Meeting the Mental Health Needs of Older Adults on Medicaid: A Pilot Study

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Purpose

It is clear that mental health problems negatively impact the capacity of older adults to remain in the community. Further, older adults with untreated mental health concerns experience serious losses in quality of life. Late life transitions and losses, such as onset of physical and cognitive illnesses and loss of family and friends, are associated with mental health concerns, most commonly depression and anxiety. Without intervention, older adults are at greater risk for deterioration of chronic health conditions, increased negative effects from physical illness, decreased quality of life, alcohol or prescription medication abuse, and even suicide. Challenging life transitions, combined with the limited financial resources experienced by Medicaid-HCBS/FE recipients, may result in even greater risk for these older adults. However, research studies show that with mental health treatment, these older adults are able to stay in their community dwellings longer, improve their mental health, and increase their quality of life (Campbell & Leaver, 2003; Davidson, Chinman, Sells, & Rowe, 2006; Noble & Douglas, 2004; Paulson et al., 1999). Building on this previous research, The KU Office of Aging and Long Term Care, in collaboration with KDOA and the AAAs developed and piloted a mental health peer support program for older adults receiving Medicaid HCBS/FE that has been found effective in reducing depression and increasing quality of life. This low cost and effective approach will now be implemented in more AAAs across Kansas.

Background

As delineated above, mental health concerns can be debilitating for older adults and when deteriorating mental health contributes to higher rates of institutionalization, Medicaid costs can increase dramatically. However, stigma and access related to mental health services for older adults have been prominent barriers to seniors receiving mental health services. Peer support programs can lessen these barriers by addressing mental health stigma. Like other stigmatized issues, people receiving help are often more receptive to accepting assistance from their peer, rather than a professional. Peer support program can address access to mental health services by utilizing older adult volunteers to provide support to participants in their home. Also as a single point of entry for older adult services, Area Agencies on Aging (AAAs) have a unique opportunity to connect older adults to necessary resources. Therefore, housing peer support programs in AAAs can provide greater access to mental health services for older adults.

In Fiscal Year (FY) 08 and FY09, the Kansas Department on Aging (KDOA) contracted with the University of Kansas, School of Social Welfare’s Office of Aging and Long Term Care (OALTC) to develop, implement, and evaluate a peer support program for older adults with mental health needs receiving the Medicaid HCBS/FE waiver. The goal of the Peer Support Program (PSP) is to decrease the negative symptoms of mental health (e.g. depression and anxiety) experienced by older adults receiving the Medicaid HCBS/FE waiver and improve their quality of life and general well-being allowing them to remain in the community. The PSP was designed by the OALTC in collaboration with the Central Plains Area Agency on Aging (CPAAA) and the KDOA. The source of funding for the PSP is through a federal-state Medicaid
partnership that utilizes the University’s available match to draw down federal administrative dollars. No State General Fund payments from KDOA are utilized.

This project has several components including: program development, a feasibility study to develop a pilot model, pilot implementation in three AAA sites (Central Plains AAA, Jayhawk AAA, and Southeast Kansas AAA), pilot outcomes, systemic evaluation of program protocols, and the creation of replication materials and a sustainability plan that would enable AAAs to provide the PSP. The OALTC has met regularly with the KDOA to receive feedback regarding project goals, research questions, barriers, and strategies for implementation and sustainability. In addition, the OALTC has provided monthly, quarterly, and year-end reports that detail the major project activities, outcomes from development of the program, implementation and analysis of the feasibility study, and preliminary outcomes of pilot study. Please refer to the following reports for details regarding development and implementation of the PSP pilot.

- FY 08 Report Meeting the Mental Health Needs of Older Adults through Civic Engagement
- FY 09 Report Feasibility Study
- FY09 Year End Report Meeting the Mental Health Needs of Older Adults: A Pilot Study

In FY10 the following was completed: expansion and completion of the pilot study, an analysis of outcomes, the creation of replication materials for the PSP as a practice model, and the development of sustainability strategies for the PSP to be delivered through AAAs. Overall, findings indicate that Medicaid HCBS/FE waiver customers had reduced symptoms of depression and reported an improvement in their quality of life particularly in regards to overall health and functioning (e.g. self-care, usefulness to others).

The purpose of this report is to provide findings from the pilot study and provide recommendations for sustainability of the program. This report also includes an updated review of the literature that incorporates the latest research and links it to the previously discussed purpose and background of this project. This review also references new information related to mental health for older adults and community tenure (see the Benefits to Consumers section below) and new information on the strengths perspective and goal setting (see Goal Setting section below). These updated sections highlight the need for peer support interventions that focus on an individual’s strengths and resources while identifying goals that will improve their physical and emotional well-being.

Peer Support Program Description

PSP is a 10-week mental health intervention that consists of pairing a volunteer (older adult who provides the peer support) with a participant (older adult who receives peer support) receiving Medicaid-HCBS/FE Waiver services. The pairs are supported by Kansas AAA staff. Prior to the beginning of the intervention, volunteers are trained to apply strengths-based mental health principles to basic topics such as aging, relationship building, goal setting, and resource
acquisition. Following the training, the AAA staff member matches a volunteer and participant. The pair meets weekly for a minimum of one-hour intervals for 10 weeks. During meetings, participants are encouraged and supported by the volunteers to establish and work toward goals (e.g. better self-care, engaging with family and friends) that participants feel would improve their mental health and well-being. Volunteers assist participants by identifying strengths, exploring resources and problem-solving skills, and helping establish achievable and maintainable tasks and goals. The strengths assessment tool guides the development and tracking of goals.

Literature Review

Prevalence

By the year 2030, there will be an estimated 71.5 million people age 65 and older, making up approximately 20% of the population in the U.S. (Federal Interagency Forum on Aging-Related Statistics, 2008). About 20% of older adults aged 55 years and older experience mental disorders. Among the most prevalent mental disorders are anxiety disorders and mood disorders (such as depression), neither of which should be considered as normal aging conditions (Adamek & Slater, 2008; Halpern, 2001). Nationwide, it is estimated that only half of older adults who acknowledge mental health problems receive treatment from any health care provider, and only a fraction (approximately 3%) of those receive specialty mental health services (Lebowitz et al., 1997; Charney, et al., 2003). This rate of utilization is commonly cited in current literature; however, recent changes in the mental health delivery system (e.g. advances in pharmacological treatment; expanded spectra of eligibility; and new policies, such as parity legislation) suggest that up-to-date data is needed (Wang, et al., 2005).

Barriers to Accessing Mental Health Services

Older adults are more likely to seek mental health services in primary care clinics than in specialized mental health clinics (Hagglund, et al.,2000). Lack of collaboration between primary care and mental health providers, stigma surrounding mental health illness, and fragmented services for older adults has long been cited as barriers to appropriate mental health services (Administration on Aging, 2005.). Other barriers to services for underserved older adults include: lack of educated providers, shortage of mental health professionals, financial costs, and transportation (Gellis, et al., 2008; Greenburg, 2004; Sanders, et al., 2008 ). Unmet need for services is greatest in traditionally underserved groups including: older adults, racial-ethnic minorities, individuals with a low socio-economic status, and individuals residing in rural communities (Bergdahl, et al., 2007; Wang, et al., 2005; Sorkin, D, et al., 2009). Research suggests that when underserved groups do receive services, they are the least likely to receive quality care despite having similar prevalence rates of mental health disorders as other groups (Sorkin, D., et al., 2009; US Department of Health and Human Services, 2001). However, current evidence provides support for home-based mental health services for older adults whose access to traditional practice-based models of care is limited (Bruce, et al. 2002; Weinberger, et al., 2009).
Stigma

Stigma associated with seeking mental health treatment disproportionately affects older adults. They cite feelings of shame or personal failure as substantive reasons for their avoidance of treatment (Halpern, 2001; Hinshaw & Cichetti, 2000; Wahl, 2002). In spite of common stereotypes that depression is an inevitable and unchangeable part of growing older, depression is not a normal part of aging and in fact, older adults are generally as responsive to treatment of depression as younger people (Karel & Hinrichsen, 2000).

Strengths Perspective

The strengths perspective is a philosophical approach to a helping relationship that posits that the goals, strengths, and resources of people and their environment rather than their problems and pathologies should be the central focus of the helping process (Saleeby, 1992). Thus, strength’s based interventions focus on the strengths of individuals and their informal support network; and coordinate helping approaches that build on an individual’s strengths and successes (Brun & Rapp, 2001; Nelson-Becker, et al., 2006). Strength’s based models of case management have been utilized by social service providers for older adults and for persons with mental illness; in both cases positive outcomes have been documented (Barry, K. et al, 2003; Macias, et al., 1997; Fast, B. & Chapin, R. (2000); Lewis, J. (1996); Rapp, C. & Chamberlain, R., 1985).

Goal Setting and Motivation

Research has long tied goal setting to positive impact on one’s self efficacy ratings (Shrunk, 1990; West & Thorn, 2001). It is also considered an important component in sustaining achievement (Locke & Latham, 1990). The value of goal setting as a motivational tool has been evaluated in a variety of populations, including older adults and it has been found to be an effective motivator (West & Thorn, 2001). For goal setting to impact self efficacy ratings, however, research indicates that goals should have specificity (Lee & Bobko, 1994; Schunk, 1990; Locke & Latham, 1990). Additional research indicates that documenting proximal goals, such as the small tasks taken to achieve a larger goal, can also increase positive impacts associated with goal setting (Bandura, 1989; Bandura & Schunk, 1981).

Benefits to Consumers

Peer-provided services have been identified by consumers as desired service options (Noble & Douglas, 2004), and peer support has been identified by persons with a stigmatizing mental illness such as depression to be a high priority treatment preference (Davison, Pennebaker, & Dickerson, 2000). Given that research demonstrates a link between depression and loneliness, social isolation or disconnectedness and poor mental health, peer support programs that provide social contact may be integral to the lessening of depressive symptoms (Cacioppo, et al., 2006; Choi & Kimbell, 2009; Cornwell & Waite, 2009). State and federal government programs such as Medicaid are increasingly recognizing the benefits of peer-provided mental health services (Center for Medicare & Medicaid Services, 2007). The Center for Medicare and Medicaid Services (2007) reported an increasing number of states interested
in providing coverage for peer support programs. In fact, in November of 2009, the Pillars of Peer Support Services Summit was convened in order to determine the amount of state support needed to establish a peer workforce (Daniels et al., 2010). Mental health needs are known to be associated with increased health care utilization and cost. Further, untreated mental disorders in older adults can lead to diminished functioning, substance abuse, poor quality of life, and increased mortality (Bartels et al. 2005; Texas Department of Aging and Disability Services, 2009).

**FY 10 Goals and Accomplishments**

The two main goals for FY10 included: 1) completion of the implementation and evaluation of the pilot PSP research model in three AAA catchment areas (Central Plains AAA, Jayhawk AAA, and Southeast Kansas AAA); and 2) development of sustainability strategies of the PSP as a practice model in pilot sites. Both of these goals were accomplished and will be discussed in detail in the following report. Highlights of the accomplishments from completing the project goals can be categorized into three areas:

- **Program maintenance in CPAAA, JAAA, and SEKAAA**: recruited participants and volunteers, screened referrals for program enrollment, trained volunteers, matched volunteers and participants, monitored match volunteers and participants for the 10 week intervention, coordinated with case managers in pilot sites to generate referrals, and developed relationships with key community agencies for recruitment of volunteers and participants

- **Data collection and analysis**: collected intervention data for participants and volunteers, cleaned and entered data, transcribed and analyzed post-intervention interviews, tracked participant and volunteer referrals, enrollment, and matches for monthly and quarterly updates

- **Sustainability planning**: identified key staff for PSP implementation within each PSA pilot site, identified program components needed to deliver the PSP as a practice model, described program procedures for implementation of the PSP as a practice model in the program manual for AAAs, conducted meeting with key AAA staff to identify minimum level of resources necessary for implementation as a practice model, met with KDOA and AAA executive staff to develop sustainability strategies based on experience in pilot sites, identified AAA staff to be trained, developed training materials for program implementation as a practice model, and identified strategies for evaluation of the PSP as a practice model

The outcomes of having accomplished project goals include a peer support practice model that: 1) has positive outcomes for participants; 2) is sustainable in current AAA pilot
sites; and 3) can be replicated in new AAA sites for a broader statewide rollout. The tools developed in the peer support research model will allow AAAs to administer a low cost and effective Peer Support Program to older adult consumers receiving HCBS/FE waiver services. The following details the findings from evaluation of the pilot study and sustainability strategies for the implementation by AAAs.

Research Questions and Methodology

In FY10, we answered several research questions related to the outcomes of the PSP pilot study and program sustainability by Area Agencies on Aging. In this section, we detail the research questions we aimed to answer and the methods used to address them.

1) **What are the characteristics of older adults receiving the Medicaid HCBS/FE waiver who participated in the PSP?**

   In order to describe the characteristics of older adults receiving the Medicaid HCBS/FE waiver who participated in the PSP, we collected basic information regarding participant demographics (e.g., age, gender, marital status, and functional limitations). We conducted univariate analyses (e.g., frequency, range, and mean) of these data and used results to provide a description of the sample of participants who completed the intervention.

2) **Did older adults receiving the Medicaid HCBS/FE waiver experience a decrease in symptoms of mental health distress after participating in the PSP?**

   AND

3) **Did older adults receiving the Medicaid HCBS/FE waiver experience an improvement in quality of life after participating in the PSP?**

   To determine if study participants decreased symptoms of depression and anxiety, and improved their quality of life, we collected data from participants before and after the intervention using standardized assessment measures: Geriatric Depression Scale (GDS), Beck Anxiety Index (BAI), and Ferran and Powers Quality of Life Index (QLI). Each measure has been tested and widely published in the literature as valid and reliable (Reynolds, K., et al. 2008). We performed paired sample t-tests to assess the change in assessment scores between pre and post-tests.

   We used qualitative data to understand participants' perceptions of the PSP program. We conducted in-depth interviews with participants, within 7-10 days of completion of the intervention, to learn how their understanding and opinion or beliefs about mental health had
changed, if and how their own mental health had improved, and how the program had affected them.

4) **What is the relationship between PSP participation and healthcare utilization?**

One aim of the pilot study was to understand the relationship between participation in the PSP and healthcare utilization before and after the intervention. We collected these data for the period 90 days prior to the intervention, the 90 days during which the 10-week intervention took place, and for the 30 and 90-day periods after the intervention. This allows us to compare healthcare utilization across similar time periods, and to assess whether any changes are maintained up to 3 months following the intervention.

To measure healthcare usage (e.g. number of visits to a healthcare provider) related to healthcare utilization we examined the number of times participants reported visiting a doctor, a professional nurse, a visiting nurse aide, or a physical/occupational therapist. People who are in a course of treatment for a chronic disease or serious illness (e.g. cancer, renal failure) and necessarily were seeing healthcare professionals on a regular basis were excluded from the healthcare utilization analysis related to healthcare usage. Only individuals with a total of 13 or fewer healthcare visits were considered in the healthcare utilization analysis; as this number seemed to correspond to individuals without serious illness. Other healthcare utilization measures included: number of emergency room visits, overnight hospital stays, nursing facility admissions, and visits to a doctor or other healthcare provider. In addition to healthcare utilization, we also tracked the following outcome factors: self-rated general health and mental health status, residential location and relocation, functional status, and social contact.

We assessed healthcare utilization data and other above listed outcome factors using a mixed effects model that accounted for the non-standard distribution of these data and repeated measures for each study participant. We also conducted univariate analyses of data on mental health status, residential location and social contact.

5) **How do the participant and volunteer describe their experience in the PSP strengths-based intervention?**

We conducted qualitative interviews with participants within 7 to 10 days of the completed match and with volunteers and participants during the 10th week of the intervention. We also tracked participant and volunteer progress on goal development and attainment through bi-weekly phone calls with volunteers. In the interviews, participants and volunteers were asked about progress made toward goals, next steps in meeting goals and/or
development of other goals/plans, whether or not they planned to meet in the future, and if they would recommend the program to others. We recorded anecdotal information at the 30 and 90 day post-intervention assessments to see if benefits of the program were continuing to accrue and if they were still meeting with their volunteer and working on goals. We collected data on volunteers to ensure we were doing no harm to the volunteers and to assist in evaluation of the program. These data provided information on participant and volunteer activities, their relationship, and their experience together during the PSP.

6) What is the difference in implementation processes between the PSP research model to confirm outcomes and the PSP practice model that will be implemented by AAAs?

To determine how the PSP practice model will be implemented by AAAs, OALTC staff and AAA staff in the three pilot sites met several times. During these meetings, we created strategies for implementation and sustainability. The meetings were also important for helping AAA staff understand the difference between the PSP practice model that they will be implementing, and the PSP research project. The research required rigid eligibility criteria, screening, in-depth assessment at multiple time points, thorough documentation, and other time-demanding tasks that are not necessary for implementation of the PSP practice model by the AAA. Additional information on implementation and sustainability was provided by KDOA staff members. The OALTC incorporated feedback from all parties, and conducted training with AAA staff at each pilot site. Trainings included information on sustainability procedures and resources (e.g., program manual, volunteer training guide). Please see Appendix A for the sustainability table, which highlights the PSP practice model.

The PSP program manual and volunteer training and facilitator guide are separate documents developed during FY10. Together, these documents will assist the AAA pilot sites in continuing the program in their catchment areas. The program manual details the steps and resources needed to carry-out the PSP practice model. It also provides several sample documents to assist with recruitment, intake, matching, and documenting outcomes. The volunteer training and facilitator guide supplement the volunteer training DVD by providing additional training activities (e.g. role plays, case vignettes), discussion questions, and handouts for trainees on important information throughout the training. These documents have been provided separately and not included as an appendix.

Sample

The target population for the PSP intervention was Medicaid HCBS/FE Waiver customers who exhibited mild to moderate symptoms of depression or anxiety. Volunteers were peers from a similar age group (55 years and older). OALTC staff enrolled 53 participants in the PSP. Of these, OATLC staff matched 40 participant and volunteer pairs. One main reason
participants were not matched after enrollment was due to health issues. In a few instances, the enrolled participant decided they did not want to participate in the study. Thirty-two participant and volunteer matches completed the intervention by the end of the study time-frame. Some reasons for the 8 uncompleted matches include: death of participant, hospitalization of participant, volunteer became ill. Our experience with recruitment and attrition in the PSP is similar to others’ experience with new program implementation and should be expected (Areán & Gallagher-Thompson, 1996). We also enrolled and trained 76 volunteers, and 38 were matched. Two of the volunteers were matched twice. In some cases volunteers were easier to recruit to the program than participants. Many volunteers remain interested in volunteering for the PSP and some, who have already been matched, have agreed to be matched again. This leaves an existing pool of available and interested volunteers for future matches in each pilot site.

Participants in each pilot AAA catchment area (CPAAA, JAAA, SEKAAA) were recruited for enrollment in the PSP. To ensure reliability across research sites, OALTC staff provided presentations to case managers so they understood the program and benefits to Medicaid HCBS/FE Waiver customers and the PSP eligibility and exclusionary criteria. The primary eligibility criterion was enrollment in the Medicaid HCBS/FE waiver program. Every enrollee of the waiver program is assigned a case manager, so participants were recruited from the pool of Medicaid HCBS/FE customers in each pilot AAA catchment area. Other eligibility criteria were mild to moderate symptoms of depression and anxiety. Case managers identified these individuals on their case loads in two ways: 1) assessing need based on an in-depth understanding of individual situations and what type of services would be best suited for each participant; and 2) using the K6 portion of the UAI to identify people that scored an 8 or higher. The OALTC also worked with KDOA to generate lists of potential participants using key UAI variables (e.g., K6 score, cognitive status, guardianship etc.). In some cases this shortened the time it took case managers to refer potential PSP participants.

For numerous reasons, including participant and volunteer safety, and research integrity, eligibility guidelines contained several exclusionary criteria. After gaining experience with program implementation and reviewing preliminary data, the OATLC re-examined and extended eligibility criteria. On a case-by-case basis, the research team allowed flexibility with a limited number of exclusionary criteria (e.g., currently receiving mental health services). These changes did not affect core eligibility requirements (e.g. Medicaid enrollment), and did not compromise the validity or reliability of study results. Eligibility was determined through interviews with potential participants. Additionally, if any risks were learned of during interviews, protocols were followed to get help as needed. Exclusionary criteria included:

- Not a Medicaid HCBS/FE recipient
- Reported history or current plans of homicidal or suicidal attempts/plans
- Self report of current/past diagnosis of psychosis
- Inability to speak and/or write English
- Mini Mental State Exam (MMSE) score of less than 16 for participants
- Receiving mental health services and/or psychotropic medications less than 3 months prior to enrollment in the PSP
- Currently experiencing financial/physical/mental/sexual exploitation or abuse
- Currently abusing alcohol or other illicit substances (CAGE)
- Has a guardian or conservator
- Younger 65 years of age

Findings

Characteristics of participants in the peer support program (research question 1)

Table 1 highlights the demographic characteristics of participants who completed the Peer Support Program. The mean age for participants was 76 years of age, with a range of 64 to 87. Most participants were Caucasian women with some high school education. At the time of enrollment, most of the participants were single and living alone in a single-family dwelling. Most participants who completed the program lived in the Central Plains AAA catchment area due to the length of time the pilot was implemented in this area compared to the other pilot sites.

Participants enrolled in the Peer Support Program reported much health-related and functional impairment at the time of enrollment. When asked if they needed the help of other persons in handling routine needs, such as everyday household chores, shopping, or getting around for other purposes, 95% said they needed that type of assistance. Finally, fifty-eight percent needed help with personal care needs, such as eating, bathing, dressing, or getting around the house.

Table 1: Demographic Characteristics of Participants who Completed the Peer Support Program

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Participants (N=32) (%) or mean</th>
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<tbody>
<tr>
<td>PSA</td>
<td></td>
</tr>
<tr>
<td>CPAAA</td>
<td>69%</td>
</tr>
<tr>
<td>JAAA</td>
<td>22%</td>
</tr>
<tr>
<td>SEK-AAA</td>
<td>9%</td>
</tr>
<tr>
<td>Age (mean)</td>
<td>76</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>22%</td>
</tr>
<tr>
<td>Female</td>
<td>78%</td>
</tr>
<tr>
<td>Medicaid enrolled</td>
<td>100%</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>97%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>High school +</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>&lt; High school</strong></td>
<td>25%</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>3%</td>
</tr>
<tr>
<td>Single</td>
<td>97%</td>
</tr>
<tr>
<td><strong>Residential location</strong></td>
<td></td>
</tr>
<tr>
<td>Single family dwelling/Apt.</td>
<td>82%</td>
</tr>
<tr>
<td>AL/ILC</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Living situation</strong></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>75%</td>
</tr>
<tr>
<td>With spouse/relative</td>
<td>25%</td>
</tr>
</tbody>
</table>

Outcomes evaluation of mental health distress and quality of life (research questions 2 and 3)

**Quantitative findings.** Standardized assessment measures were used to determine changes in depression, anxiety, and quality of life. The GDS and BAI have a range of scores that indicate normal, mild, moderate, or severe levels of depression and anxiety. The QLI measures overall quality of life as well as subcategories of health and functioning, social and economic, psychological/spiritual, and family. The QLI creates a range of scores that indicates how "satisfied" an individual is with various aspects of their life. Below is a list of the range of scores a person can attain on each assessment and what the score indicates.

<table>
<thead>
<tr>
<th>GDS</th>
<th>BAI</th>
<th>QLI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4, normal</td>
<td>0-7, minimal</td>
<td>0-30</td>
</tr>
<tr>
<td>5-8, mild</td>
<td>8-15, mild</td>
<td>higher score= greater satisfaction</td>
</tr>
<tr>
<td>9-11, moderate</td>
<td>16-25, moderate</td>
<td></td>
</tr>
<tr>
<td>12-15, severe</td>
<td>26-63, severe</td>
<td></td>
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Participant scores on the GDS and BAI indicated minimal to severe levels of depression or anxiety prior to starting the intervention. Most participants scored in the mild to moderate categories on either scale. However, in some cases, clinical interviews by OALTC staff and reports from case managers identified additional and more severe signs of depression or anxiety. Therefore, the depression and anxiety experienced by some participants may be higher than what is reflected in the average scores on the GDS and BAI scores.
Table 1: Pre and Post Intervention Mean Scores from Standardized Assessments, N=32 Participants

<table>
<thead>
<tr>
<th></th>
<th>Pre-Intervention (n=32 completed)</th>
<th>Post- Intervention (n=30(^2) completed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDS</td>
<td>5.77</td>
<td>4.03*</td>
</tr>
<tr>
<td>BAI</td>
<td>12.60</td>
<td>11.27</td>
</tr>
<tr>
<td>QLI Total</td>
<td>19.37</td>
<td>20.74</td>
</tr>
<tr>
<td>Health and Function</td>
<td>16.61</td>
<td>19.42*</td>
</tr>
<tr>
<td>Social and Economic</td>
<td>21.72</td>
<td>21.84</td>
</tr>
<tr>
<td>Psych/Spiritual</td>
<td>21.46</td>
<td>21.92</td>
</tr>
<tr>
<td>Family</td>
<td>20.52</td>
<td>20.52</td>
</tr>
</tbody>
</table>

*statistically significant \(p<.05\)

Pre and post-intervention assessment results confirm a positive relationship between involvement in the PSP and improved assessment scores on the GDS and Health and Functioning sub-category in the QLI standardized measures. The amount of improvement in symptoms of depression from the GDS pre-test to post-test for the GDS was statistically significant. Participants’ mean GDS score was 5.77 before the intervention, and improved 1.74 points to a mean of 4.03 following the PSP intervention \((p<.05)\). Thus, average depression scores shifted to the normal range.

There is a trend towards a difference in QLI scores before and after the intervention \((p=.007)\). The mean total score improved from 19.37 before the intervention to 20.74 following the intervention. On average, participants showed improvements in their quality of life after spending time with a PSP volunteer. Individually, 21 out of 30 (70%) Medicaid HCBS/FE waiver customers who participated in the PSP intervention improved their quality of life score. In addition, the pre and post intervention scores were significantly different in the Health and Functioning sub-category of the QLI. The mean health and functioning scores started at 16.61 and improved 2.81 points to a mean of 19.42. The pre- to post test scores for the other QLI subscales were very small and were not statistically significant. It appears that the PSP has greater potential for improving health and functioning indicators.

Scores on the BAI, which measures anxiety symptoms, did not improve to the level of statistical significance \((p=0.26)\). However, it is important to note that 74% of the participants with mild, moderate, or severe anxiety showed improvements in their quality of life following the PSP intervention. With a larger sample, statistical significance might have been achieved. Also, the BAI assessment indicators may not be adequate to capture the symptoms of anxiety that might be ameliorated by the PSP intervention.

\(^2\) Thirty-two participants completed the intervention. However, one participant died and one participant was hospitalized immediately following their 10th week with their volunteer. Therefore, post-intervention data regarding depression, anxiety, quality of life, and the healthcare utilization were not collected and included in this analysis.
Overall these findings validate the use of the Peer Support Program with customers receiving the Medicaid HCBS/FE waiver who have mild to moderate symptoms of depression. Additionally, as explained below in the qualitative component of the study, many participants reported an improvement in their quality of life, after they completed the PSP intervention. This was particularly true in the area of health and functioning (e.g. health, ability to care for self, usefulness to others).

**Qualitative findings.** In addition to the quantitative data that were collected from participants throughout the program, qualitative data was collected on each participant through the use of semi-structured, open ended qualitative questions during the 10th meeting, and during the 7-10 day post-intervention interviews. These questions allowed participants to describe ways that their mental health status, understanding of mental health, and overall quality of life improved throughout and following the intervention. Several common themes emerged: 1) improved mental health; 2) decreased social isolation; 3) improved understanding and opinion of mental health; and 4) increased self-care.

We asked participants if they believed their mental health had improved during the intervention. Of those who responded to this question, 80% (20 out of 25) reported that they thought their mental health was better after the intervention. One participant reported that after the intervention, his depression and anxiety felt more manageable. Several respondents stated that prior to the PSP intervention they lacked motivation to get out of bed or leave the house. Following the PSP intervention, they reported feeling more motivated to engage in the community and in activities they enjoy. Many of these respondents attributed their new motivation to their relationship with their volunteer and/or the goal-setting component of PSP. One participant noted that before the intervention she did not want to get out of bed or brush her teeth. After participating in the PSP she likes to “get her home in order” and has made the decision that “life is not over”. Others reported feeling better, less negative and having an improved mental attitude. Another participant described how she believed that her improvement in mental health came from the elation she felt after reaching her goals.

A few of the participants used the example that their improved mental health was related to having an increased support system and someone to visit them. One participant reported that she thought her mental health had improved during the intervention because it put a support system in place to help her. Another participant felt “valuable” again and appreciated her volunteer’s visits because she was homebound.

Some participants also reported that they had an increased understanding of their own mental health. One participant noted, “I understand more about depression and how it affects me than I did before, so I’m getting a better understanding of it…”. A few told us they learned to recognize their own symptoms of depression and social isolation. Recognizing this helped them overcome these symptoms and connect more with others. Additionally, many participants reported the program had changed their opinions or beliefs about mental health in a positive way. For example, one participant reported that before the program, she thought that older adults who were “hard to handle mentally” were put away in nursing homes. Following the
PSP intervention, her opinion had changed and she stated that “a lot of people stay home and all [older people] have their strengths”. Another participant reported having a newfound respect for mental health and that exploring mental health through the intervention had been helpful to her.

Although not asked directly about it, during the post-intervention interview 62% of the participants noted that their self-care had improved after participating in the program. Some reported increased self-care related to the PSP included: exercising, eating better, receiving dental care, procuring better walking supports, and reducing hoarding behaviors. Participants attributed some of these improvements to the goal-setting component of the PSP. For example, one participant identified walking three times a week as her goal. The volunteer assisted the participant in identifying manageable steps toward reaching that goal (e.g. identify a walking route, identify a walking partner, walk 10 minutes on Monday, etc.).

During the post-intervention interview process when asked how the PSP affected them, most of the participants (78%) described improvement in their quality of life because of the PSP. When asked how meeting with the volunteer helped their lives, some participants told us that meeting with the volunteer gave them more determination, more “spark” and a more positive outlook in their lives. As an example, one participant shared that she had felt worthless before the intervention, as if she had nothing left to give. After meeting with the volunteer and sharing activities and encouragement with her, the participant felt joy and appreciation that the volunteer was coming just to see her. The participant noted, “I’m housebound and feel worthless with no value and nothing left to give. It’s a temptation to get depressed. She gave me somebody go look forward to who was coming just to see me…. I appreciated that.”

The qualitative data describe how participants who completed the program felt their own mental health had improved, social isolation decreased, and self-care improved. They shared how their opinions about mental health changed in a positive way, and some felt that they had a more positive outlook as a result of meeting with the volunteer. These findings add participants’ perceptions of their improvement to the statistically significant improvement in their depression and quality of life health and functioning score. The participants’ stories provide important detail and add depth to the changes captured by the standardized assessment instruments. Overall, findings indicate that the Peer Support Program was a positive force in participants’ lives that contributed to their improved mental health and quality of life.

Outcomes evaluation of healthcare utilization and other factors (research question 4)

We assessed general health and mental health status, healthcare utilization, social contacts, and residential status before and after the PSP intervention, and again at 30 and 90 days post-intervention. We expanded the pilot into two new AAAs later than anticipated due to unforeseen circumstances. Because of this delay and the amount of time it takes to complete the intervention, several participants have not yet reached 30 and 90 days past the end of their intervention period. Therefore, we have not been able to collect 30 and 90-day data on all participants who have completed the intervention. However, healthcare utilization data produced
thus far has shown significant results. We will continue collecting these data into FY11, as permitted to build on and validate the current findings.

All of the participants who rated their mental health status 30 days after the intervention reported that their mental health was the same or better than immediately following the program. The majority (89%) of PSP participants who rated their mental health status 90-days after the intervention reported that it was the same or better than what they had reported 60 days earlier. This suggests a long-term positive effect of the PSP. This finding was confirmed by statistically significant changes in GDS scores and by qualitative data. We also determined change in general health ratings over time. Overall, results showed a positive direction towards improvement in self-rated health. Data indicated that health ratings, rated on a 5-point Likert scale, increased 0.23 per 90-day period or about half a rating category from the pre-intervention assessment through 90 days post intervention. Additional analysis confirmed a positive change or maintenance of health status for 83% of the sample.

The data indicate there is a statistically significant reduction of health care usage for participants not treating a serious/chronic condition (e.g. cancer or renal failure; p=.02). The analysis used for these data provided an estimate of change in healthcare usage. The average number of healthcare provider visits was 3.4 visits in the 90-days prior to the intervention. Health care usage was reduced after the intervention. Estimates based on our analysis indicate that for every 100 people enrolled in the study, we expect that the number of healthcare provider visits would go down by 76 visits in the 90 days following the intervention. This analysis controlled for age and gender.

Because of the low number of nursing facility, ER, and hospital admissions we were unable to conduct an analysis to determine a pre-post intervention trend in these types of admissions. Residential relocation is another low incidence event. Only two participants permanently moved to nursing facilities after the intervention. Finally, we assessed the amount of social contact with friends, family, or other social groups at the post, 30 and 90-day assessments. Participant social contacts stayed the same or improved during each assessment period.

Overall, findings indicate that healthcare usage decreased significantly following participation in the PSP intervention. Additional data, as more participants reach the point of 30 and 90 days post-intervention, will provide a better picture of the relationship between Medicaid customers’ participation in the PSP intervention and reductions in their use of costly healthcare services. Self-rated physical health status improved over time and mental health status stayed the same or improved as far as 90 days after the intervention. Also, participants maintained their residential location and social contacts stayed the same or improved at 30 and 90 days post-intervention. Participants have shown improvement in their emotional well-being and quality of life both immediately following and long after the intervention is complete.
Participant and volunteer experiences in the PSP strength’s based intervention (research question 5)

Throughout the 10-week strengths-based peer support intervention, the participants and volunteers were given several opportunities to share their experiences with the PSP program staff. Data were gathered through bi-weekly progress notes, 10th meeting interviews, 7-10 post-intervention interviews, and 30 and 90-day post intervention interviews. The following section is a summary of how the participants and volunteers described their PSP strength’s based intervention experience during the interviews; special attention is paid to the goal setting component of the PSP.

The Peer Support Experience. Overwhelmingly, volunteers and participants both reported positive peer support experiences. Most individuals participating in the PSP noted that they enjoyed the process and valued the connection they had made with another person. In fact, 75% of the matches continued meeting past the 10 week PSP intervention:

I felt like I made new friends and somebody was coming to see me every now and then…and it’s encouraging to know that somewhere out there, somebody’s thinking about you. -Participant, Central Plains region

The greatest benefit to me is that I have a new friend…We decided early that we wanted to continue visiting as friends even after the official ending of our match. Many weeks we have two visits. –Volunteer, Jayhawk region

I think she’s a very wonderful lady and I got to meet a nice friend. We’re still going to do things afterwards…we’re going to continue to be good friends. –Volunteer, Southeast Kansas region

The benefits of participating in the PSP process for participants are outlined below and in the previous section of this report. However, it should also be noted that many volunteers reported benefitting from the PSP experience. Some volunteers talked about being inspired by the participant, learning new skills, and having something worthwhile to do. One volunteer shared her own struggles with isolation and how meeting with the participant helped her to get out of the house. A few volunteers shared that they learned more about aging and mental health in older adults and how to recognize symptoms of depression and anxiety. One individual noted:

“I have a greater respect for mental health. Exploring these things during the program have been very helpful. I used to be a trucker and I’d say sometimes you got to get out of the truck and touch things. What the PSP does is like getting out and touching.” – Volunteer, Jayhawk region
**Goal Setting.** Over the course of the match, volunteers assisted participants in working toward a goal(s) that the participant identified. Goals frequently centered on improving self care; reengaging in life and activities; and reconnecting with family members. Examples of participant goals are as follows:

- Begin an exercise program
- Learn to paint
- Reconnect with friends and family members
- Do physical therapy exercises daily
- Attend church services more frequently
- Go to the senior center
- Expand social network

During the bi-weekly phone contacts with OALTC staff, the volunteers provided feedback on the goal setting process. Many volunteers reported that prior to discussing goals, they focused on establishing a rapport with the participant. Further, most volunteers commented that taking the time to establish a relationship created a comfortable environment for discussing goals. Most matches set a goal by the third visit. The following is an example of a match, where the volunteer waited to discuss goals until after several meetings of sharing stories with each other and building rapport:

“She had said I had lots of interesting experiences and I had even read her some of the short stories I had written a long time ago. Now she asked if I had ever considered writing a book… She even brought me one of her books to read. It was written by an elderly woman living in a rest home in Western Kansas. After reading it cover to cover I decided I could write stories every bit as interesting as her’s…. I have started writing almost daily while sitting in my recliner with my legs elevated.”—Participant, Jayhawk region

A few volunteers stated that the participants preferred not to use the phrase “goals” when identifying an item(s) to work on that might improve their lives; in these cases the volunteer and participant used phrases like “what we are working on”, when discussing progress with each other and OALTC staff. The following is a case study of a participant, who declined to use the word “goal”, but who worked with her volunteer on a plan to improve her mobility.

The female participant was in her 80’s. Prior to the PSP intervention, the participant had been in a significant car accident that resulted in injuries that made it difficult for the woman to walk without support. However, the woman was reluctant to use supports, such as a cane or walker, because she preferred to be able to walk on her own. Nonetheless, in order to get around her rural home, she was using two broomsticks for support when she walked.
At the point of the PSP referral, the woman had been homebound for several months with limited social interaction. She identified getting to know another person as one the primary reasons for accepting the referral, but she indicated that she was not sure she had a goal. After spending two visits with her volunteer building rapport, the pair identified “getting better walking support” as one of the things that they would work on. During bi-weekly phone calls, the volunteer stated that she encouraged the participant to replace the broom sticks with better walking supports because of fall concerns. The volunteer and the participant identified steps that may lead to acquiring medical equipment. Examples of the steps they identified are: contact the SEKAAA case manager for assistance, contact participant’s doctor, contact medical supply companies, and contact family members for assistance in purchasing the walking support. By the end of the PSP intervention, the participant did replace the broom sticks with a doctor approved cane. In doing so, the participant is now at a lower risk of falling and may have increased her chances of continuing to live independently in her home. She is also better equipped to leave her home because she can more easily walk with the cane in public places. In the following quote the participant discusses her experience with the PSP and her PSP volunteer:

As in the case above, the individuals who declined to use the word “goal” (or did not set goals; two participants), still indicated in post-intervention interviews that they had benefitted from the program and were able to give concrete examples of how. Commonly cited benefits included increasing social contacts, discussing problems/concerns with an individual their age, having something to look forward to in the week, and making a new friend. At the start of the intervention, most of the individuals who did not set goals identified the regular social interaction with the volunteer and not goal setting, as the primary reasons for entering the PSP.

Goal Attainment. At the post intervention interview, participants were asked how they felt about their progress towards accomplishing their goals. Frequently, participants had more than one goal. Twenty-six of the 32 participants stated that they had accomplished at least one of their goals. Most respondents who did not accomplish a goal(s) over the course of the ten week intervention stated that they were very satisfied with their progress toward meeting their goal(s) and they continued to work toward goal attainment. Three respondents stated that they had made limited progress toward a goal. In the cases where limited progress was made toward an identified goal there were often extenuating circumstances, such as weather or illness that limited an individual’s ability to make progress toward goals. For example, an individual set a goal of attending exercise classes at the senior center, but was deterred due to snow and ice during the 10-week intervention period. Another participant set a goal to locate and attend a church once a week, but shortly after setting the goal, fell and was injured, making it difficult for her to leave her home; and thus, making it difficult to achieve her goal. In addition to the three participants who made limited progress toward goal attainment, two participants did not
establish goals at all. However, overall participants stated that they were very satisfied with their progress and happy about their achievements:

*Now I’m kind of elated with reaching my goals!...I think reaching my goals made me think about other things I might like to do. In this way, I’m more varied and less bored.*  
Participant, Jayhawk region

Occasionally during the goal setting and attainment process, the volunteers contacted OALTC staff for support about program concerns, like how best to assist the participant in achieving a goal. For example, a volunteer phoned OALTC staff to discuss her participant’s goal of returning to her home in Western Kansas to live alone. The volunteer was unsure that the participant, who lived with her caregiver, would be able to return home due to chronic illness and care needs. However, the volunteer stated that the participant was “insistent on working toward returning home to Western Kansas”. The OALTC staff coached the volunteer to assist the participant to identify proximal goals, or steps, which might increase the participant’s likelihood of returning home. Among other steps, the match identified physical therapy as a step toward building the participant’s strength. By the end of the intervention, the participant had started physical therapy and was exercising regularly.

In addition to programmatic concerns, occasionally a volunteer would request assistance with a concern they had for the participant. In most of those cases, the volunteers encouraged the participant to phone their AAA case manager. Occasionally, if the need was more imminent, the volunteer sat with the participant while she phoned her case manager or the volunteer made the call for the participant. For example, a participant shared with her volunteer that she had received an eviction notice. The volunteer sat with the participant while she phoned her case manager. In another situation, a volunteer arrived at a participant’s apartment and was informed by her neighbor that the participant had been taken to the emergency room. The volunteer phoned the participant’s case manager to let her know that the participant had been hospitalized. During the pilot study, case managers provided feedback that the extra set of eyes and ears was helpful for them in between visits to ensure their client’s needs were being met.

*Because the peer volunteer is going into the home weekly, the peer volunteer has helped me be aware of things, needs that my senior had that I wasn’t aware of. And sometimes the volunteers have actually made referrals that have been helpful to my senior or they’ve been able to inform me about what’s going on so I’ve been able to follow up. You know, with my visits being every thirty to ninety days, you aren’t aware of all that’s going on as much as someone who goes in weekly. Before the peer support program, I would just wish that there was more that I could do for them as far as, you know because I’m limited with how often I can visit them and a lot of them can’t get out very easily because of their health condition or don’t want to get out because of their health conditions, as far as say a senior center. And so being able to refer them to a peer volunteer has just been really helpful to them and to me because I feel like I’m not*
just leaving them without a really good referral and without someone whose going to potentially make a difference in their life.  Case Manager, CPAAA region

During the post intervention interviews, all the participants and volunteers stated that they would recommend the program to other people interested in volunteering or who needed mental health support. This recommendation is backed up by the fact that of the 32 completed matches to date, 24 continue to meet in person or over the phone after the intervention. The following are examples of responses we received related to recommending the PSP:

Yes! Some of the [older adults] here are just kind of going along, but everything is hum, drum.  They don't look for things to participate in.  You've got to get out of the rut and fully enjoy life.  Participant, Jayhawk Region

Definitely, I’d recommend the PSP to someone who wanted to volunteer.  Volunteers feel good about themselves and learn skills along the way. Listening sounds too trite; It’s the skill of being there for someone else and knowing when to talk and when not too. Volunteer, Jayhawk Region

One the reasons cited by volunteers for recommending the program to others was that they perceived the goal setting process as helpful for the participants and volunteers alike. For example, some volunteers stated that they benefitted from the process because it caused them to reflect upon their own goals:

I realized goals are more important than I thought.  They provide encouragement to do things you might not do otherwise. –Volunteer, Central Plains region

Thirty and 90 days post-intervention. At 30 and 90 days post-intervention participants noted that they were still appreciative of the program and they were still doing things to keep themselves engaged in life and others. One participant noted, “[The program] helped me an awful lot because now most of the time I get up and get dressed.” In fact, many volunteers and participants continue to meet at 90 days post-intervention. Most participants reported staying connected with their goals at 30 and 90 days after the intervention. Many continued to participate in activities that they had started or increased during the intervention such as going to church, bible study, crochet class and the senior center.

Several participants have continued to experience positive outcomes from the program 90 days post-intervention. The following four case studies illustrate these long-term benefits.

- **Case Vignette 1:** The participant is a female in her 70s. At the beginning of the PSP intervention the participant described functional limitations with activities of daily living due to recovery and complications from a pace-maker implant. She was depressed and anxious about her health and functional limitations. The participant set very basic goals to regain some control of her environment, including getting her house cleaned and walking more. At 30 days post-intervention the participant noted that she felt that she was getting healthier and taking care of herself. At 90 days post-intervention the
participant reiterated that setting goals for herself was still very helpful when she felt overwhelmed. She felt that she was able to get out and do more things, including connecting with family and church.

[PSP] helped me a lot. I didn't have many people coming to see me … [My volunteer] had compassion and understanding, [she] listened to me. I had no energy and was so afraid. I was scared to check out things that were wrong with me. I didn't know what was wrong, too scared to go check it out. She gave me motivation … not to be afraid of the consequences. This program has really been beneficial for me.

- **Case Vignette 2:** The participant is a male in his 70s. Shortly before the PSP intervention began the participant lost his wife and became bed-ridden due to obesity and chronic health conditions. The participant’s goal was to get out of bed. The volunteer had experienced similar health conditions in the past and helped motivate the participant to get out of bed and seek medical attention. Through the encouragement of the volunteer, the participant did seek medical care and went to a nursing facility for a short rehabilitation stay. Following the intervention, the participant reported that he had lost 125lbs. and was excited to share the news with his volunteer. Although the participant and volunteer don’t stay in touch regularly, they did develop a significant relationship. Shortly after sharing the news of his weight loss, the participant relapsed and found himself in bed again. The volunteer has since reestablished contact with the participant. The volunteer has shared with us that he is committed to helping the participant continue to maintain his health.

[PSP] did help. At first I didn’t have any goals, but now I am feeling better… The goals are probably a little more important now [than they were when I started PSP].

- **Case Vignette 3:** The participant is a female in her 60s. When the PSP intervention started, the participant felt distressed about her health and inability to do some physical activities that she had enjoyed in the past. She was worried about being cooped up and sedentary. The participant set the goal of increasing her physical activity. The volunteer encouraged the participant to become involved with the local Senior Center. She began taking exercise classes and connecting with others through crocheting. Ninety-days after the intervention the participant still actively participated in the Senior Center. The participant was able to use a hobby from her past to connect with others and start her own crochet group at the Senior Center. The case manager has relayed to research staff that five months after the intervention was complete, the participant reported that she is doing much better and has continued her Senior Center activities.

I’m a 9 [out of 10] on a happiness scale. I’m happier now than I’ve ever been and I know it’s a lot because of [my volunteer] and looking forward to seeing her
every week. But another thing too, is working on these things, on goals. This needs to be all over the state for all seniors, especially the homebound.

- **Case Vignette 4:** The participant is female in her 70s. Prior to the start of the PSP intervention, the participant moved to an assisted living facility. She told us that she became depressed due to the smaller living space in a different community. The volunteer and participant worked on the participant’s goal of reengaging in activities she used to enjoy prior to moving. These included crocheting, crafts, and involvement in her church. Over the 10 weeks, the pair focused on these activities. Ninety-day post-intervention, the participant is still actively involved in her assisted living community, started a crochet group, and has found ways to stay connected with her church. The volunteer and participant continued to stay in touch at the 90-day assessment.

  *She’s given me more determination to get better. Working with [volunteer], she has a tendency to smile and laugh. She takes things lightly and that’s affected me positively… Yeah, I was hurting so much from arthritis… Now I’m just on 3 pills a day for pain. I was on about 10 or 12.*

Overall, both participants and volunteers were very positive about the PSP. Setting and striving towards goals provided a focus for the pairs and positively impacted the physical and mental health of many participants. The high percentage of participants that met at least one of their goals indicates that the relationship with the volunteer provided motivation to achieve their goal. Many of the goals attained have resulted in a decrease in social isolation, increase in self-care, and re-engagement in life. This indicates that the PSP may have helped improve the outlook of several participants and could potentially lead to extended community tenure. Additionally, these findings provide insight into the factors that resulted in improvements in depression and quality of life.

**Transition from a peer support research model to a practice model (research question 6)**

During FY 10, one of the primary focuses of the OALT C staff was creating a transition plan to advance the PSP from a research model to a practice model. To do so the OALT C staff worked closely with AAA pilot site staff at CPAAA, SEKAAA, and JAAA and the KDOA to develop sustainability strategies for the major components of the peer support model. The sustainability table outlining these strategies can be found in the appendix. The PSP components include:

- Recruitment and referrals of volunteers and participants,
- Screening of volunteers and participants,
- Intake of volunteers and participants, training of volunteers,
- Matching and providing support for matches,
- Documentation of outcomes
The following section will outline sustainability strategies developed for each program component. It will also provide a comparison of the PSP research model and the PSP practice model.

**Identifying a PSP coordinator.** In the PSP research model the PSP coordinator was an OALTC staff person. The transition to a PSP practice model will require that an AAA PSP program coordinator be identified. Cost restraints may require that program coordinator duties either be allocated to existing staff or an unpaid volunteer/staff person. Dialogues with AAA staff at current pilot sites offered suggestions for potential PSP program coordinator candidates. Staff from all three AAA sites stated that an unpaid practicum student would be qualified to act as the program coordinator. Other cost effective suggestions for a PSP program coordinator included recruiting an in-house AAA older adult volunteer or utilizing a community partner, such as a RSVP (a federally funded senior volunteer program) volunteer/staff person. The program coordinator will work closely with a paid AAA staff person, who in the current AAA pilot sites, will most likely be the Case Manager Supervisor.

**Recruitment and referrals of volunteers and participants.** The initial step in the PSP practice model is recruitment and referrals. Participants referred to the PSP must be Medicaid-HCBS/FE Waiver recipients age 65 or older who are either at risk of experiencing mental health concerns or are currently experiencing mild to moderate mental health concerns. Thus, PSP participants should be referred to the program via their AAA HCBS/FE Waiver case manager. It is anticipated that there will be no change in the participant referral process from the current research model to the PSP practice model.

In the research model, recruitment and referral of volunteers has been conducted by OALTC staff. The following forms of volunteer recruitment have been used:

- newspaper ads
- brochures
- flyers
- presentations to community groups such as senior centers and churches
- networking with providers
- presentations to AAA case managers

In the practice model, the AAA staff/student will take on the volunteer recruitment role. The AAAs have also indicated they will coordinate with community partners to assist in volunteer recruitment efforts; thus alleviating some of the time spent recruiting by the AAA staff/student. For example, RSVP would be a natural partner for recruiting PSP volunteers. Other potential community partners or referral sources are listed below:

- Churches
- Hospitals
- Libraries
- Senior Centers
- Local chapters of AARP
- Local media outlets, such as volunteers-needed press releases in local papers
- Area aging and mental health coalitions
- Community volunteer centers such as RSVP
- Community mental health centers
- Services groups, such as the Lions Clubs, Optimists, etc.
- Organizations of retired professionals such as retired teachers, federal employees, etc.
- Other community aging agencies and networks

While implementing the PSP research model, OALTC staff have already established partnerships with many of the above listed organizations. When transitioning from the research model to the practice model, the OALTC staff will share a list of PSP contacts and partnerships developed during the pilot study with the AAAs.

**Screening of volunteers and participants.** The next step in the PSP is *screening*. In the research model of the PSP, OALTC staff screened out potential volunteers and participants on the following criteria:

- Not a Medicaid HCBS/FE Waiver recipient (participants only)
- Reported history or current plans of homicidal or suicidal attempts
- Self report of current/past diagnosis of psychosis
- Inability to speak and/or write English
- MMSE score of less than 23 for volunteers, less than 16 for participants
- Receiving mental health services and/or psychotropic medications less than 3 months prior to enrollment
- Currently experiencing financial/physical/mental/sexual exploitation or abuse
- Currently abusing alcohol or other illicit substance
- Has a guardian or conservator
- Younger than 55 years of age (volunteer), 60 years of age (participant)
- Record of felony involving real or potential harm to others (volunteers)
- Unable to access transportation to complete home/community visits (volunteer only)

The above listed criteria were designed to accommodate the outcome evaluation process of the PSP research. Several of the listed criteria were identified for research purposes only and will not be necessary in the practice model. As PSP moves forward, the OALTC recommends that AAA staff/students screen volunteer and participants based on the following criteria. These criteria were developed in collaboration with PSP pilot site AAA staff.

**Participants**

- Medicaid-HCBS/FE Waiver recipient
- 65 and older
- Score of 8 or higher on the K6 screening portion of the UAI
- Not currently experiencing psychosis
- Not experiencing late stages dementia or other serious cognitive impairment
- Not currently experiencing abuse, neglect, or exploitation
- No guardian or conservator
- No history of violent behavior

Volunteers

- 55 and older
- Access to transportation
- Pass a criminal background check
- Not actively abusing substances (CAGE can be used as a brief screening tool; see Appendix B)
- Available to commit 1 hour per week of time
- Interest in providing “high-impact” volunteer support
- Agree to complete PSP training requirements

Intake of volunteers and participants. The step following screening is *intake*. The PSP research model intake process for both volunteers and participants included several components that were research specific and may not apply to the practice model. The research model intake process included:

- Mental health screening instruments were administered to both volunteers and participants, including the Geriatric Depression Scale (GDS), Beck Anxiety Inventory (BAI), and the Ferrans and Powers Quality of Life Index.
- A clinical interview was conducted for both the participant and the volunteer. The interview included the individual’s background information such as education level, prior/current occupation, and other hobbies and interests.
- Healthcare utilization patterns prior to the intervention were assessed in participants, but not volunteers.

Practice model intake process. In the practice model, the volunteer intake process will be simplified and require less staff time. An AAA staff/student will conduct a brief intake interview after screening to acquire basic background information and interest of volunteers and participants. The purpose of asking these questions is to facilitate the participant-volunteer matching process. Suggested intake questions related to an individual’s interests are based on experiences from the pilot study and AAA PSP pilot site staff feedback and include (see the program manual for the PSP Volunteer/Participant Intake Form):

- What is your current/past occupation?
- What are your hobbies/interests?
What are your social network affiliations (e.g., church, groups, clubs, organizations, etc.)?

Intake for participants in the practice model may include the AAA staff/student briefly discussing the participant’s background/interests and what the participant would like from the PSP program with his or her case manager at the point of referral. This would reduce AAA staff/student time spent on participant intake.

**Training of volunteers.** The step following intake for volunteers is volunteer training. In the research model OALTC staff provided a three to six hour Power Point presentation training that covered basic issues in mental health, strengths assessment and goal setting, confidentiality, communication skills, and safety and crisis intervention. For the practice model, the OALTC staff has developed a Medicaid-HCBS/FE Waiver PSP Volunteer Training DVD and accompanying facilitator guide. The DVD will reduce the amount of AAA staff time needed for preparing and conducting the training. The training DVD retains all the content listed above in the research model training.

Based on meetings with AAA pilot site staff, the training will likely be facilitated by an AAA staff/student, even though the training is in DVD format and could be administered without a staff person present. This is an advantage in rural areas where geographic proximity of volunteers to the AAA home office can be a barrier to volunteer training. Also of note, AAA staff indicated that there were potential opportunities for AAA community mental health partners to facilitate the training at no cost. Flexibility in who facilitates the training and where it is administered is built into the structure of the Medicaid-HCBS/FE Waiver PSP Volunteer Training DVD and accompanying facilitators guide (see volunteer training facilitator guide for more details).

**Matching.** The step following training is matching. In the research model, OALTC staff matched volunteer and participants based on geographic location, gender, and common interests identified during the intake process. In the practice model, AAA staff/student will coordinate with case managers to match volunteers to participants. They will continue to match based on the above listed criteria.

**Support for matches.** After volunteer and participants are matched, some level of support should be provided. In the research model, OALTC staff provided professional support for the match in the following ways: 1) OALTC staff accompanied the volunteer on the initial PSP meeting with the participant. 2) The staff person made introductions and assisted the match in beginning to fill in a strengths assessment. 3) During the remaining nine visits, the OALTC staff person contacted the volunteer bi-weekly to collect data and to inquire if the volunteer had any concerns regarding the program or the participant. 4) Finally, the OALTC staff person attended the tenth and final PSP meeting to both collect data and to assist the match in ending the PSP relationship.
In the practice model, the participant’s AAA case manager will act as the primary staff person providing professional support for concerns related to the participants care needs; the case manager will be able to bill for this support. The following is a list of identified billable services related to the PSP:

- AAA Case Manager refers a HCBS/FE Waiver consumer to the PSP
- AAA Case Manager introduces a participant to the PSP volunteer if it coincides with an already scheduled case management visit
- The PSP volunteer contacts AAA Case Manager about concerns involving the participant
- The PSP volunteer contacts the AAA Case Managers every 2 to 3 weeks to update on progress and obtain any additional support regarding the participant

As mentioned in the above list, the AAA case manager may be able to meet with participants and volunteers on their first match if that meeting corresponds to a regularly scheduled case management meeting with the participant. However, the AAA student/staff may also accompany the match on their first meeting. During PSP training, volunteers are instructed to contact the AAA PSP case manager every other week to update them regarding their time with the participant and their progress together. The time estimate for the bi-weekly phone contact is 15 to 20 minutes and is based on average length of bi-weekly calls in the research model. Also, volunteers are instructed to contact the AAA student/staff regarding programmatic questions (e.g. using the strengths assessment, specific program policies, etc.) As is the case with all components of the PSP, individual AAAs may devise an alternative means of supporting the matches then those outlined above. However, these are the guidelines that are recommended and they are based on the information resulting from the PSP pilot project.

**Documenting Program Outcomes.** The final step is documenting outcomes. In the research model, outcomes were thoroughly documented to measure program success (see outcomes evaluation sections of this report). Documentation efforts for the practice model will be less intensive and will be based on individual AAA needs and staff time available to collect program data. Minimally, the OALTC is recommending that AAAs collect output data such as number of individuals enrolled and served, number of complete matches, number of minorities served, number of rural residents served, etc. AAA pilot site staff has indicated that collecting and organizing output data will likely not require significant staff/student time and is standard AAA programmatic practice.

Depending on time, resources, program monitoring, and possible future expansion of the PSP program, AAAs may choose to document program outcomes, as well as outputs. There are different ways to document program outcomes and some are more complex than others. In the program manual, the OALTC has provided the AAA staff with the following suggestions and accompanying evaluation tools (see program manual for sample PSP evaluation forms):
• Output tracking might include: number enrolled, number matched, number completed, and demographic information. This will provide basic information about how the PSP is functioning and who is using the services.

• Participant Outcomes Questionnaire might include: asking volunteer and participant program outcomes related questions after completion of the intervention and collecting anecdotal information about participant/volunteer experiences. This will provide data that the intervention is meeting the expectations of participants.

• Outcome tracking might include: administrating assessments before and after the intervention. Assessments could measure depression, anxiety, quality of life, or healthcare utilization (visits to the ER, hospital, primary care physician, nursing facility etc.) This would provide information on changes that may be due to the PSP intervention.

OALTC relied on information gathered from the PSP research model and feedback from the AAAs to identify sustainability strategies for implementation of the PSP practice model. The three AAA pilot sites are eager to move forward with implementation of the practice model and recently five additional AAAs have expressed interest in providing the PSP in their catchment areas. The OALTC has created a flexible program that can be adapted to fit the needs of each individual AAA. The OALTC can continue to provide technical assistance as the PSP is introduced into additional AAAs.

Recommendations and Next Steps

The Peer Support Program shows great promise as an intervention to address the mental health needs of older adults on Medicaid in a resource effective manner that builds on the strengths of older adults. The pilot results and experiences of the participants and volunteers, as well as AAA staff demonstrate the PSP can yield important benefits at many levels. Findings from the Peer Support Program indicate that the program has benefitted Medicaid HCBS/FE waiver customers who participated in the following ways. Level of depression showed statistically significant improvement after the intervention was complete as did health and functioning as measured by the Quality of Life Index. Data gathered regarding healthcare utilization showed a statistically significant reduction in the use of healthcare providers and indicated that physical and mental health status was maintained over time. The qualitative data support these findings. Participants reported improved mental health and self-care due to decreased isolation and goal setting. Also, participants noted that they had an improved understanding of their own mental health and their opinions about mental health had changed in a positive way.

Volunteers and participants overwhelmingly enjoyed the program and each of them agreed they would recommend it to others. Ninety-one percent of participants were able to identify and develop goals. Those who chose not to develop goals still reported benefits from the program such as increasing social contacts which can assist in improving mental health.
Eighty-one percent of participants reported accomplishing at least one of the goals they had developed with their volunteer. Volunteers reported receiving similar benefits from program such as learning more about aging and mental health and identifying symptoms of depression. Seventy-five percent of volunteers and participants who completed the intervention continued to meet after their 10th meeting.

AAA executive staff and case managers both provided positive feedback about the program. Case managers were appreciative of the extra set of “eyes and ears” that volunteers provided between their case management visits. AAA executive staff at the three pilot sites and five additional catchment areas have reported to KDOA that they are interested in maintaining and implementing the PSP practice model.

As the proportion of older adults in the community continues to increase, the need for appropriate mental health services for this group will also increase. The Peer Support Program can help overcome barriers such as limited resources, lack of access, and stigma surrounding traditional mental health services, that often stand in the way of older adults receiving effective mental health treatment. The collaboration between KDOA, OALTC, and the AAAs to develop and implement the PSP model has proven to be a success. As the PSP model is expanded into additional areas, we expect positive outcomes will continue to accrue.
References


Center for Medicare & Medicaid Services, Department of Health and Human Services, (2007). Letter from Dennis G. Smith, Director - Center for Medicaid and State Operations.


Appendix
### Major Components of the Peer Support Program

<table>
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<tr>
<th>Recruitment and Referrals of Volunteers and Participants</th>
<th>Sustainability Strategies for the Peer Support Program as a Practice Model for HCBS/FE customers</th>
<th>Area Agency on Aging- PSP Practice Model for HCBS/FE Customers</th>
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| **Volunteers:** Recruitment and referral of volunteers to the PSP should involve community partners to alleviate time spent for recruitment by the AAA. Practicum students could also help with recruitment. Community partners could include:  
  - RSVP  
  - Churches  
  - Other community agencies and networks  
| **Volunteers:** AAAs could work with community partners such as RSVP, practicum students, and other community partners to recruit volunteers to the PSP.  
**Participants:** For the Medicaid HCBS/FE population case managers could be the primary referral source for participants. AAA staff and case managers could coordinate with one another on referrals for potential participants for enrollment.  
**Volunteers:** AAAs could work with community partners such as RSVP, practicum students, and other community partners to recruit volunteers to the PSP.  
**Participants:** AAA staff such as the case manager supervisor/RSVP program coordinator could coordinate with case managers with potential participants for enrollment.  
**OALTC will provide template documents for recruitment**  
**Screening of Volunteers and Participants:** Screening of volunteer and participants should be based on the following criteria:  
**Volunteers:**  
  - 55 and older  
  - Has access to transportation  
  - Passes a criminal background check  
  - Not actively abusing substances (use CAGE for brief screen)  
  - Available to commit 1 hour per week of their time  
  - Ability to and interest in providing “high-impact” volunteer support  
  - Agree to complete PSP training requirements  
**Participant:**  
  - Receiving Medicaid HCBS/FE waiver services  
  - 65 and older  
  - Score of 8 or higher on the K6 screening portion of the UAI  
  - Not currently experiencing psychosis  
| **OALTC will provide template documents for recruitment**  
**AAA staff such as the case manager supervisor/RSVP program coordinator, practicum students, or intake staff could screen volunteers and participants for appropriateness to the program based on the recommended criteria.**  
**OALTC will provide a template screening and intake form for AAAs.** |
| Intake of Volunteers and Participants | Volunteers: A brief intake after screening should be conducted to acquire basic background information and interests of volunteers in order to make the best match possible. Suggested questions include:
  - What is your current/past occupation?
  - What are your hobbies/Interests?
  - What are your social network affiliations?

  - Participants: Participant background and interests should be discussed with case managers when referrals are made OR directly with potential participants.
  - Above listed intake questions should be asked of either the referring case manager or potential participant. Also, information should be gathered regarding the receipt of mental health services in order to determine the level of need and make an appropriate match with a volunteer. |

| Training of Volunteers | Training of volunteers can be done in a number of ways. We have developed a DVD that can be used as a supplement to in-person training or as a stand-alone format to be followed-up with a volunteer trainer. An approximately two-hour DVD training and handouts for volunteers will be provided to AAAs. Some options for delivery of the training could include:
  - A trainer/facilitator could provide in-person training to volunteers with the DVD as a supplemental guide.
  - Volunteers could view the training at the AAA. AAA staff/students could be available to answer questions in-person mid-way through the training and after the training is complete. |

| | Volunteers: AAA staff such as case manager supervisor/RSVP program coordinator or practicum students could conduct a brief intake for basic background information and interests of volunteers based on recommended questions. |

| | Participants: AAA staff such as case manager supervisor/RSVP program coordinator or practicum students could find out about participant background and interests with case managers when referrals are made OR contact potential participants. |

| | If needed OALTC will provide template consent form for volunteers and participants. |

| | AAAs can partner with local providers such as the community mental health centers, RSVP, or other community programs to administer the volunteer training by conducting an in-person training using the DVD as a supplemental guide for the training facilitator. |

| | Each pilot will receive a copy of all needed training materials. |

| | OALTC will train case manager supervisors in each AAA pilot site on the Peer Support Program |
| **Volunteers could view the training in their home or respective community and follow-up with AAA staff/students either in-person or by phone following the training.** |
|---|---|
| **and information in the volunteer training.**|
| **Matching** |
| ▪ Matching of volunteers to participants should be based on geographic location, gender, and common interests identified during intake. |
| ▪ Matched volunteers and participants should receive an initial briefing about the program and one another prior to the first meeting. Briefing information could include: |
|   o Information gathered at intake |
|   o Other information that may help identifying goals for the participant (e.g., participant has mentioned wanted to get reconnected with their church) |
|   o Physical/mental health concerns that may help volunteers identify needs of the participant |
| **AAA case manager supervisors/RSVP program coordinator or practicum students** could coordinate with case managers to match trained volunteers with participants based on geographic location and common interests. |
| ▪ **AAA case managers** could brief the volunteer and participant prior to the first meeting regarding the recommended information. |
| ▪ **AAA case managers could accompany volunteers to the first meeting with participants** if it coincides with the next case management/follow-up meeting with the participant. Alternatively, the program coordinator (e.g. practicum student, other AAA staff) could accompany the volunteer on the first visit. If comfortable, the volunteer could also meet with the participant unaccompanied. |
| **Support for Matches** |
| ▪ Volunteers will need some level of support during the 10-week intervention. Options to provide support include: |
|   ▪ Volunteers could be trained to contact AAA staff for questions re: programmatic issues. |
|   ▪ Volunteers could be trained to contact case managers for any concerns involving participants, this would be billable time. |
|   ▪ AAA staff or case managers could call volunteers to follow-up every 2 weeks to provide additional volunteer support and follow-up on progress. |
| ▪ **Volunteers could call AAA case manager supervisors/RSVP program coordinator** for questions regarding the program. |
| ▪ Volunteers could contact **case managers** for concerns involving participants, this would be billable time. |
| ▪ Volunteers could call **case managers** every two weeks or as needed to follow-up on how the meetings are going and obtain any additional support, this would be billable time. |
Time for follow-up over the phone is estimated at 15 to 20 minutes a phone call.

| Documentation of Outcomes | AAAs may want to document outcomes of the program in different ways depending on time, resources, program monitoring and justification, and future expansion of each AAA program. Documenting healthcare utilization outcomes will be important to AAA for future funding. Outcomes could be documented in the following ways:
| | • Tracking of program output would include: number enrolled, number matched, number completed, and demographic characteristics.
| | • Evaluation of the program would include asking volunteer and participant program satisfaction questions after completion of the intervention. Collection of anecdotal information about participants’ experience is valuable.
| | • Tracking program outcomes would include documenting clinical outcomes by administering pre and post-tests measuring depression and/or anxiety and quality of life.
| | • Tracking healthcare utilization would include examining ER, hospital, nursing facility, and doctor visits etc. following the intervention.
| | • AAA staff such as case manager supervisor/RSVP program coordinator or practicum students could record program output, evaluation, and/or outcomes as needed.
| | • The OALTC will provide concise evaluation forms to be modified as needed. |