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Home-Based Mental Health Services for Older Adults: A Review of Ten Model Programs

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Abstract

Objective—The objective is to provide information on successful programs providing home-based services to mentally ill elderly in order to assist other communities wishing to establish such programs.

Participants—The ten programs described in this article were selected by peer review from applications for an award given by the American Association for Geriatric Psychiatry and were participants in an invitational conference.

Results—Eight of the programs were components of a community agency while two were components of a medical school department of psychiatry. Six of the programs focused primarily on individuals with anxiety and depression and employed a range of individual psychotherapies. The other four accepted patients with any psychiatric diagnosis including dementia and included medication management as part of their services. The numbers served by the ten programs ranged from about 50 to 300 new cases per year, and the staffing ranged from 2 to 13 often with a combination of full and part time. The annual budget for the ten programs ranged from \$30,000 to \$1,250,000. Budget sources usually included some combination of public funds, philanthropy, and fee-for-service income.

Conclusions—Despite the logistic and fiscal challenges of providing home-based services to mentally ill older adults there are many long-standing successful programs that can serve as models for communities wishing to establish similar programs. A great opportunity exists for a unified outcome research endeavor as well as expansion into many more communities.

Of the almost 40 million people over the age of 65 in the United States, nearly 10% (9.2%) are considered housebound and in need of home-based care (1, 2). Based on epidemiological studies, the burden of depression and other mental disorders in homebound older adults is twice as great as in their community dwelling counterparts (3–4). Regardless of its severity, their untreated or undertreated mental health problems exacerbate medical, functional, and

social problems, and lead to higher rates of healthcare use, premature institutionalization, and mortality (5).

Being homebound is a significant barrier to the detection of mental health problems and mental health services delivery. A growing number of communities are developing programs designed to improve the identification, treatment, and ongoing care of mental health problems in homebound older adults. The purpose of this paper is to assist communities wishing to establish such programs by describing several diverse community-based programs providing home-based mental health services and identifying key factors relevant to their potential effectiveness and sustainability.

Methods

In 2008 the Geriatric Mental Health Foundation (GMHF) of the American Association for Geriatric Psychiatry (AAGP) announced the creation of the Deirdre Johnston Award given to a program for excellence and/or innovation in geriatric mental health outreach services. The Award was funded by Mr. Arnold Snider in recognition and appreciation for the in-home care provided to his mother, Kate Mills Snider, by Dr. Deirdre Johnston. The application process for the Award was designed to identify outstanding programs that could serve as models for communities wishing to start similar programs.

This report presents information on ten model programs. Nine were applicants for the Award and the tenth is a previously described program that coordinates the review process for the award and is ineligible to receive it (6). The programs selected for inclusion were identified by the authors after review of all of the applications. They were chosen primarily for program excellence, but also to represent a broad range based on geography, community size, and the clinical model. At least one of the programs has published an article describing its activities (7).

Representatives from the programs attended an invitational one and a half day conference in October 2011 to discuss the current best practices and what steps are needed to move the field forward. A report from the conference that includes detailed descriptions of the programs is available on the GMHF Web site (8). One other program was represented at the conference, Maximizing Independence at Home (MIND) from Johns Hopkins. This randomized trial of in-home care coordination versus enhanced care-as-usual will provide valuable information but is not included because it is primarily a research project. It is described in detail in the above mentioned conference report.

Results

Table 1 summarizes the features of the programs, including location, start date, parent agency, target population, clinical focus, services offered, the model used, approximate numbers served, staffing, annual budget and budget sources, and statistics monitored.

The states represented are California (2), Colorado, Georgia, Kansas, Massachusetts, New York (2), North Carolina, and Pennsylvania. Six of the programs began after 2000, and four began prior to that. Two date back to the 1970s. Eight of the programs are components of a

larger community agency, typically a mental health agency or senior-oriented agency, while two are in the psychiatry department at a medical school.

Clinically, the programs fall into one of two categories. Four (SPOP, OASIS, the Fuqua Center, and the GO Program) provide services for all diagnoses (including dementia) while the other six focus on individuals with anxiety and depression. The programs that accept all referrals provide a full spectrum of mental health services including medication management while those that focus on depression and anxiety emphasize individual therapy. The programs that focus on depression and anxiety employ short term therapy approaches, such as cognitive behavioral, problem solving, or strength-based therapy. One program (Senior Reach) followed the Gatekeeper model (9) whereby residents in the community are trained to recognize and refer individuals who are likely to benefit from the program. The numbers served by the ten programs range from about 50 to 300 new cases per year (mean=163.8 std=93.7 and the staffing ranges from about 2 to 13 often with a combination of full and part time (mean FTE=4.6, std. = 2.0).

The annual budget for the ten programs ranges from \$30,000 to \$1,250,000 (mean = \$368,900, std.= \$355,821). After excluding the budgetary outliers, two of which are low (PATHS and the Home Psychotherapy Program) and one of which is high (OASIS), the remaining seven programs have budgets ranging from \$110,000 to \$600,000 (mean \$333,571, std.= \$159,470). Most rely on some combination of fee-for-service, philanthropic, and/or public funds. Fee-for-service revenue was usually a combination of Medicare, Medicaid, and private insurance. Accepting Medicare reimbursement meant that patients had to meet Medicare's definition of homebound which includes both individuals who are unable to leave the home as well as those for whom it would require a taxing effort to do so. The Home Psychotherapy Program has low costs as the services are provided by doctoral students as part of their degree program. All of the programs track some data, but with their limited resources and mandate to provide service this is usually limited to cases seen and average number of visits. Some programs track outcomes by whether the original treatment goals are met and these tend to be favorable.

Discussion

There have been many reports on programs that provide home-based mental health services for older adults but we believe this is the first report based on peer reviewed selection of high quality programs that applied for an award. We believe the most important finding is a simple one: Despite all of the funding and administrative barriers, many communities find a way to provide these services and there are many excellent programs that have stood the test of time. Although they use different models, what they have in common is a strongly held belief in the need for the program in their community, an ability to work within the framework of their parent organization and to form partnerships with others, and a commitment to overcome the obstacles that constantly arise. An organization wishing to start such a program might begin by reallocating a portion of the effort of two to three current staff members, devoting six to twelve months to a planning process, and setting a budget of about \$100,000 to \$350,000 per year for the first few years.

At the conference mentioned in the Methods section representatives from the invited programs made many observations that we believe can be useful to those considering starting such a program. The comments can be grouped into three general areas: clinical, administrative, and financial.

Clinical issues

- There is a great unmet need for providing mental health services to older adults who cannot or will not go to an office based setting and this can be effectively communicated through data and stories;
- Many successful approaches exist and any community with a desire to meet this need can find a model to guide their development;
- There is often a need to bring in other services such as transportation, meals, financial counseling, legal advice, and involvement in activities;
- Medication management is required for programs that see patients across the full diagnostic spectrum;
- Planners should explore at the outset the available screening, assessment and outcome tools and pay particular attention to those in the public domain.

Administrative issues

- Given the complex needs, the program can fit within many different types of mental health, health, social or aging service organizations;
- Start developing relationships and, where appropriate, partnerships at the outset;
- Identify and stay in touch with the most important referral sources;
- Growing the base of support requires evidence in terms of both quantitative data and human stories;
- Have a seat at the table both within the parent organization and at relevant community meetings;
- Keep a simple data base at the start and expand it over time;
- Balance the number of referrals accepted with the availability of the program staff in order to meet expectations without risking high turnover.

Financial issues

- Strive for a broad financial base including clinical revenue, grants, support from other entities, and contributions;
- Plan for sustainability at the beginning;
- To obtain fee-for-service reimbursement it may be necessary to partner with an entity that can credential providers;
- Receiving fee-for-service reimbursement requires that claims submissions be completed accurately and completely;

- Weigh the benefits versus demands of a grant or contract before applying for it.

Conclusions

A recent Institute of Medicine report on the mental health needs of older adults (10) emphasizes the importance of outreach services, specifically mentioning providing service in individuals' homes. Most communities recognize the need for home based mental health services but may be unsure how to start a successful program. We believe that among the ten programs briefly described here, and in more detailed narrative form elsewhere (8), any community will find one or more models that can both inspire them to move forward and inform a decision about how to best proceed. An opportunity also exists to learn from and collaborate with home based health care programs such as the Geriatric Resources for Assessment and Care of Elders (GRACE) program (11).

It is also our opinion that the success of these programs offers an opportunity for a foundation or government entity to move this much needed service forward in two ways. First, while the individual programs described in this report all see the value of outcome research they often lack the time, funding, or analytical expertise to do this. External funding could allow them to form a consortium and, with centralization of effort and methodological support, develop a unified approach to program evaluation. The second opportunity is to build on the success of these programs by funding, through competitive application, additional programs in other communities. The design of such programs could build upon the experiences of model programs such as those described here. As more communities start such programs they could evolve from a relatively rare service to a commonplace one, as has happened with adult day centers over the past three decades (12).

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Senior Reach, Colorado: Vicki Rodgers

Fuqua Center for Late-Life Depression, Emory University, Atlanta, GA: Eve Byrd

Senior Outreach Services (SOS), Four County Mental Health Center, Independence, KS: Steve Denny

Maximizing Independence (MIND) at Home, Johns Hopkins University, Baltimore, MD: Deirdre Johnston

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Service Program for Older People (SPOP), NY, NY: Nancy Harvey

Professional Assessment and Treatment of Homebound Seniors (PATHS), Rochester, NY: Paul Caccamise

Geriatric Outreach (GO) Program, Wake Forest School of Medicine Department of Psychiatry, Winston-Salem, NC: Karen Byrd & Cathy Wilson

Journey's Way Geriatric Counseling Service, Philadelphia, PA: Misa Romasco

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Table

Characteristics of model programs providing home-based services for older adults with mental illness

Program	Institute of Aging Home Psychotherapy Program, San Francisco, CA	Older Adult System of Integrated Services (OASIS), San Mateo County Health System, San Mateo, CA	Senior Reach Jefferson County, CO	Fuqua Center for Late Life Depression, Atlanta, GA	Senior Outreach Services (SOS) Independence, KS	Elder Mobile Mental Health Project, Lynn, MA	Service Program for Older People (SPOP), homebound component NY, NY	Professional Assessment and Treatment of Homebound Seniors (PATHS), Rochester, NY	Geriatric Outreach (GO) Program, Winston-Salem, NC	Journey's Way Geriatric Counseling Program, Philadelphia, PA
Started	2001	1980s	2005	1999	2004	2008	1970s	2006	2005	1973
Parent agency	Institute on Aging	County health system	Jefferson County Mental Health Center	Emory University	Mental Health Center	Greater Lynn Senior Services	same	Lifespan, which is a fiduciary agent for 4 organizations that collaborate	Wake Forest University	Intercommunity Action (Interact)
Target population	Frail 60 and over living in S.F. mainly frail, marginalized low income.	Seriously mentally ill 60 and over in San Mateo County	Over 60 living independently not currently with a therapist.	Older adults with signs/symptoms of mental illness, including dementia.	Over 60 with any mental health condition already being seen in the MHC	Over 60 in 5 county area who need mental health services but can't access them	Homebound 55 and over with any mental health condition	Over 60 with anxiety or depression who can't or won't go to an office setting	Homebound over 60 with any mental health condition	Over 60 who need mental health evaluation and will not or cannot use office based services. Mainly very low income.
Clinical focus	Mainly chronic mental illness, also new onset depression or anxiety	All diagnoses	Depression, anxiety, life crises	All diagnoses	Mainly depression and anxiety	Mainly depression and anxiety	All diagnoses	Depression and anxiety	All diagnoses	Mainly depression and anxiety
services	Home based psychotherapy by doctoral level students. Typically 10–12 visits but can be longer.	Full range including psychiatric, intensive case management, individual therapy, medical escort, and assertive community treatment	Public education to train “gatekeepers,” individual therapy	Treatment as clinically indicated, provided by advanced practice nurses	Introductory outreach visit followed by individual therapy for as many sessions as needed. Also case management.	In-home counseling with no minimum or maximum. Also refer for other services as needed.	Full spectrum, same as clinic based services	Counseling, up to 9 sessions	Evaluation and follow up treatment as clinically indicated	Assessment and counseling by social workers, also coordination with PCP

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Program	Institute of Aging Home Psychotherapy Program, San Francisco, CA	Older Adult System of Integrated Services (OASIS), San Mateo County Health System, San Mateo, CA	Senior Reach Jefferson County, CO	Fuqua Center for Late Life Depression, Atlanta, GA	Senior Outreach Services (SOS) Independence, KS	Elder Mobile Mental Health Project, Lynn, MA	Service Program for Older People(SPOP), homebound NY, NY	Professional Assessment and Treatment of Homebound Seniors (PATHS), Rochester, NY	Geriatric Outreach (GO) Program, Winston-Salem, NC	Journey's Way Geriatric Counseling Program, Philadelphia, PA
model	Individual psychotherapy in the context of a multidisciplinary team approach	Full service including medication management and assertive community treatment	Gatekeeper model of public education and strength based therapy of up to 10 sessions. About 11,000 gatekeepers trained.	Full service including medication management	Combination of Gatekeeper approach to public education, individual therapy, and case management	Diagnosis and counseling	Full service including medication management	Cognitive behavioral and problem-solving therapies	Full service including medication management	Assessment, counseling, and coordination of care
# served	About 50 unduplicated patients/year	200 open cases at any time	About 200/year.	About 130 unduplicated cases/year	117 year 1, 151 year 2, 161 year 3. Average 5–10 sessions over 6 months.	15–20 new referrals/month	150 patients/month, 340 visits/month	60/year	About 50 new cases per year, about 300 total since program began	172 unduplicated cases last FY. Try and work within 20 visit framework
staffing	6 doctoral students per year with oversight by program director	FT manager, 4.6 masters level practitioners, MH nurse, 1.5 FTE psychiatrists, others through full service partnerships	5.75 FTE therapists, all masters level.	Executive director, 2 project coordinators (1 clinical, 1 outreach), 2 advanced practice nurses	3.5 bachelors level case managers, 1.5 masters level therapists	1.0 SW, 1.0 counselor, both with masters. 0.2 FTE supervisor	FT director, 4 FT and 6 PT LCSWs, 2 PT psychiatrists	1 LMHC, 1 MSW, 1 geriatric psychologist, 2 LCSW's	MD program director 0.4 FTE, geriatric nurse practitioner 0.8, LCSW 0.8	6 LCSWs, 3 FT and 3 PT
Annual budget	\$30,000	\$1,250,000	\$275,000	\$110,000	\$325,000	\$250,000	\$600,000	\$74,000	\$300,000	\$475,000
Budget sources	Sliding scale private pay income covers the costs, along with some local grant support	Fee-for-service (Medicare, Medi-Cal, private insurance) \$536,000, Mental Health Services Act from State \$340,000, realignment income from State \$380,000	Mainly local governments. (Denver regional is biggest) along with some foundation support. Little 3 rd party billing due to credentialing hurdles.	Fee-for-service (Medicare, Medicaid, and private insurance) and foundation funds	Over first 3 years \$300,000 in fee-for-service income mostly Medicaid (\$250,000)	70% grants and 30% fee-for-service reimbursement from community health center. SW is credentialed through community health center.	Fee-for-service (Medicare, Medicaid, private insurance), New York City Department of Health and Mental Hygiene, . foundation support	\$60,000 Area Agency on Aging, \$14,000 United Way, some donations	Mainly from endowment, about \$30,000 from fee-for-service (Medicare, Medicaid, private insurance)	Almost all from government sources. City office of behavioral health \$350,000. AURA \$75,000. Community Behavioral Health \$50,000. \$5,000 in client contributions
Statistics kept	In process of developing data base	Ethnic distribution, diagnoses, # visits, types of services, No	Numbers served. Improvement in outcome measures.	Have started to track clinical global impressions and change in	Remain independent, need for inpatient treatment,	% agreeing to counseling, reports of improvement, # hospitalizations	Length of time in program, % of clients meeting their treatment	Improvement or stabilization of anxiety or depression	Active data base, see article in AJGP2010; 18:1141-1145. Longitudinal f/u	Mainly # cases. Want to do outcome analysis but can't analyze

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		outcome data.		behaviors	change in symptom levels		goals, psychiatric hospitalizations, # of visits, diagnosis, time from intake to 1 st visit.		study just starting	data with recent computer conversion.
Comments	In home program is a component of the Psychology Dept, which has several other programs as well	Large comprehensive program. Funding sources include both insurance (mostly Medicaid and Medicare) and government	Strong government funded program. Has published its results and helped others to replicate the model (including SOS in Independence, KS).	Big impact with housing authority in keeping people from going homeless. "go-to" program for geriatric mental health services	Successful program in rural area that is generating solid fee-for-service revenue	Promising program still in early development	Longstanding very active program.	Demand is good, depends on community funding and interagency collaboration	Well established local program designed to also serve as national resource center for home based geriatric mental health programs	"Go to" place in Philadelphia for services and consultation. Has waiting list. Treatment works but funding remains a big problem.

Abbreviations used: FY-fiscal year, FT-full time, PT-part time, FTE-full time equivalent, LCSW-licensed clinical social worker, MSW-masters of social work, SW-social worker, LMHC-licensed mental health counselor, MH-mental health, PCP- primary care provider