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BEHAVIORAL HEALTH AND NEW MODELS OF SERVICE DELIVERY FOR AN AGING WORLD: PUBLIC/PRIVATE PARTNERSHIPS TO DEVELOP BEST PRACTICES OF CARE FOR OLDER ADULTS

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ABSTRACT

Individual and societal initiatives in areas of research, education, and health care policy have resulted in unprecedented gains in life expectancy. It is true that today more people in the world are living longer and have opportunities for higher quality lives than ever before. However, the resulting rapid rise in number of older adults has become a source of concern: Experts of many countries, in anticipation of looming problems, such as overburdened health care and pension systems, are now seeking opportunities to work together to find common solutions for globally-shared problems. The good news is that while all countries are experiencing change brought on by aging populations, the rate of change varies substantially from country to country; differences in historical events have produced differences in demographic profiles. Some countries have relatively large numbers of older adults, comprising large percentages of their populations; others have fewer older adults, with slower growth in numbers and percentages of older adults relative to other age groups. These differences have led to variations for the type and pace of response mounted by individual countries for problems associated with increasingly large older adult populations. In turn, these variations in response provide opportunities for countries to learn from one another. This brief review will outline potential issues associated with aging populations and discuss strengths and challenges for the integration of primary medical care with behavioral health as an innovative, best practices approach to the provision of care for aging persons of the world.

KEYWORDS: global aging, best practices, evidence-based practice, integrated care, behavioral health

Background

Global aging is often described as a great achievement of the 20th century; advances such as better nutrition, reduction in infectious diseases, and greater access to medical treatments have led to significant increases in life expectancy. It is true that today more people in the world live longer and have opportunities for higher quality lives than ever before. However, the resulting increase in number of older adults has also brought other issues to the fore: Gerontologists now note the eminent need for policy discussions to address the increasing incidence of late-life, health-related conditions [1] and the growing worldwide shortage of health care professionals and care workers for older adults [2,3]. Experts in aging studies increasingly recognize the burgeoning crisis in workforce recruitment of too few younger persons and call for new perspectives on older adult workers [4,5] and age of retirement [6]. Aging researchers and specialists are working to understand late life solitude [7,8] and develop interventions to offset loneliness and mental health disorders resulting from social isolation [9]. The scientific literature for these and other issues clearly indicate that proactive steps need to be taken to avoid the potential, long-term, negative consequences of not understanding older adults as unique consumers of care. The recognition that all countries are now stakeholders in the global aging phenomenon has highlighted the need for gerontology professionals of the world to work together to find common solutions for common problems.

Demographics

A substantial body of research is available to provide direction for understanding the increases in life expectancy now seen throughout the world. All studies, including those focused on behavior of individuals [10,11] and those reporting on societal initiatives

[12,13], reach the same conclusions: Countries making significant investments in education and research, particularly in the sciences and medicine, and in the development and implementation of safety regulations, through public and health policies, are showing substantial and unprecedented gains in longevity for citizens.

When life expectancy gains are measured against fertility rates and examined next to population projections, a bigger picture emerges: Regardless of whether population gain or loss is experienced over the coming decades, the growing number of older adults for a country will be reflected as an increasingly large percentage of its population. This shared reality of changing demographic profiles is called global aging and prompting countries to refocus resources toward older adult issues. That these demographic shifts toward aging populations are expected to gain momentum through at least 2050 [14] is now becoming a global source of concern.

Best Practices

While all countries are experiencing change brought on by aging populations, the rate of change can be seen to vary quite substantially. Differences in historical events have produced relative differences in demographic profiles, which, in turn, have led to significant variation for the type and pace of response mounted by individual countries for problems associated with increasingly large older adult populations. This variation provides opportunities for countries to learn from one another.

The sharing of information for best practices of care is one way to address needs of older adults now and in the future. A best practice is broadly defined to include any practice or method empirically supported to be the best, agreed upon way to successfully accomplish a task [14]. The concept has gained wide purchase in the sciences, but also in business, education, and other areas of study that include application of practical knowledge. A similar, overlapping construct for healthcare professions is that of evidence-based practice, which includes the integration of scientific knowledge with clinical expertise, values of patients, and available resources to improve patient outcomes [15]. The similarities of best practice(s) and evidence-based practice appear to be obvious: both are intended to promote consistency of program development and practice, through development of guidelines; and, both call for the examination of what has and has not worked, through study of the ever-growing, global knowledgebase and by personal communication exchanges of information. Any model of care rooted in best practices and adopted for use with older adults can be tailored to meet cultural needs of specific countries. As best practices information is developed and disseminated by countries currently experiencing high percentages of older adults and already moving to formulate and implement policies and programs [16,17], professionals in countries with relatively smaller percentages of older adults, who may at this time acknowledge a greater focus on direction of resources toward concerns of youth, can nonetheless begin to work in anticipation of future needs and, hopefully, offset problems produced by their own growing older adult populations.

Behavioral Health – Primary Care Integration

Behavioral health is a relatively new term for care that "…encompasses prevention, intervention, and recovery from mental health and substance use conditions" [18]. Although behavioral health and mental health are sometimes thought to be the same, the focus of behavioral health includes in equal emphasis to mental health conditions the promotion of health and wellness behaviors. The use of the term behavioral health is gaining widespread acceptance in clinical applications as it avoids stigmatizing labels attached to the concept of mental health, acknowledges behavioral involvement in mental health conditions, and includes the possibility of behavior change as a critical component of modern approaches to healthcare.

The integration of primary care and behavioral health (PCBH) serves as an example of both best practices and evidence-based practice and offers a new perspective, which is proving particularly relevant for aging populations [19]. This team-based model employs a biopsychosocial approach to service delivery, which utilizes complementary skill sets of behavioral health professionals in primary care practices [20]. Team members representing biological (i.e., medical), psychological, and social aspects of care, each responsible for specialized areas of expertise engage in task sharing (i.e., task shifting) to make best use of provider resources [21]. Under the direction of a physician, nurses and nurse practitioners, mental health providers, social workers, community health workers, and other specialists work together to provide comprehensive care and promote best short- and long-term outcomes for patients [22].

The body of research supporting PCBH comprehensive care has grown rapidly in the last decade. Studies are available that report improved treatment outcomes, reduction in costs, promotion of independence within communities for patients, and increased satisfaction for both patients and providers [20,23,24]. Further, research now empirically supports that PCBH allows for the development of interventions targeted to social and psychological factors related to medical care outcomes. Such issues as loneliness and social isolation [25,26], depression [27], anxiety [28], elder abuse [15], trauma-related problems [29], and additional emotional and mental health needs [30] are being assessed and treated effectively by PCBH.

Despite the benefits and promise of PCBH, challenges exist that must be addressed for this new

approach to reach its full potential as a true biopsychosocial model of comprehensive care. Research supports that older adults usually consult primary care physicians as a first point of contact with the health care system, even in circumstances when a suspected mental health issue has prompted the contact. The traditional model of medical care, still in effect for most forms of medical practice, has worked very well for illness and injury, with primary care referrals, when necessary, typically focused on medical problems [23, 31]. Outside of the integrated practice, however, gaps have been identified for mental health and substance abuse issues that in the traditional model are treated without utilization of the skills of behavior specialists [23]. The PCBH model addresses this: Specialists with training in the use of tools for behavioral assessment are employed to evaluate mental health and substance-related problems, which are now shown by research to be comorbid with a wide variety of acute and chronic health conditions seen in older adults [32,33]; behavioral assessment results can be provided before the primary care physician conducts a medical evaluation or in response to a referral, in cases when the physician suspects a behavioral health issue is involved in the presentation of medical symptoms. In the U.S., issues related to mental health are the leading cause of disability, with fewer than 20% of persons receiving needed care. That evidence-based treatments in mental health closely correspond to evidence-based treatments in medicine provides a strong foundation for the integration of mental health into the primary care setting [31]. The comprehensive PCBH approach is proving beneficial as an extension of medical care in the mental health arena; among its benefits beyond the addition of behavioral assessment are the ability to offer brief and longer-term behavioral interventions and the provision of a means to develop and direct community support for follow-up care, particularly in low access, low resource, underserved areas [19,30,34].

Additional challenges for the PCBH approach are definitional in nature and include the need to resolve such practice issues as professional boundaries, maintenance of patient confidentiality from the integrated practice into community-based support systems, and reimbursement for professionals other than physicians working within the PCBH practice [30,35]. Although physicians are the acknowledged directors of PCBH teams, there are often included in the PCBH model other licensed professionals, who have the ability to directly bill clients and third party payment systems (i.e., insurance providers) for their services, and who may be responsive to practice guidelines developed by disciplines other than medicine. These concerns should be resolved as PCBH matures and consensus is reached among professionals concerning just what constitutes evidence-based practice for PCBH and which models deliver best practices for older adult outcomes [31].

Conclusion

Demographic shifts toward increases in percentage of older adults are impacting the global landscape in predictable ways. New perspectives are emerging for basic issues of aging, such as what it means to be old – e.g., many current policies for retirement in place around the world were based on decades-old perspectives on definitions of aging and health status [36]. Also, rapid increases in the number of older adults with specific conditions are leading to expanded models of heath care that include more formal and informal service provision by non-medical, multidisciplinary personnel. This is supported by the global shortage of gerontology and geriatric specialists trained in unique aspects of older adult care [2,37–39]. While talk among healthcare professionals over the last couple decades has been directed toward efforts to attract interested persons to specialties of older adult care, it is now clear that recruitment efforts have fallen short: simply put, there are not going to be enough specialists available for most societies to meet the needs of large percentages of older adults. This situation is creating a "global marketplace" [2, p. 950] for specialists and already impacting both developed countries [39] and emerging countries that have historically imported medical personnel [37].

A related issue is a global rise in need for workers who provide direct, informal care of older adults [40]. In the United States, most long-term, informal assistance is nonmedical and non-technical in nature, includes an average of 20-25 hours of unpaid assistance per week, and is typically provided by family members in the home setting [41, pp. 325–327]. In fact, the amount of care provided for elders by their adult children in the U.S. has more than tripled over the last 20 years and is expected to continue to increase. This is due, in part, to the desire of people needing care to remain in their homes [42], but also to economic realities of growing health care costs and expenses associated with institutionalization of elderly persons for issues that can be addressed outside of formal healthcare settings. Growth in informal care needs is paralleled by significant growth in public and private models of home-delivered medical care, which will also continue to increase along with the number of older adults and the concomitant rise in assistance needs for conditions such as neurocognitive disorders (i.e., dementia conditions, including Alzheimer's disease).

The new practices of tele-health are gaining empirical support as useful adjuncts to integrated primary care to help reach older patients overcome such barriers as lack of transportation and work schedule conflicts [43]. The optimal PCBH situation of co-locating professionals for mental and physical health together, in the same facility is not always possible in rural or large geographic regions with few providers; this is especially true for mental health specialists, who are known to be highly underrepresented outside of urban areas [44]. The use of technologies may be able to reach some older adults with mental and/or physical health

concerns, but brings with it the issue of health literacy. Many otherwise literate, older persons are not familiar with and/or do not have access to internet-based technologies, which are increasingly used in lieu of written information (e.g., instructions); recent reports indicate most older adults still prefer direct communication with primary care providers and word-of-mouth to access information for health-related issues. Computer-based access and know-how are increasingly common for young and middle-aged adults and may in time signal an important shift in use of virtual technologies in care provision. However, the current lack of these skills for older adults will continue in a shorter time frame to negatively impact their functionality, even as telehealth approaches gain ground [45,46].

In sum, the integration of behavioral health and primary care is providing new direction for the expansion of traditional healthcare to include mental health and substance abuse issues and reach into previously underserved areas to address largely unmet needs. The opportunity in the developing models for specialists to become partners in integrated care promises to result in a true biopsychosocial, comprehensive care and enhance the quality of care for older patients.

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