

**Independent Living**

**Functional Health Status.** With older adults, because of the prominence of multiple chronic conditions, the rule-of-thumb in health assessment is to “focus on function”. Functional assessments complement disease identification by providing information about how the disease, or other factors, may impede the ability to function in a number of domains. There are two common levels of functional assessment, the basic activities of daily living (ADL) and the instrumental activities of daily living (IADL). The “basic” activities are just that – essential activities to live independently, such as the ability to eat, bathe, toilet, transfer and dress. Whereas “instrumental” activities of daily living are more complex activities, including money management, shopping, food preparation and housekeeping. A number of valid instruments are available for assessments at both these levels. Over 23.7 million older adults (62%) report limitations in activities of daily living (ADL), with limitations in functional ability strongly related to increased age.

In a community study of functional levels of older adults with chronic mental illness, it was noted that 25% of the sample had severe limitations at the ADL level, defined as regularly requiring assistance with at least four ADL’s. The majority (53%) of subjects had psychiatric symptoms. The most common psychiatric diagnosis was depression (42%), followed by schizophrenia (22%) and bipolar illness (13%). Twenty-nine percent of the subjects also had a serious medical problem that required medical treatment and polypharmacy and drug misuse were common among the sample.

**Housing Stabilization.** The surge in older homeless people is driven largely by a single group — younger baby boomers born between 1955 and 1965. This group has made up a third of the
The total homeless population for several decades. The emergence of an older homeless population is creating daunting challenges for social service agencies and governments already struggling with this crisis of poverty.

Homeless older adults may have “aged on the streets” or may have become homeless for the first time as an older adult. Data from a study in Boston revealed that most elderly homeless people were newly homeless with a history of stable adult employment. Most were last housed in a private rental unit and a plurality had lived alone. The common causes of their homelessness were, in decreasing order of frequency: financial problems, mental health problems, relationship breakdown, physical health problems, and issues related to work. Newly homeless older adults require intensive prevention activities, including the opportunity to be placed into subsidized housing.

Chronically homeless older adults who age into elderly homelessness often have critical health and service needs in addition to their obvious housing needs. Homeless seniors are more likely to experience multiple medical issues at a time and often have chronic illnesses that go untreated. Substance use disorders, particularly alcoholism, are not uncommon among the elderly homeless population and are often presented alongside mental health disorders, especially among the chronically homeless population. The mental health issues of the elderly are also particularly important when examining the reasons that older people become or remain homeless. Mental illnesses associated with memory loss, for example, can affect the ability to secure housing as acquiring housing often involved multiple appointments and self-initiated persistence. Elderly chronically homeless people often require intensive service coordination such as case management.

**Social Connections and Social Isolation**

The health risks posed by social isolation may be particularly severe for older adults, especially as they are likely to face stressful life course transitions, health problems, and disabilities. Older adults who experience one or another aspect of social isolation are at greater risk for all-cause mortality, increased morbidity, diminished immune function, depression, and cognitive decline. However, a large body of research suggests a potentially strong correlation between perceived isolation and mental health problems, especially depression. Loneliness is a key predictor of depression among older adults, in particular. Similarly, perceived social support is more important for mental health outcomes than indicators of social connectedness, such as received support and network size. To the extent that mental health problems put individuals at risk for physical health problems, perceived isolation may affect physical health through its impact on mental health.
Consumer and Family Satisfaction with Mental Health Care

The National Behavioral Health Quality Framework (NBHQF) promotes the key concept of person or family-centered care. The NBHQF recommends measuring the dissemination and uptake of patient- and family-centered engagement in preventive, clinical, and recovery settings. There are several recommended evaluation measures, including the Consumer Evaluation of Care: which captures family members reporting on their participation in treatment planning; and Perceptions of Care Survey (PoC) for both inpatient and outpatient care; and the Patient Assessment of Care for Chronic Conditions (PACIC) survey which measures specific actions or qualities of care and patient engagement in care. Inherent within the MHSA legislation are the core values of consumer input and engagement in services.

California utilizes the Mental Health Statistical Improvement Project (MHSIP) Consumer Survey which collects information on satisfaction with care, access to care, participation in treatment planning and quality of life. The MHSIP Survey is utilized by counties to give consumers and family members the opportunity to provide input/feedback on services for quality improvement purposes. The MHSIP is a requirement of the Substance Abuse and Mental Health Services Administration (SAMHSA) Community Mental Health Services Block Grant (MHBG) and a requirement of California W&I Code Sections 5600-5623.5 (Bronzan-McCorquodale Act).

Health Services Utilization

The quality of the health and social services available to older adults and their caregivers affects their ability to manage chronic conditions and long-term care needs effectively. Older adults are high utilizers of health care services, predominantly due to their prevalence of chronic conditions. Approximately 80 percent of older adults have at least one chronic health condition, and approximately 60-65 percent have two or more conditions. Older adults with serious mental illness have an increased rate of mortality and are also at greater risk of receiving inadequate care, including lower quality of health care. In an analysis of Medicare claims, older adults (≥ 65) with mental illness were found to receive poorer medical care after MI than older adults without a mental disorder. The presence of psychiatric illness was associated with a 19% increase in 1-year mortality. Researchers confirm that older adults with evidence of mental disorder are less likely than younger and middle aged adults to receive mental health services and that, when they do, they are less likely to receive care from a mental health specialist.

Recent data indicate that an estimated 20.4 percent of adults aged 65 and older met criteria for a mental disorder, including dementia during the previous 12 months. The increasing diversity in the older population will affect the provision of mental health/substance use
services, requiring training in the provision of culturally competent care in the coming decades.

Because of their coexisting physical conditions, older adults are significantly more likely to seek and accept services in primary care versus specialty mental health care settings. Older Americans underutilize mental health services for a variety of reasons, including: inadequate insurance coverage; a shortage of trained geriatric mental health providers; lack of coordination among primary care, mental health and aging service providers; stigma surrounding mental health and its treatment; denial of problems; and access barriers such as transportation.

**Continuity and Integration of Care**

Behavioral health problems—such as alcohol or medication misuse or abuse, depression, and anxiety—are prevalent in older adults, and each affects up to 15% of older adults. These problems have a substantial impact on older adults. They are associated with decreased quality of life, functioning, and treatment adherence; poor physical health; and overuse of medical services. Despite the impact of these problems, they are often undiagnosed and undertreated.

Integrated care models can improve treatment engagement and outcomes for older adults, when compared to more traditional methods for delivering behavioral health services. These models may also improve communication and coordination between primary care and behavioral health specialists, and decrease stigma associated with accessing behavioral health services.

Given improved quality of care and decreased costs, integration of behavioral and physical health fits well within models of health reform promoted within the Affordable Care Act, including: Patient- Centered Medical Homes, Accountable Care Organizations, and the Medicaid Health Home initiative.

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