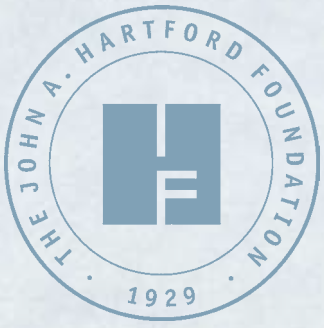
The John A. Hartford Foundation

2011 ANNUAL REPORT

Dedicated to
Improving Health Care
for Older Americans

"It is necessary to carve from the whole vast spectrum of human needs one small band that the heart and mind together tell you is the area in which you can make your best contribution."

THIS HAS BEEN THE GUIDING PHILOSOPHY of the Hartford Foundation since its establishment in 1929. With funds from the bequests of its founders, John A. Hartford and his brother George L. Hartford, both former chief executives of the Great Atlantic and Pacific Tea Company, the Hartford Foundation seeks to make its best contribution by supporting efforts to improve health care for older Americans.



The John A. Hartford Foundation
www.jhartfound.org

Goal Statement

The current goal of the John A. Hartford Foundation is to improve the health of older Americans. Established in 1929, the Foundation is a committed champion of health care training, research and service system innovations that will ensure the well-being and vitality of older adults. Its overall goal is to improve the health of older adults by creating a more skilled workforce and a better-designed health care system. Today, Hartford is America's leading philanthropy with a sustained interest in aging and health.

Through its grantmaking, the Foundation seeks to:

- Enhance and expand the training of doctors, nurses, social workers and other health professionals who care for elders, and
- Promote innovations in the integration and delivery of services for older people.

Recognizing that its commitment alone is not sufficient to realize the improvements it seeks, Hartford invites and encourages innovative partnerships with other funders, as well as public, non-profit, and private groups dedicated to improving the health of older adults.

The John A. Hartford Foundation

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Approximately 20 percent of adults age 55 and over suffer from a mental disorder, such as depression and anxiety.

Report of the Chairman

Norman H. Volk, Chairman

I am privileged to introduce the John A. Hartford Foundation's 2011 Annual Report. This issue explores a topic that has taken an important place in our national discussion on health care: mental health and the older adult. The incidence of mental illness in the elderly—and the demand it places on our health care delivery systems—is reaching a crisis level in the United States. One in eight Americans over age 65 has depression, and one in sixteen suffers with some other serious mental illness, such as schizophrenia, bipolar disorder, delirium, or an anxiety disorder.

Despite their critical need for care, many older adults with mental illness are either undertreated or receive no treatment at all, suffering needlessly. It is perhaps no coincidence that the prevalence of suicide among people over age 65 is significantly higher than in other age groups.

In the Foundation's view, one underlying contributor to these problems looms larger than any other: there is a serious shortage of mental health professionals trained in geriatrics. Of approximately 39,000 psychiatrists in the United States, fewer than 2,000 are certified geriatric psychiatrists. Some estimate that we will need three times that number by 2020. In nursing, very few graduate programs include aging as a topic in their mental health curricula, and no certification examination exists for a specialty in geriatric psychiatric nursing. Even more troubling, one survey found that among licensed social workers—who may well be the largest group of mental health professionals in the country—only nine percent identified aging as their specific field of practice.

Despite these challenges, quality care does exist, and there is exciting progress to report. This 2011 issue of the Annual Report recounts the stories of several older adults who successfully overcame mental health challenges with the help of appropriately trained professionals. This publication also reviews the Foundation's efforts to improve the lives of mentally ill older adults, describing ongoing initiatives that emphasize practice, education, research, and policy. In particular, it showcases tested models of care delivery, the dynamic work of the Geropsychiatric Nursing Collaborative, our centers of excellence in geriatric psychiatry and the committed policy efforts of a number of social work Scholars and Fellows.

A Year of Reflection and Planning

In 2011, the Foundation took time out from making new grants and focused its energies on determining how it will approach its future grantmaking in aging and health. At the same time, the Foundation continued to monitor and support its portfolio of approximately 70 active grants, paying out $19.6 million for the year. In advance of the 2012 completion of an updated strategic plan, Foundation Trustees, however, did authorize two awards.

A $1,258,800 award over three years supported the Hartford Foundation Communications and Dissemination Initiative Expansion, building on previous work with Strategic Communications and Planning, a socially responsible consulting firm specializing in advising nonprofit organizations.

A $140,000 grant over two years went to Grantmakers in Aging (GIA) to help provide stability during its current period of leadership change and geographic relocation. This funding will allow GIA to develop a long-term plan covering strategy, operations, and

finance and will permit this leading affinity group of funders to broaden its base of supporters. A new monthly Webinar series to provide timely and relevant information regarding new ideas in grantmaking is an important component of the grant.

Financial Report

The Foundation's endowment ended 2011 at approximately $478 million after disbursement for grants and expenses. The investment return on the Foundation's portfolio in 2011 was positive for the third consecutive year, after a double-digit loss in 2008. The portfolio's full-year performance was ranked in the top quartile among 108 peer foundations and endowments in the Northern Trust universe. As market volatility increased significantly in the second half of 2011, driven by slow economic growth and the European sovereign debt crisis—while not as severe as the turmoil in 2008 and 2009—the Foundation reduced exposure to public equities and increased allocation in short-term cash investments, continuing to favor a more defensive investment posture. We continue to believe that the best approach to achieving the Foundation's long-term investment objective is to maintain a well-diversified portfolio in order to navigate the challenging investment environment.

Transitions at the Foundation

Finally, I would like to welcome three new Trustees who joined our Board in 2011: Charles A. Dana, John R. Mach, Jr., MD, and Audrey A. McNiff.

Owner of the Newport Shipyard, Mr. Dana serves on the board of the Dana-Farber Cancer Institute, the advisory board of Children's Hospital of the Medical University of South Carolina, and the board of the Dana Foundation. Dr. Mach is currently president and general manager of Univita's Complex Case Management division. In the past, he has served as chairman and CEO of United Healthcare's Evercare health plans. Ms. McNiff is a retired partner at Goldman Sachs and also serves on numerous boards, among them the Fidelity Charitable Gift Fund, Mount Holyoke College, and Lawrence Academy in Massachusetts.

I would also like to extend a welcoming hand to our newest program officer, Walfrido B. Patawaran, to Jessica L. White, our grants and evaluations coordinator, and to Rutuma M. Gandhi, who serves as the Foundation's accountant.

A year of reflection and strategic planning, along with an ever more positive forecast for the national economy, has renewed my sense of optimism for the future of the John A. Hartford Foundation. Even during our brief hiatus from new grantmaking, we have maintained our committed support to our ongoing initiatives and continued to provide leadership in the field of aging. Our staff and Board have worked tirelessly and have made exceptional achievements in our common work. I look forward to the coming year and have deep faith that the Foundation will make ever greater strides in our efforts to improve the health care of all older adults.

Norman H. Volk

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The John A. Hartford Foundation
2011 Annual Report

MENTAL HEALTH AND THE OLDER ADULT

Of the 40 million Americans age 65 and over, about 7.5 million have a mental health disorder (such as depression, anxiety disorder, bipolar disorder, or schizophrenia). This number is expected to grow as the number of older people increases. Many older adults with mental illness suffer needlessly. They may not have been diagnosed or are receiving inadequate or, worse, no treatment. This can change, but it will require sustained efforts on the part of health care providers; older adults, their families and caregivers; policy makers; academic institutions; and funders.

Every person with a mental health condition has a unique story. In this Annual Report we share just a few stories to demonstrate how effective assessment and treatment can change people's lives. Programs funded by the Hartford Foundation over the past 30 years focused on mental health are improving the lives of older adults by changing clinical practice, education, research, and health policy.

Introduction

"It is well known that the world population is aging," says Dilip V. Jeste, MD, Director of the Hartford Center of Excellence in Geriatric Psychiatry, and Estelle and Edgar Levi Chair in Aging, University of California, San Diego. "What is not well known is the fact that the numbers of older people with mental illness will increase disproportionately faster than those of older adults in the general population." By 2030 the number of Americans over age 65 with psychiatric disorders is estimated to double to 15 million.[1]

"What is not well known is the fact that the numbers of older people with mental illness will increase disproportionately faster than those of older adults in the general population."

Dilip V. Jeste, MD
Director, Hartford Center of Excellence in Geriatric Psychiatry
University of California, San Diego

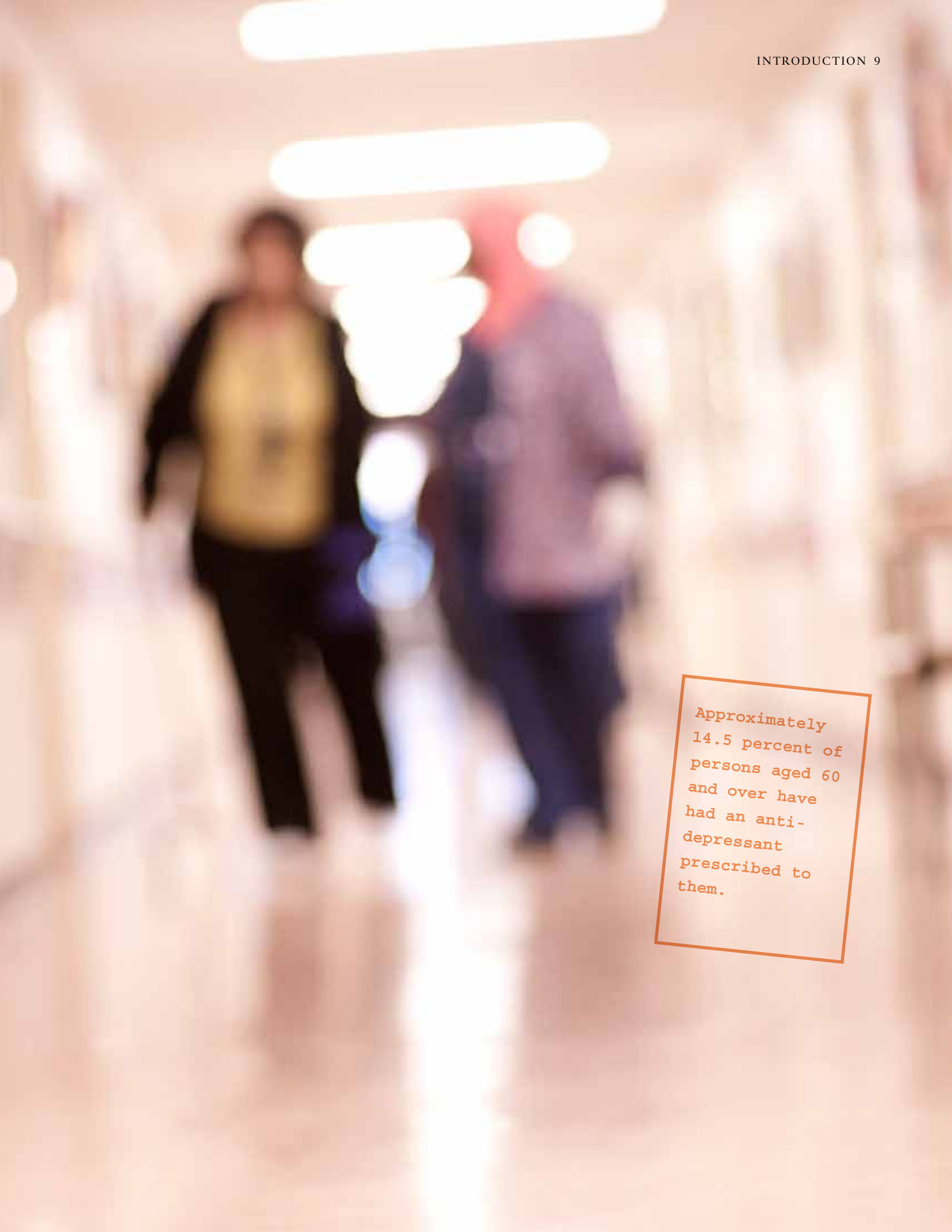
Several factors account for the expected growth in the numbers of older adults with mental illnesses. People in the Baby Boom generation (born between 1946 and 1964) have been shown to have a higher risk for depression, anxiety disorders, and substance use disorders than people born before World War II. As Baby Boomers age, the number of older people with mental illness will grow. In addition, the stigma around mental illnesses is diminishing across age groups as research improves our knowledge of the underlying causes and treatment of mental health disorders. This means that more people will come forward to be diagnosed and treated.

Life expectancy for people with serious mental illnesses is currently 20 to 25 years shorter than that for the general population. People with schizophrenia or another serious mental illness may die young from suicide or because they receive poor care for general health problems. As the quality of care improves, they will live longer.

Mental Health Issues Faced by Older Adults

Depression

"When older adults become depressed it is usually not for the first time," says Hartford grantee Jürgen Unützer, MD, MPH, Professor and Vice-Chair, Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle. They may have had several previous episodes of depression, and they may or may not have been treated. Even if they have had depression in the past, older adults are significantly less likely than younger adults to seek and to get help when they develop depression. One reason is the belief that it's normal for older adults to be depressed. Older adults may experience the death of a spouse, family members, and friends. They may have health problems, decreased physical function, and possibly financial difficulties. Older adults (and people around them) may think



Approximately 14.5 percent of persons aged 60 and over have had an anti-depressant prescribed to them.

that it is a natural part of aging to be depressed. Even health care providers may believe that depressed mood is a normal reaction to the experiences of older age.

"Just because there are reasons for depression doesn't mean it can't be treated," says Dr. Unützer. Project IMPACT (Improving Mood-Promoting Access to Collaborative Treatment for Late-Life Depression), a Hartford-funded program lead by Dr. Unützer that is addressing late-life depression, is described on page 17.

"Just because there are reasons for depression doesn't mean it can't be treated."

Jürgen Unützer, MD, MPH
Professor and Vice-Chair
Department of Psychiatry and Behavioral Sciences
University of Washington, Seattle

Recognizing and treating depression in older adults may be complicated by the presence of one or more medical problems. About half of older adults with depression also suffer with chronic pain. Many have other medical conditions, such as heart disease, diabetes, cancer, neurologic disorders, and various health problems related to older age. A patient seen by a primary care physician often is being treated for one or more medical problems, which become the primary focus. Mental health issues, like depression, may not receive adequate attention. When antidepressant medications are prescribed there may not be adequate follow up to make sure they are working. Some people need to try different drugs or different doses before they find a regimen that helps.

"There is a strong relationship between depressive symptoms and disability related to medical illness," says Charles F. Reynolds III, MD, Director of the Hartford Center of Excellence in Geriatric Psychiatry, and Endowed Professor in Geriatric Psychiatry, University of Pittsburgh Medical Center. Six to ten percent of older adults receiving health care in primary care practice settings have clinical depression. This number jumps to 20 to 30 percent among older adults seen in chronic illness specialty clinics, acute inpatient facilities, skilled nursing facilities, and other long-term care settings.

Another complicating factor for older adults is the connection between depression and cognitive impairment. "Close to half of older adults with major depression also have mild cognitive impairment," says Dr. Reynolds.

"An often overlooked group of older adults who have high rates of depression is caregivers of people with dementia," says Kathleen C. Buckwalter, PhD, RN, former Director of the Hartford Center of Geriatric Nursing Excellence at the University of Iowa. Other groups for whom depression is often not recognized or is inadequately treated include African-Americans and Latinos, particularly men.

A potentially dire consequence of untreated depression in older adults is suicide. Adults over age 65 have a disproportionately higher rate of suicide than other age groups. Of every 100,000 people in the United States ages 65 and older, 14.3 died by suicide in 2007 (the most recent year for which data are available).[2] This is higher than the national average of 11.3 suicides per 100,000 people in the general population. White men age 85 and older had an even higher rate, with 47 suicide deaths per 100,000.

"Treating depression not only helps the individual older person—it also saves costs for the health care system," says Cornelia Beck, PhD, RN, Co-Director of the University of Arkansas for Medical Sciences Hartford Center of Geriatric Nursing Excellence. According to a 1999 report by the Surgeon General, older people with depression visit the doctor and emergency room more often, use more medication, incur higher outpatient charges, and stay longer at the hospital than those without depression.[3] A study by Dr. Unützer and colleagues found that older adults with diabetes, congestive heart failure, or both, who also had depression, incurred almost twice the health care costs as those with the same medical conditions but no depression.[4]

75 percent of older adults who die by suicide have seen their physicians in the month before their death.

Anxiety Disorders

Anxiety disorders also affect many older adults, sometimes along with depression. Anxiety disorders (such as panic disorder, obsessive-compulsive disorder, and social phobia) cause people to be filled with fearfulness and uncertainty. The symptoms are more severe and last longer than brief bouts of anxiety associated with stressful events.

One study found that anxiety symptoms were present in 15 percent of white and black men and women aged 70 to 79 without depression and 43 percent of those with depression.[5] Having an anxiety disorder has been linked to a greater chance for coexisting psychiatric and medical problems, substance abuse, and the use of multiple medications.[6]

"Treating depression not only helps the individual older person—it also saves costs for the health care system."

Cornelia Beck, PhD, RN
Co-Director
Hartford Center of
Geriatric Nursing
University of Arkansas
for Medical Sciences
Little Rock, AR

Other Mental Illnesses

If depression and anxiety are the diabetes and high blood pressure of mental illnesses, the so-called serious mental illnesses, bipolar disorder and schizophrenia, are the heart disease and cancer. Neither is well understood and accurate diagnosis can be difficult. But both conditions typically begin in young adulthood. Bipolar disorder is characterized by mood that shifts over time from a high energy state that may include

"Some people with schizophrenia get better as they get older provided they have adequate medical and psychosocial care."

Dilip V. Jeste, MD
Director
Hartford Center of Excellence in Geriatric Psychiatry
University of California, San Diego

delusional manic highs to severe depressive lows. Schizophrenia is characterized by profoundly disordered thoughts (like auditory hallucinations), lack of emotions, and difficulty relating to other people. While these illnesses and their social consequences still reduce life expectancy, thanks to improved treatments, more people are now living with these conditions into old age. Still, this success is so recent that very little research has documented the experiences of adults with serious mental illness as they age and few attempts have been made to develop interventions to help improve the quality of life of older adults with these serious mental illnesses.

When Dr. Jeste began conducting research on schizophrenia in older adults some of his colleagues discouraged him. "People told me this is a disappointing and frustrating area because schizophrenia is a dementing disorder that gets worse with age," says Dr. Jeste. He found that this was not necessarily true. "Some people with schizophrenia get better as they get older provided they have adequate medical and psychosocial care." However, older adults with schizophrenia often do not get the best care.

Researchers at the Hartford-funded Centers of Excellence in Geriatric Psychiatry at the University of California, San Diego (UCSD) and the University of Pittsburgh have made major advances in understanding and managing bipolar disorder and schizophrenia (page 41), as well as late-life depression, anxiety disorders, dementia, and delirium. Most of these are lifelong problems, but delirium—a reversible, but sudden and severe confusion—is an acute mental health condition that occurs with greater frequency as people age. It occurs in approximately 25 percent of older hospitalized patients, up to 50 percent of older surgical patients, and up to 75 percent of older intensive care unit patients (where it is sometimes known as ICU-psychosis). Older adults with delirium tend to have longer hospital stays, more functional impairment, delayed rehabilitation, and higher risk for death compared to patients who do not develop delirium.[7]

Delirium is serious and potentially life threatening, but often goes unrecognized. The solution requires better education of doctors, nurses, and other health care providers who encounter older adults in hospitals and other care settings. Programs funded by the Hartford Foundation are taking on this challenge (pages 30 and 52).

Shortage of Geriatric Mental Health Providers

There is a shortage of mental health professionals available to provide services to older adults, and this will become more dire as the number of older adults with mental health conditions steadily rises. Four specialties share most of the responsibility for managing mental health—psychiatry, psychology, social work, and nursing. There are simply not enough geriatric specialists within these disciplines to meet the growing need.

Of the approximately 39,000 psychiatrists in the United States, fewer than 2,000 of them are certified geriatric psychiatrists. It's been estimated that at least 6,000 certified geriatric psychiatrists will be needed by 2020.

Fewer than 2,000 of the 39,000 psychiatrists in the United States are certified in geriatrics.

Geropsychiatric nursing also faces challenges. Master's level prepared advanced practice nurses (APRNs) provide a large share of mental health services to older adults, yet their preparation in geriatric mental health is uneven and often inadequate. Few graduate programs specifically prepare advanced practice geropsychiatric nurses. This means there are insufficient numbers of practicing APRNs specializing in geropsychiatry and not enough geropsychiatric nursing faculty to research ways to improve care for older adults with mental illness or to teach gero-psychiatric content to nursing students.

Few graduate nursing programs include the topic of aging in their mental health curriculum and there is no certification examination for a specialty in geriatric psychiatric nursing. Thus, not enough nurses are prepared in this field.

Social work is one of the largest mental health professions providing services for people of all ages in the United States. A 2006 survey of licensed social workers found that only nine percent identified aging as their primary field of practice. Nearly 75 percent of these social workers worked in some capacity with older adults but had not necessarily been trained to do so. In 2009 to 2010, only about three percent of bachelor of social work graduates and about seven percent of masters of social work graduates completed a specialization in aging.

The critical shortage of geriatric social workers has multiple causes, including limited funding in gerontology in the 1990s, which diverted social work scholars and doctoral students to other fields, especially child

welfare. Restricted funding for gerontology also reduced the prestige of geriatrics in academic institutions. Consequently, the system of faculty role models, peer networks, research assistantships, and other support that universities often provide to nurture careers ultimately suffered. The result was a lack of faculty trained in aging and very little geriatric content in social work education.

Negative perceptions about working with older adults, and especially older adults with mental illness, accounts for some of the workforce deficiencies. Other barriers exist, some of which are financial. After residency most psychiatrists begin full-time clinical practice, forgoing geriatric specialization and an academic career, at least partly because of insufficient funding for fellowships.

The Department of Psychiatry at UCSD has had a research fellowship program in geriatric psychiatry, funded by the National Institutes of Health (NIH), since the early 1990s. "For over 20 years we could not recruit any post residency psychiatrists for this fellowship because the salaries were too low," says Dr. Jeste. After receiving funding from the Hartford Foundation as a Center of Excellence in Geriatric Psychiatry, the UCSD program has recruited twenty-one psychiatrists into its research fellowship program.

Call to Action by the Institute of Medicine

In 2008, the Institute of Medicine (IOM) issued the report *Retooling for an Aging America: Building the Health Care Workforce*, which warned of an "impending health care crisis as the number of older patients with complex health needs increasingly outpaces the number of health care providers with knowledge and skills to adequately care for them." The report recommended urgent action to expand and strengthen the geriatric health care workforce.

Institute of Medicine Report *Retooling for an Aging America*

To address workforce issues specifically around mental health care for older adults, in 2010 the U.S. Congress mandated a new study, *The Mental Health Workforce for Geriatric Populations*. The IOM report will examine the mental and behavioral health care needs of Americans over 65 years of age and make policy recommendations through a competent and well-trained mental health workforce. Dr. Buckwalter, a Hartford grantee, is a member of the work group preparing this report, which is expected to be published in the summer of 2012.

Focus on Practice, Education, Research, and Policy

Even if efforts to prepare more geriatric specialists are successful, this will not completely solve the problem of providing greater access to high quality mental health services for older adults. "The reality is that older adults with mental health issues often seek help from their primary care physician, who may not have adequate training in geriatric mental health," says Dr. Buckwalter. "It's not as simple as increasing the numbers of geriatric psychiatrists, psychologists, nurses, and social workers," says Dr. Unützer. "We have to train all health professionals who see older adults to spot mental health problems and connect people to the right professionals."

"We clearly need more personpower with the appropriate education and skills in geriatric mental health, but that alone is not enough," says Lois K. Evans, PhD, RN, van Ameringen Professor in Nursing Excellence, University of Pennsylvania School of Nursing, Philadelphia, and a Hartford grantee. More research is also needed. "There's still not enough evidence to guide practitioners on what models of care work best with older adults, many of whom are reluctant to come in for psychiatric treatment," she says.

Addressing the crisis in mental health care for older adults requires sustained efforts in four critical and interrelated areas—practice, education, research, and policy. "Practice is the platform on which services are delivered," says Dr. Unützer. "Education creates the workforce to provide those services. Research creates more effective treatments that can be used in practice. And policy makes it possible to deliver and pay for these services."

John A. Hartford Foundation Mental Health Initiatives

To achieve the goal of improving the health of older adults via a more skilled workforce and a better designed health care system, the Hartford Foundation has placed a special emphasis on mental health, specifically in the areas of practice, education, research, and policy. Initiatives are aimed at nurses, social workers, physicians, and interdisciplinary teams. These programs address the shortage of geriatric mental health providers, as well as the barriers older adults encounter regarding mental health services.

In 1999, the Foundation began tackling late-life depression with funding for a multidisciplinary care model called Project IMPACT: Improving Mood – Promoting Access to Collaborative Treatment for Late-Life Depression (page 17).

Less than three percent of older adults see a mental health professional for their mental health problems.

To improve the education of nurses in the care of older adults suffering depression and other mental health disorders, the Foundation funded the Geropsychiatric Nursing Collaborative in 2008 (page 29). To address the shortage of psychiatrists specializing in geriatrics and the creation of research in this area, the Foundation provided funding in 2004 to establish two Centers of Excellence in Geriatric Psychiatry, at the University of California, San Diego (page 42), and the University of Pittsburgh (page 52).

To support social work faculty who address issues around aging, the Foundation provided funding in 1999 for the Hartford Geriatric Social Work Faculty Scholars Program. In 2000, the Foundation funded the Hartford Doctoral Fellows in Geriatric Social Work Program. "Research conducted by the Scholars and Fellows frequently impacts policy on the city, state, and federal level," says Barbara J. Berkman, DSW/PhD, Director, Hartford Geriatric Social Work Faculty Scholars Program (page 61).

These Hartford-funded mental health programs—as the following stories will highlight—are improving care and changing the lives of older adults, their families and caregivers.

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PRACTICE

Project IMPACT: Improving Mood – Promoting Access to Collaborative Treatment for Late-Life Depression

Project IMPACT was launched in 1999 with a multi-site clinical trial to test a collaborative approach to treating late-life depression in primary care settings. The project—eight grants totaling $11 million over five years—received $8 million from the Hartford Foundation and $3 million from other funders including the Hogg Foundation, the California Healthcare Foundation and The Robert Wood Johnson Foundation.

"Most older adults with depression show up in the office of a primary care doctor because they're comfortable in that setting and that's where they get the rest of their health care," says Jürgen Unützer, MD, MPH, Professor and Vice-Chair, Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, who led the initiative. Yet primary care physicians are not the best qualified health care providers to treat depression. They have limited time and competing priorities. Only one in five older adults treated for depression in primary care improves.

PRACTICE

Twenty-seven years ago, the son of my housekeeper killed my daughter. She was fifteen. Everything changed in my life—completely. Before that I had happiness, a good family, everything was nice—but it turned into nothing. I was in shock.

For years and years I accumulated all the pain for myself. I tried to be strong for my son and my other daughter. My husband died six months later of a heart attack. So I found work to support my family. I thought I was strong and people told me I was strong. But it's not true. I suffered. I cried. I was bleeding inside. I don't know if people understand about depression. It puts your soul far away from you.

The years passed and I stayed in the same home. My children grew up and moved away. A year ago I lost my property. Before that I thought I could control everything. After that everything came on top of me and destroyed me. I tried to sleep and I could not. I felt like I was in a big bucket of oil trying to get out. I tried but I couldn't. Life was terrible. I didn't want to live anymore.

I went to Kaiser and said to my doctor, I'm depressed. She gave me pills, but they didn't help. Then my doctor sent me to see Rita.

–Elizabeth

After the deaths of her daughter and her husband, Elizabeth struggled with depression for over 20 years.

"I don't know if people understand about depression. It puts your soul far away from you."

Elizabeth

Elizabeth is a 66-year-old woman who was referred to me by her primary care doctor. When she came to see me she was on an antidepressant medication, but it wasn't really working. The first thing we did was increase the dose of her medication. About two months into treating her, she told me about her daughter having been murdered. She'd never been seen for that nor had she talked to any health care provider about that incident in her past. She's the type of lady who will walk in with a smile on her face and look like she's doing fine and yet be hurting deeply inside. I recommended a book called *When Bad Things Happen to Good People*, which she found incredibly comforting and helpful. I also got her into a depression class that I lead. She felt supported by the other people in that group, so I encouraged her to keep coming.

As part of the behavioral activation component of the program, she made a plan to contact her sister with whom she had not been in contact for many years. Elizabeth showed incredible improvement. We use a depression rating scale called the Patient Health Questionnaire to assess and track patient's progress over time. Elizabeth's score was originally very high at 24 and it went down to 1. She's continuing to do well.

Rita Haverkamp, RN, MSN, CNS
Depression Care Manager
Kaiser Permanente,
Southern California

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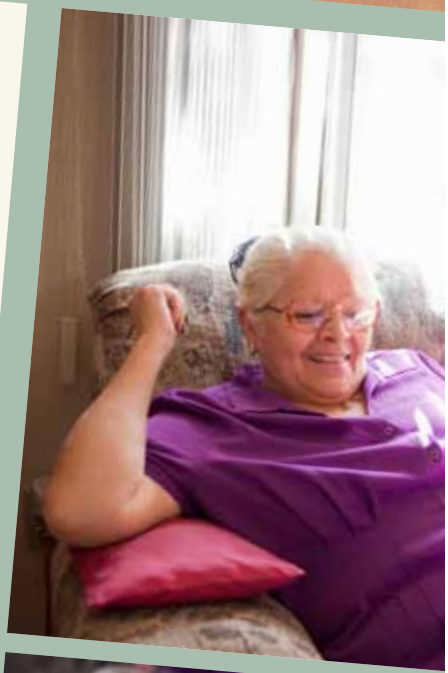


"Now my life is beautiful. I open my eyes in the morning and I don't feel depression. I want to see my garden. I want to see how the flowers are growing. Life may not always be easy, but it's good."

Elizabeth

A Clinical Practice Model that Changes Lives

"The IMPACT model provides resources to help primary care physicians do a better job with depressed patients," says Dr. Unützer. In every primary care office where IMPACT is offered, a staff member (nurse, clinical psychologist, or social worker) is trained to be a depression care manager. The depression care manager becomes the primary contact for the patient, distributing education about depression and its treatment, supporting use of medication, and providing brief counseling.

Primary care practices offering IMPACT also have a consulting psychiatrist assigned to the practice. The psychiatrist advises the depression care manager and primary care physician on treatment plans and meets directly with patients, if needed.

Primary care physicians may have just a few minutes to explain depression and its treatment to a patient. Depression care managers can offer much more time. They can discuss how the depression is affecting the patient's life and recommend strategies. This made a big difference for Elizabeth, who attributes her recovery from depression to her depression care manager, Rita Haverkamp. In addition to individual counseling sessions, Ms. Haverkamp offers a depression class (a form of group therapy). Elizabeth attended the depression class and sat quietly at first, letting others talk. Gradually she began to tell her own story. After many years of trying to protect herself from the pain of her loss by isolating herself, Elizabeth began to trust others. "Rita helped me to open up and feel like a person again," says Elizabeth. "She came into my life to save my life. She's an angel to me."

Elizabeth carries the book *When Bad Things Happen to Good People*, which Ms. Haverkamp recommended, wherever she goes. Regularly reading passages helps her to cope. "From reading the book I realized it's not only me. The book helped me to open my heart."

Rita Haverkamp, a depression care manager, meets with Elizabeth to help her develop strategies to overcome depression.

What is Depression?

Most people who suffer with depression experience prolonged, strong, pervasive feelings of sadness. Not just having a bad day, but a state that they can't find their way out of. They may also lose interest in things that are important to them, like their children and grandchildren. Nothing that used to give them pleasure makes them happy. Some people with depression have other feelings, like feeling guilty, like they're in other people's way, like the world would be a better place without them. They may feel worthless and helpless. People who are depressed often don't eat well because of a lack of appetite. They may lose weight. They often don't sleep well. They feel like they have no energy, and they have difficulty concentrating. Being in a state like that for weeks on end can become overwhelming. (Major depression is diagnosed when symptoms persist for two weeks or more.) Some people start having thoughts of death and suicide. Most of the 36,000 people who commit suicide each year in the United States struggle with depression. Older men are the number one risk group for committing suicide.

Older men may be less comfortable with identifying depression as a problem to a health care provider, and they are less likely to receive treatment for depression than women. In men, depression may also manifest slightly differently with higher rates of irritability and anger and higher rates of alcohol or other substance use.

Jürgen Unützer, MD, MPH
Director, Project IMPACT

Sometimes antidepressant medications are ineffective or cause side effects and the patient may not tell the doctor. The depression care manager monitors the patient and recommends changes in drugs or dosing as needed. In Elizabeth's case, the effect of adjusting her medication dose was dramatic. A few weeks later she came to see Ms. Haverkamp and said, "I feel my soul inside of me. I can feel I'm Elizabeth again."

Depression care managers are taught counseling strategies, called behavioral activation and problem-solving therapy. These counseling methods can be accomplished in a few short sessions and they can help a person improve with or without medication. Behavioral activation involves encouraging the patient to become active again, with exercise or things they enjoy. Ms. Haverkamp encouraged Elizabeth to set goals for ways she could improve her mood. During one of the depression classes, a participant mentioned that she wanted to contact her brother. "When I heard that it clicked in my mind, I have a sister in Oregon," says Elizabeth. "I'd like to call my sister." Elizabeth hadn't spoken with her sister for 20 years. She was too depressed. "After she made that contact her sister invited Elizabeth to visit her in Oregon and she had a fabulous time," says Ms. Haverkamp. The sisters are now back in touch and have a warm and supportive relationship.

"Now my life is beautiful," says Elizabeth. "I open my eyes in the morning and I don't feel depression. I want to see my garden. I want to see how the flowers are growing. Life may not always be easy, but it's good."

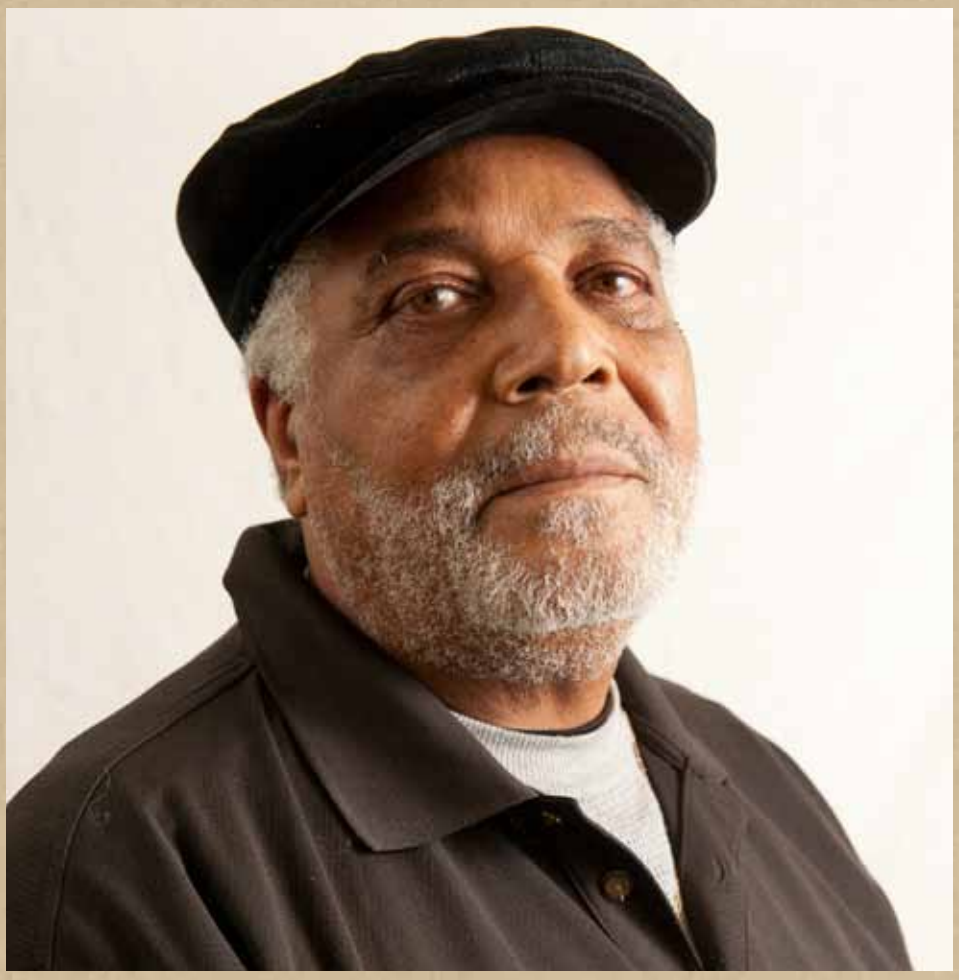
VERNON'S STORY

One of my sisters passed in 2010. This was the first time I couldn't get over the emotions on my own. My sister and I were really close. When she had the stroke it really hit me because I talked to her that morning and she seemed to be fine. They found her on the washroom floor. I jumped up and went to New York, and I was there until she passed. During that time, my blood pressure went up, and it took a long time to get myself back together. I mentioned to my doctor that I felt like I had some depression. That's when he referred me to a social worker, Jesse Merjil.

We had about six sessions, and we talked about some of the things holding me back. I had gotten to the point where I didn't want to get up and do anything. He got me back out walking every day. It helped me a lot. I went on vacation to Virginia to attend my class reunion and spend some time with my daughter and two grandboys. I had a wonderful time. If I hadn't gotten out of the mood I was in I wouldn't have gone.

Since I came back I've started chemotherapy for prostate cancer. But it's not affecting me like it affected me last year when I had it. I'm not depressed. I'm doing the best I can to fight it. My spirits are up. Without Jesse I don't know what would have pulled me out of the depression.

Vernon, age 66
Client of Jesse Merjil, LCSW
Project IMPACT Depression Care Manager
LifeLong Over 60 Health Center
Oakland, California



Vernon recovered from depression with support from his depression care manager and his family, including his surviving sister (far right).

A Proven Model

Elizabeth, Vernon, and Maria are by no means isolated cases. In fact, the IMPACT model was tested in a large study, the results of which were reported in 2002 in the *Journal of the American Medical Association*.[1] About 1,800 older adults (average age, 72) with major depression, dysthymic disorder (a milder form of depression that lasts more than two years), or both who were being treated in primary care settings were enrolled in the study.

Five to ten percent of older adults seen by primary care physicians have major depression.

The study showed that the IMPACT team care approach more than doubles the effectiveness of the usual treatment for depression for older adults in primary care settings. Usual care involved treatment by a primary care physician or referral to a mental health specialist. After one year, about half of the participants in the IMPACT group reported a 50 percent or more reduction in depression symptoms, compared with 19 percent of those in the group receiving usual care. Patients improved at all 18 of the study sites.

"We found that with the added support and close follow-up provided by the IMPACT team, patients felt better, functioned better, and enjoyed life more fully than patients in the group receiving usual care," says Dr. Unützer. "We also learned that this is a smart way to spend health care dollars." Patients in the IMPACT group had improvements in overall health and physical functioning. This reduced their need for expensive treatments over time. The total cost of health care for patients in the IMPACT group was $3,300 less than the cost for patients in the group receiving usual care. This was true for all categories of health care costs, including inpatient and outpatient care and pharmaceutical drugs.

IMPACT Program

Project IMPACT and this study were featured in the 2002 Hartford Foundation Annual Report (http://www.jhartfound.org).

Achieving Widespread Implementation

The study clearly demonstrated the success of the IMPACT program for treating and managing patients with late-life depression in primary care settings. Several studies by other investigators have confirmed the findings. But studies alone are not enough to get health care organizations to adopt IMPACT. "We knew that just publishing findings in high-profile journals doesn't help practices to put a program into place," says Dr. Unützer.

MARIA'S STORY

Maria is a 78-year-old woman who was referred to me by her primary care physician. She was experiencing classic symptoms of depression, such as lack of energy, frequent crying episodes, and occasional feelings of hopelessness. Maria had been the primary caregiver for her mother for more than 20 years. Her mother had just died at age 98. Maria had defined herself as a caregiver and she was having difficulty finding her purpose in life. One of her sisters had moved out of New York and her other sister was always demanding things from her. Maria was socially isolated and had difficulty meeting new people. She missed having friends.

As Maria's depression care manager, I suggested some concrete tasks, such as going to a senior center in her neighborhood. Little by little she started making friends there. This gave her the self-confidence to address other problems in her life. Her sister who lived outside New York wanted her to move to the same state. Maria did not want to go. I used some problem-solving techniques with Maria, such as considering the pros and cons of such a move and thinking about why it was difficult for her to say no to her sister. We also did some role playing. I will never forget Maria's relief after she told her sister she decided not to move. Maria has also become more assertive with her other sister.

Marcia Honigsztejn, LCSW
Project IMPACT Depression Care Manager
Woodhull Medical Center
Brooklyn, New York

Maria's depression care manager, Marcia Honigsztejn, helped her take control of her life and overcome her depression.

Dr. Jürgen Unützer and Rita Haverkamp lead a training session on implementing the IMPACT model for the Los Angeles County Department of Mental Health. "I love that I have an impact on patients, and also that I'm involved in helping others provide a level of care that is absolutely essential for older adults with depression," says Ms. Haverkamp.

With an eight-year $2.4 million grant from the Hartford Foundation in 2004, the IMPACT Implementation Center was established at the University of Washington in Seattle to help health care organizations put the IMPACT model into practice. A set of tools was developed, including treatment manuals, job descriptions, and patient tracking and team building tools. The IMPACT Implementation Center also offers telephone consultations with staff and others who have already implemented IMPACT. The Center offers most materials free of charge on the IMPACT Web site (www.impact-uw.org).

The Center also developed a training program, which includes a two-day in-person workshop and a Web-based version of the program. There is a fee for these training activities, which has allowed the IMPACT Implementation Center to become self-sustaining. Over 5,000 clinicians have so far received this training. "This is an example of how foundation money can not only change something in health care but create something that sustains itself over the long run," says Dr. Unützer.

The IMPACT model has been implemented in over 600 practices in more than 30 states, including Kaiser Permanente in Southern California, which serves three million members. Several large health plans have incorporated core components of IMPACT into their care delivery. One example of successful regional implementation is in the state of Minnesota with a state-wide initiative called DIAMOND (Depression Improvement Across Minnesota: a New Direction; www.icsi.org). Six Minnesota health plans agreed to finance this model of depression care, which has been implemented in more than 85 primary care clinics, reaching up to 1.5 million Minnesotans. IMPACT is now a benefit covered under these insurance plans in Minnesota.

The IMPACT model has been endorsed by national organizations, such as the Agency for Healthcare Research and Quality and the National Council for Community Behavioral Health.

Endnote

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EDUCATION

The John A. Hartford Foundation Geropsychiatric Nursing Collaborative

Nurses represent the largest group of health professionals caring for older adults, but most nurses lack knowledge and skills regarding mental health issues in older adults. To address this, the John A. Hartford Foundation funded the Geropsychiatric Nursing Collaborative (GPNC) in 2008 with a grant of $1 million.

"Geropsychiatric nursing is about aging and it's about mental health, and those are two relatively stigmatized areas," says Lois K. Evans, PhD, RN, van Ameringen Professor in Nursing Excellence, University of Pennsylvania School of Nursing, Philadelphia, one of the leaders of the GPNC. There are few nurses with strong training in both those areas. "We realized that if we were going to get more nurses prepared to care for the large, growing cohort of older adults with mental health issues, we would need to infuse geropsychiatric content and clinical learning into nursing educational programs at all levels," says Dr. Evans.

Nurses armed with the appropriate knowledge and skills can have a profound effect on the lives of older adults with mental health conditions.

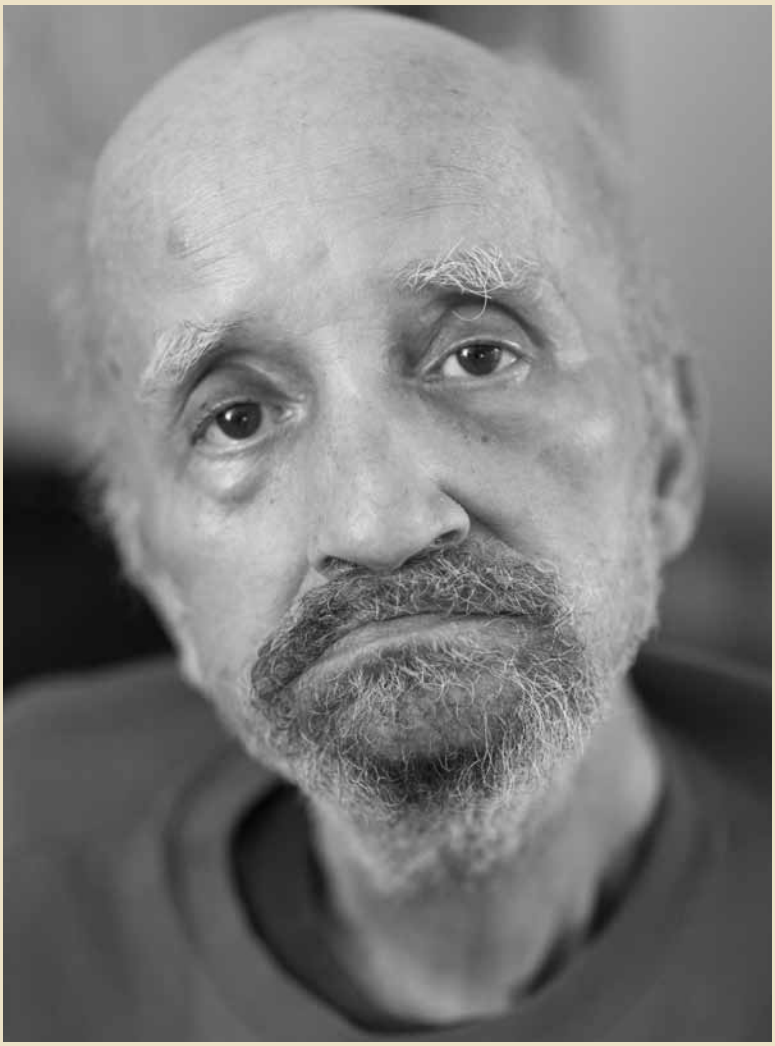
EDUCATION

I got a call from my dad's home health aide saying that my dad had fallen and he was in the hospital. When I got to the hospital, my dad said that he went to a party at a hotel with some Indians, and they were all his relatives. I said, 'Dad that must have been a dream.' He said, 'Maybe it was,' and then he just kept talking about these Indians. I was confused because he kept thinking it was so real. The doctors at the hospital didn't know why he passed out and fell. They kept him in the hospital for a couple of weeks for testing. He kept talking about the Indians, and he talked about how his mother left him fifty million dollars. I kept saying, 'Dad, stop playing,'

because my dad is a joker. I said, 'Your mom didn't leave you fifty million dollars.' Then he said, 'Your mom is dead and my mom is alive.' I said, 'Dad, your wife is still alive. My mom is your wife. She's still alive. Your mother is no longer here.' He said, 'No, no, no.' That's when I realized he's really confused. But I really didn't understand the extent of his confusion. I kept trying to put it off, thinking it was because of the fall or he doesn't remember because he's a little old. I guess I was in denial about my dad's mental state.

–Mignonne, daughter of Roberto

I came to the University of Pennsylvania School of Nursing to get my master's degree in psychiatric nursing, but I did not have an interest in geropsychiatry at the time. In fact, I was disappointed to be placed at LIFE (Living Independently For Elders) for the clinical practicum. I was afraid it might be boring because I thought, 'There isn't much a nurse can do with this population.' I was very, very wrong.



Treating Roberto was an excellent learning experience. We went to assess him for depression and we determined that he was actually delirious. He had an acute onset of change in mental status. It was fluctuating and he was disoriented. It was a marked change from his normal behavior. I was able to identify these features of delirium because of a required course I took at the University of Pennsylvania called *Mental Health and Aging*. Once the delirium was treated, Roberto left the nursing home and moved to an independent, supportive living environment.

This was an eye-opening experience and helped me to realize how nurses can treat acute and chronic mental health conditions and really improve quality of life. I can now definitely see myself focusing on an older adult population.

Ashley King, MSN, RN
Advanced Practice Nurse
Center for Family Guidance
Marlton, New Jersey

Ashley King

"I realize how nurses can treat acute and chronic mental health conditions and really improve quality of life..."

Roberto recovered from delirium because Pamela Z. Cacchione and her student, Ashley King, recognized the condition.

Roberto is an 82-year-old man who is a member of Living Independently For Elders (LIFE) (www.lifeupenn.org). LIFE is a community-based Program for All-inclusive Care for the Elderly (PACE) that provides care for nursing home-eligible older adults and is operated by the University of Pennsylvania School of Nursing. Roberto was living alone in an apartment with help from a home health aide when he fell and wasn't found for 24 hours. He developed rhabdomyolysis, which is a breakdown of muscles, and kidney failure. Roberto was hospitalized for several weeks and then went to a nursing home for rehabilitation.

I'm a nurse practitioner focusing on the geropsychiatric needs of the LIFE members. While Roberto was at the nursing home, the staff called and asked me to evaluate him for depression. I brought along Ashley King, a psychiatric nurse practitioner student doing her clinical practicum at LIFE. When we evaluated Roberto, he talked a lot about Indians. It became clear there was something more serious than depression going on. He clearly had delirium and we needed to address it. I was glad to have a student with me that day because this was a good teaching case. Ashley had the opportunity to evaluate the patient, review his chart, and communicate with his primary care providers to tease out what might be causing the delirium. She also followed him over time as he improved. It's wonderful to see how well he's doing now.

Pamela Z.Cacchione, PhD, RN, BC
Advanced Practice Nurse
Living Independently For Elders (LIFE)
Associate Director
Hartford Center of Geriatric Nursing Excellence
University of Pennsylvania School of Nursing
Philadelphia, PA

"I said, `Dad, your wife is still alive. My mom is your wife. She's still alive. Your mother is no longer here.' He said, `No, no, no.'"
Mignonne
Daughter of Roberto

"My dad got so much support from the nurses and social workers at LIFE, if it hadn't been for them I wouldn't have known what to do with him. He probably would have ended up staying in the nursing home permanently."

Mignonne, daughter of Roberto

At some point in their careers, every nurse will encounter and/or care for older adults with mental health issues. Therefore, all nurses must have the skills to recognize and treat mental health conditions or refer the patient to an appropriate mental health professional. For the patient, this may mean the difference between functioning independently and being permanently incapacitated.

Roberto's case was particularly complex, and having a nurse recognize his delirium and make sure he received effective treatment meant that he could eventually leave the nursing home and live in a supportive housing environment. After falling at home and not being found for 24 hours, Roberto was hospitalized. He had a breakdown of his muscles (rhabdomyolysis) and kidney failure. His daughter immediately noticed a change in his mental status, but she did not understand what it meant.

Roberto was treated in the hospital for his physical problems, but no one addressed his delusions, mistakenly attributing them to the irreversible condition of dementia. He was discharged to a nursing home for rehabilitation where he drastically lost weight. The staff at the nursing home thought his weight loss was due to depression. Because of his affiliation with LIFE, they called Pamela Z. Cacchione, PhD, RN, BC, a geriatric nurse practitioner focusing on geropsychiatric care at LIFE, to evaluate him.

(Left) Interdisciplinary team meetings, like those held at LIFE with the participation of nurses and nursing students, provide a holistic approach to physical and mental health care needs of older adults.

All Nurses Need Skills to Care for Older Adults with Mental Health Issues

Hartford Center of Geriatric Nursing Excellence
University of Pennsylvania

What is Delirium?

Delirium is a sudden, fluctuating and usually reversible state of mental confusion that affects up to 50 percent of hospitalized older adults. People with delirium may be disoriented and have memory problems. They have difficulty thinking clearly, focusing, and paying attention. They also may be agitated, have sleep disturbances, and in some cases have hallucinations (for example, hearing or seeing something that is not there) and delusions (false beliefs).[1] Older adults with delirium are more likely to have longer hospital stays, more functional impairment, delayed rehabilitation, more frequent hospitalization, and higher mortality.[2] Causes of delirium include an underlying medical condition (such as a urinary tract infection), medications, or withdrawal from medications.

Delirium may be mistaken for dementia, depression, or psychosis because of similar signs and symptoms. Dementia is irreversible and results in a slow, progressive decline in memory and other cognitive functions. With delirium, a person can go from being cognitively intact to cognitively impaired very quickly, and it tends to fluctuate throughout the day. The diagnosis may be complicated because delirium can occur along with dementia. In fact, having dementia is a risk factor for delirium.

Recognizing delirium is important because it indicates that there is a medical condition that must be identified and treated. The underlying condition is not always readily identifiable, and there may be more than one cause. In up to one-half of older adults with delirium two or more conditions are responsible for the delirium. Delirium is treated by correcting the underlying problem and managing the behavioral and psychiatric symptoms.

Living Independently For Elders (LIFE)

Dr. Cacchione brought nursing student Ashley King, and the two of them determined that Roberto had signs of delirium, such as inattention, fluctuating levels of consciousness, and acute onset of delusions. They also discovered he had a hospital-acquired bowel infection. The infection was causing diarrhea and was the actual cause of the weight loss.

Working with a team of health care professionals, they determined that the delirium had multiple causes. It most likely began in the hospital with an electrolyte imbalance related to the rhabdomyolysis and kidney failure. The bowel infection that became apparent when he was in the nursing home caused dehydration and a further electrolyte imbalance. These exacerbated the delirium.

Roberto was treated with intravenous fluids, antibiotics, and other appropriate interventions focused on keeping him safe and functioning. This resulted in gradual improvement of both his physical and mental status.

"My dad got so much support from the nurses and social workers at LIFE," says Roberto's daughter, Mignonne. "If it hadn't been for them I wouldn't have known what to do with him. He probably would have ended up staying in the nursing home permanently."

"When I told my dad he was moving to supportive housing and brought him his key he was ecstatic. He told everyone, 'I've got my own place'." Roberto continues to go to the LIFE day center three days a week where he can socialize with other members and receive primary and mental health care and rehabilitation services. He still has some memory problems, but he no longer has delirium.

"The fact that Roberto was able to leave the nursing home was a huge accomplishment," says Dr. Cacchione. This probably would not have happened if it hadn't been for a nurse with the knowledge and skills to identify the problem and make sure he received the appropriate care.

Less than 20 percent of geriatric nurse practitioner programs include any geropsychiatric content in their curricula

The John A. Hartford Foundation Geropsychiatric Nursing Collaborative

Improving Mental Health of Older Adults

A 2004 survey of all nursing graduate programs in the United States found that less than 20 percent of geriatric nurse practitioner programs and only 38 percent of psychiatric mental health advanced practice programs included any geropsychiatric content in their curricula.[3]

To address this inadequacy, the John A. Hartford Foundation awarded the American Academy of Nursing a grant to create the Geropsychiatric Nursing Collaborative (GPNC). The aim of this initiative was to improve the education of nurses at every level in the care of older adults suffering depression, dementia, and other mental health disorders.

The leaders of the GPNC hail from three of the Hartford Centers of Geriatric Nursing Excellence—Cornelia Beck, PhD, RN, Louise Hearn Chair in Dementia and Long-term Care and Professor, College of Medicine and College of Nursing, University of Arkansas for Medical Sciences; Kathleen C. Buckwalter, PhD, RN, Professor Emerita, University of Iowa; and Lois K. Evans, PhD, RN, van Ameringen Professor in Nursing Excellence, University of Pennsylvania School of Nursing.

"Rather than develop a new subspecialty area—advanced practice nurse in geriatric mental health—we decided we could get a bigger bang by making sure all nurses have basic competence in recognizing and assessing mental health issues and providing basic care," says Dr. Evans. Accomplishing this required building awareness in schools of nursing and compiling curriculum materials that faculty can easily access.

The GPNC had two main goals: 1) establish a core set of geropsychiatric nursing competencies for all levels of nursing education, and 2) develop and disseminate geropsychiatric nursing curricular materials. "Nursing competencies" is a term used in nursing education that describes the skills, knowledge, or other characteristics required for a particular type of nursing practice.

Nursing student Ashley King learned important lessons as part of family meetings and the interdisciplinary team of health care providers focused on Roberto's recovery.

In this case, the GPNC articulated the essential knowledge and skills required to assure that high quality mental health care is provided to older adults.

One reason nursing faculty may not teach mental health is they don't feel comfortable with the material. "Unless we provide some tools for them, it is unlikely that this content will be integrated into undergraduate and graduate programs," says Dr. Evans. Therefore, the GPNC compiled a comprehensive set of curricular materials on geriatric mental health. These are posted on a Web site called Portal of Geriatric Online Education (POGOe) (www.pogoe.org/series/Geropsychiatric-Nursing-Curriculum-Materials). POGOe is a free public repository of geriatric educational materials in various e-learning formats, including lectures, exercises, virtual patients, case-based discussions, and simulations. The GPNC materials can be accessed by typing "geropsych" into the search box.

Portal of Geriatric Online Education (POGOe)

The materials posted on the POGOe Web site are among the most frequently accessed on the entire site. For example, in November 2011 these materials received the highest number of hits for the site, which houses over 700 gero-focused curricular products.

This project is being accomplished with the help of doctoral and master's level students at the Universities of Arkansas, Iowa, and Pennsylvania. One of these students is Lauren Massimo, MSN, CRNP, a doctoral student and a Hartford Foundation Building Academic Geriatric Nursing Capacity Scholar. Ms. Massimo became passionate about a career addressing mental health in older adults when she was a master's degree student and wrote about depression in the older adult. "I realized that depression is frequently missed in the elderly, and there are higher rates of mortality and suicide as a consequence," she says.

With assistance from a home health aide (bottom photo, right) Roberto is able to live independently. He travels several times a week by van to the LIFE day center to socialize and receive health care services.

"The fact that Roberto was able to leave the nursing home was a huge accomplishment."

Dr. Pamela Z. Cacchione
Associate Professor of
Geropsychiatric Nursing
University of Pennsylvania
School of Nursing
Philadelphia, PA

Hartford Building Academic Geriatric Nursing Capacity Initiative

After receiving her master's degree, Ms. Massimo co-taught a course on caring for the older adult to undergraduate nursing students at the University of Pennsylvania School of Nursing. "The care of older adults with mental health issues is very complex, and we did a good job of integrating it into our course curriculum," she says, "but I think it could have been even better if we had had more resources."

Ms. Massimo is now on the team of nurse professionals compiling and disseminating those resources, which she believes will be especially useful for nursing schools that lack a strong geriatric and mental health focus. Materials are organized into manuals within four domains: assessment, management, approach to the older adult, and role. Each online manual has abstracts describing the topics and provides access to materials that can be used or adapted, such as Web sites, podcasts, and slide presentations. The manuals are user-friendly and save time, making it more likely that faculty will be able to weave these mental health topics into their curriculum.

"If I had these resources just a few years ago when I was teaching the course on caring for the older adult, I would have taught these very sensitive topics even more effectively," says Ms. Massimo. By including these topics in the curriculum, nursing students like Ashley King will be better equipped to appropriately care for older adults with mental health issues like Roberto.

Endnotes

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RESEARCH

Hartford Centers of Excellence in Geriatric Psychiatry

Academic geriatric psychiatrists are needed to provide mental health services to older adults, conduct research to improve care of older adults with mental disorders, to educate future geriatric psychiatrists, and to inspire more medical students to specialize in geriatric psychiatry. Currently there is a dangerous shortage of geriatric psychiatrists in the U.S.

To address this shortage, the John A. Hartford Foundation provided grants in 2004 to establish two Centers of Excellence in Geriatric Psychiatry at the University of Pittsburgh and the University of California, San Diego. These centers were selected because of their expertise and capacity to train faculty in geriatric psychiatry.

RESEARCH

University of California, San Diego
Hartford Center of Excellence in Geriatric Psychiatry

I've started multiple businesses. Right now, I'm a real estate broker. For me, being fully invested in doing activities is what keeps me from becoming depressed. When I wake up and there's nothing to do, that's when I don't want to get out of bed. But if I say 'Okay, there are six things that have to be done today,' and at the end of the day I did four of them, then well, not a bad day.

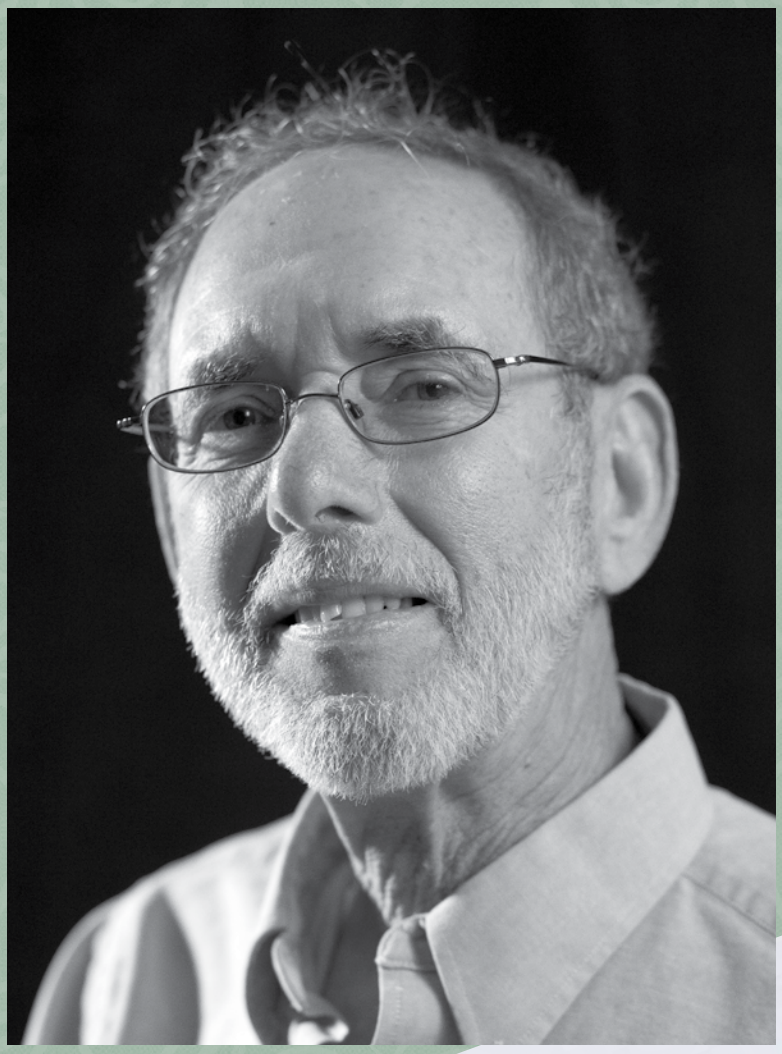
I never tell people, 'Hey I'm bipolar.' I saw a TV show where a guy with a mental illness pulls out a knife. It's a shame that this is the perception that people have. It shouldn't be like that. Being bipolar should be just something that I happen to be, like being right-handed.

Several years ago I became reclusive and a psychiatrist suggested I join the Depression and Bipolar Support Alliance. I eventually became a peer facilitator and I became very adept at that. While doing that I met Dr. Colin Depp and got involved in some interesting studies he was conducting. I'm very opinionated so I had a lot of fun doing it.

I co-authored a study with Colin looking at how people with bipolar disorder cope with the illness. One lady in the study said she knew she was starting to get ill when she wasn't taking care of her garden. The plants were dying. This type of research is critical because it's not hard science like sequencing the genome. This is dealing with people. We need people like Colin to deal with people like me.

Having a mental illness is like pushing a rock up a hill and it's always coming back at you. People see mentally ill people as weak. To me, it takes even more strength than the average person has.

–David



I'm interested in understanding how bipolar disorder changes with age and in developing psychosocial interventions that can augment pharmacological treatment. Several years ago, I conducted a clinical trial focused on trying to improve people's capacity to manage their illness through behavioral means. David was one of the research participants, and he was very vocal about his experiences with bipolar disorder. That lead to a nice partnership where I have, throughout the years and in various studies, sought his opinions about how to align the research protocols that we developed with the interest of people who actually have bipolar disorder. We also collaborated on a research project. We developed a Web-based questionnaire to address the question, how do people with bipolar disorder throughout the lifespan manage their illness. We obtained data on about 1,000 people, analyzed the data, and published a report. This is an example of community-based and participatory research in which people with the illness are directly included in the process.

Colin A. Depp, PhD
Assistant Professor
Department of Psychiatry,
School of Medicine
University of California, San Diego
Hartford Center of Excellence
in Geriatric Psychiatry

Dr. Colin Depp collaborates on research with David, who was a coauthor on a recent study.

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ORIGINAL PAPER

Disability and Self-Management Practices of People with Bipolar Disorder: A Web-Based Survey

Colin A. Depp · John L. Stricker · David Zagorsky · Lisa C. Goodale · Lisa T. Eyler · Thomas L. Patterson · Barry D. Lebowitz · Dilip V. Jeste

Received: 4 January 2008 / Accepted: 12 November 2008 / Published online: 6 December 2008

Abstract In a web-based survey asking adults diagnosed with bipolar disorder about illness management, we obtain frequency of self-reported usage and perceived helpfulness of 27 self-management strategies. We correlated the strategies was corre
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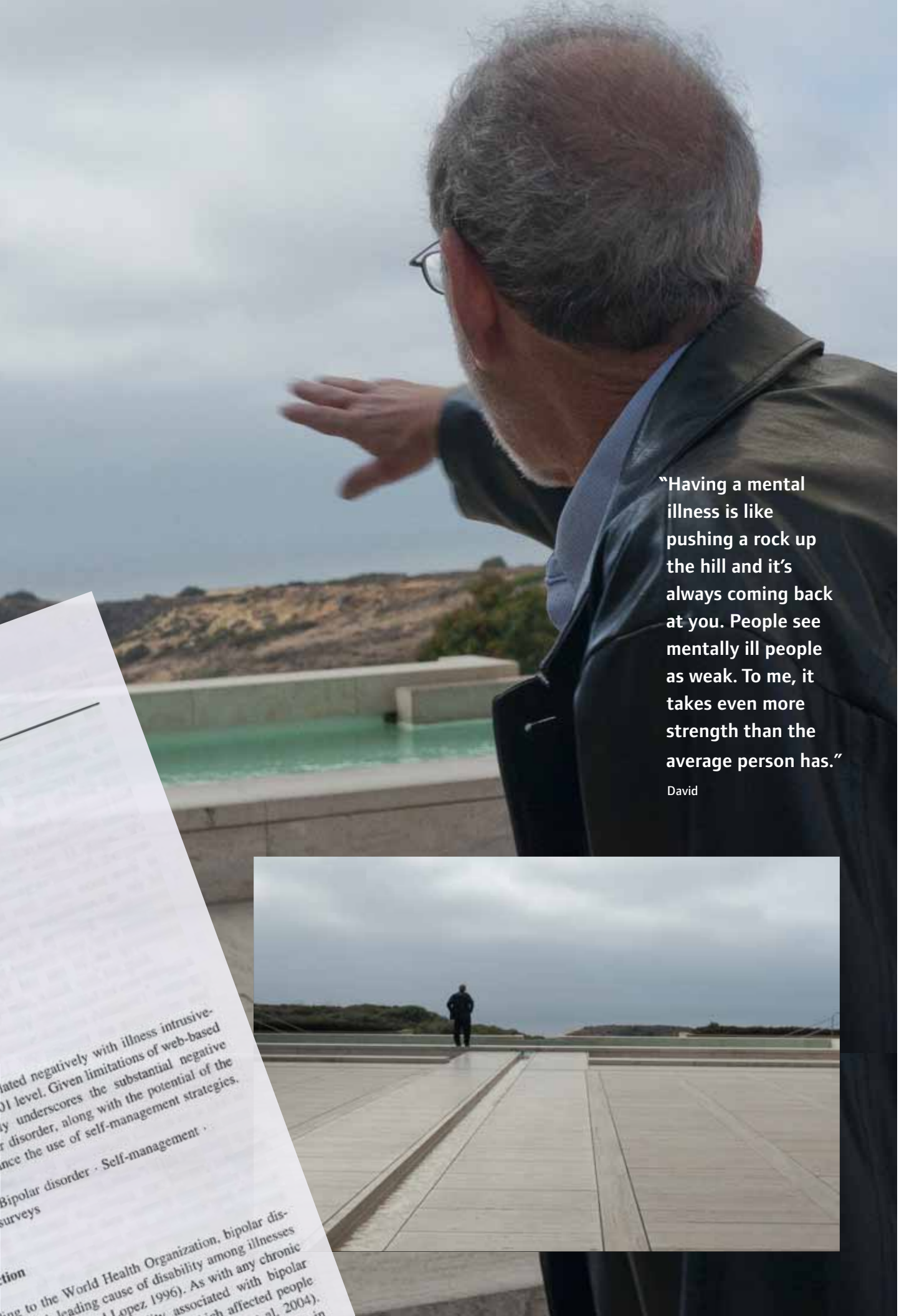

"Having a mental illness is like pushing a rock up the hill and it's always coming back at you. People see mentally ill people as weak. To me, it takes even more strength than the average person has."

David

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University of California, San Diego, Hartford Center of Excellence in Geriatric Psychiatry

The University of California, San Diego (UCSD), Department of Psychiatry was designated as a Hartford Center of Excellence in 2004 because of its impressive track record of research focused on older adults with schizophrenia, bipolar disorder, and other psychotic disorders. The designation as a center of excellence has provided additional funding and prestige to support faculty development and recruitment to ultimately address the shortage of geriatric psychiatrists. Hartford-funded researchers study important mental health issues faced by older adults and design interventions tailored to the needs of these individuals.

Improving Care for Older Adults with Mental Illness

"Older adults with schizophrenia, bipolar disorder, and other mental illnesses are among the most disenfranchised groups in the country," says Dr. Dilip V. Jeste, Director of the Hartford Center of Excellence in Geriatric Psychiatry at UCSD. They are older and they have serious mental illness, yet they are the least likely to get adequate care for their mental and physical health problems. "Our research goals are to understand the basic pathology of these illnesses and to improve interventions for them," he says.

Research at UCSD focuses on psychosocial and behavioral interventions in addition to medication management. Dr. Jeste and his colleagues have developed and tested several interventions, such as cognitive behavioral therapy, social skills training, and work rehabilitation. Hartford-funded Scholars are actively participating in these studies as researchers and by implementing and disseminating innovative interventions.

Hartford Center of Excellence in Geriatric Psychiatry
University of California, San Diego

Approximately 2.4 million Americans are affected by schizophrenia.

Aging with Bipolar Disorder

Most research on bipolar disorder has been done in children, adolescents, and younger adults. Researchers at UCSD are interested in the experiences of adults with bipolar disorder as they get older. Contrary to widely held beliefs, bipolar disorder may become easier to manage with age, especially with the right support systems in place. As people get older they often gain insights into their illness that help them manage. For example, they may become more adherent to medications and better able to recognize early warning signs of illness, resulting in better control of symptoms.

David, who is 67 years old and was diagnosed with bipolar disorder as a young man, participates in research at UCSD. About 30 years ago, he was told by a medical professional to expect the severity of bipolar disorder to get worse with age with more frequent episodes. "I told myself, whatever happens I have to work against that," says David. "I became hyperaware of when I started ratcheting down or up." To help with his mood changes, David developed some coping strategies. For example, "I try to keep myself in the moment, take deep breaths, and meditate," he says. "It took me a long time to learn that. It's not something at 24 years of age I would have thought of doing." David notes that each person with bipolar disorder needs to learn techniques that work for them.

David has identified three key aspects of managing his illness. First is medical management, which involves appropriate drug therapy. Second is recognizing the triggers when his mood is going markedly

What is Bipolar Disorder?

Bipolar disorder is a mood disorder that was previously called manic depressive disorder. There are different types of bipolar disorder, and thus the experience of this illness varies widely. In general, it's characterized by shifts from periods of higher energy and activation called mania to periods of depression and reduced energy. During the manic phase there's often a sense of euphoria, little need for sleep, and racing thoughts. Some people don't experience the elation. Instead they become very irritable. Episodes of full-blown mania generally don't last long, possibly two or three weeks. During this phase people with the disorder may engage in impulsive or irrational actions. Sexual activity tends to increase. They may engage in risky sexual behaviors impulsively without having a history of such behavior.

Some people with bipolar disorder have delusions, such as having special abilities or gifts. They may have very exaggerated beliefs that are out of touch with reality; for example, they may believe that somebody famous is in love with them.

After the manic phase there's a tendency to lapse dramatically into a depression, which lasts much longer than the manic phase. The depression in a person with bipolar disorder tends to be more severe than in a person who has major depression without the mania. Depression in bipolar disorder is generally harder to treat, and thus is the most disabling aspect of the illness for most people. Some people with bipolar disorder will have just one episode of mania in their entire lifetime and struggle with depression for the rest of their life.

Ipsit V. Vahia, MD
Hartford Scholar
Assistant Professor
Department of Psychiatry
University of California, San Diego

up or down. And third is having a support system, which includes health professionals like psychiatrists and psychologists and also family members and people he trusts. "One thing I preach to other people with bipolar disorder is to have a mirror," says David. "A mirror is someone you trust who can tell you honestly, without being spiteful, that you're not acting normally. You have to set that up when you're feeling rational."

With the help of David and others with bipolar disorder, the researchers at UCSD are identifying specific coping techniques. "In general, we find that older adults with bipolar disorder do better if they're provided adequate care and social support," says Dr. Jeste.

Aging with Schizophrenia

Alana Iglewicz, MD, Hartford Geriatric Psychiatry Research Fellow, Department of Psychiatry, UCSD School of Medicine, discovered early in her career the complicated issues involved in aging with schizophrenia. In fact, a conversation she had with an older man with schizophrenia motivated her to pursue psychiatry. He explained that when he was younger he was integrated into the lives of his parents and other family members and had their help with many aspects of his life. After his parents died, for the first time he had to manage his own medications and seek out social avenues.

What Dr. Iglewicz found interesting about this man was that his symptoms actually became more tolerable as he got older. "He explained that he still had the experience of hearing voices that other people couldn't hear, but he was able to make sense of it in a way he wasn't able to when he was younger," says Dr. Iglewicz. This experience is typical of many older adults with schizophrenia.

What is Schizophrenia?

Schizophrenia is a psychotic disorder, or psychosis. The name schizophrenia means break from reality. It's characterized by a cluster of symptoms, such as auditory hallucinations (hearing voices), other forms of hallucination (such as seeing, feeling or smelling something that isn't there), delusions (false unshakable beliefs), and disorganized thinking. People with schizophrenia may act in ways that are grossly inappropriate or out of the norm of what is acceptable in society. They may mutter to themselves and have an inability to generally take care of themselves without having any insight into why. These are called "positive" symptoms. People with schizophrenia may also have "negative" symptoms, such as lack of motivation, inertia, or lack of facial expression. Not everyone with schizophrenia has all the symptoms.

Subtypes of schizophrenia include paranoid type, disorganized type, and catatonia (characterized by muscle rigidity and unresponsiveness, sometimes alternating with great excitement and confusion). The classification of schizophrenia is based solely on symptoms rather than any biological or neurological findings.

Ipsit V. Vahia, MD
Hartford Scholar
Assistant Professor
Department of Psychiatry
University of California, San Diego

Dr. Jeste, whose research focuses on older adults with schizophrenia, must often fight against the conventional belief that schizophrenia is a dementing illness that starts early in life and only gets worse with age. "One of the goals of our work has been to look at what factors increase the chances for older people with schizophrenia to recover and to have sustained remission from their illness," he says. Remission means that the person has only a minimal degree of symptoms. As an example, Dr. Jeste cites John Nash, the Nobel Laureate, who has paranoid schizophrenia and was the subject of the film *A Beautiful Mind*. As he got older he started to get better. By studying how high-functioning people with schizophrenia manage their illness, Dr. Jeste and his colleagues hope to find ways to help everyone who struggles with this illness.

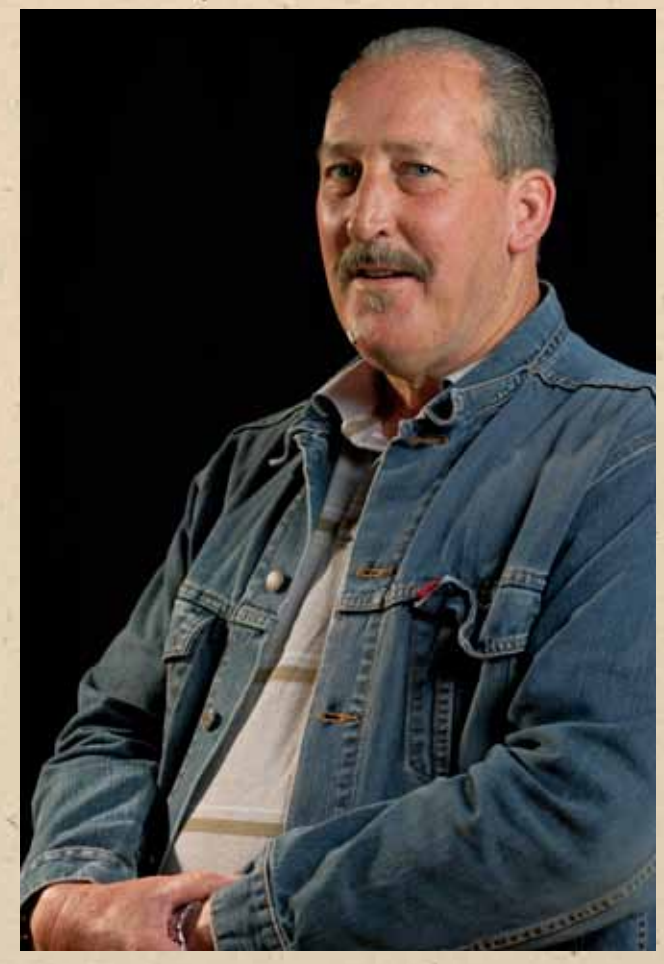
For example, Kenneth, age 55, who has schizophrenia and participates in research at UCSD, has learned some skills that help reduce his paranoia when meeting new people. "I learned how to react when I get paranoid, when I get afraid, when I come up to an individual to ask for information and I don't know the person and don't know how they're going to react," says Kenneth.

The researchers at UCSD are also studying late-onset schizophrenia. While schizophrenia usually starts early in life, Dr. Jeste and his colleagues have found that it can manifest for the first time in older age. Late-onset schizophrenia tends to be more common in women than in men, is usually the paranoid type, and there are different treatment considerations.

"For many older adults with schizophrenia or bipolar disorder the biggest problems are societal attitudes, stigma, and poor health care," says Dr. Jeste. Through their research, Dr. Jeste and his colleagues are attempting to change attitudes, so that people with mental illness can be seen as real people who happen to have these illnesses. "They are getting older and we can help them get better," he says.

"You're always going to have a mental illness. A mental illness is not going to go away. You have to pick it up and deal with it every day. You can't just put it down and walk away from it."

Kenneth, who was diagnosed with schizophrenia as a young man, participates in research at the University of California, San Diego.



Complicated Grief

"When Arthur died I didn't try taking antidepressants or going for therapy. I felt that I could handle it on my own. I realize now that you really need help. You need to have somebody to talk to."

Rosalee, participant in a research study on complicated grief

Researchers at UCSD are also studying complicated grief. Grief over the loss of a loved one can be a very intense, painful, and disruptive experience. For most people, even though they continue to miss a person who has died, retain memories, and grieve from time to time, the intensity of the feelings decreases over time. For those with complicated grief this normal healing process does not occur. Several months or even years after the death the feelings are as intense as if the person died yesterday. "People say things like time moves on but the grief stands still," says Sidney Zisook, MD, Professor, Department of Psychiatry, and Residency Training Director, UCSD School of Medicine, who is a lead researcher on complicated grief studies and is a mentor to Hartford Scholar Dr. Alana Iglewicz.

Drs. Zisook and Iglewicz have found that complicated grief lasting six months or more can become very difficult to treat. Standard treatments for anxiety or depression, including medications and psychotherapy, tend not to be effective. A new form of treatment called "complicated grief therapy," which is a hybrid of several forms of psychotherapy, was developed by Katherine Shear, MD, at the University of Pittsburgh School of Medicine, a Hartford Center of Excellence in Geriatric Psychiatry. An initial study showed that this therapy is effective.

Dr. Shear is now conducting a larger, multi-site study to further test the intervention and to study the potential role of medications, alone or in combination with complicated grief therapy.

Rosalee, age 76, lost her husband three years ago after a long illness that was misdiagnosed for years before correctly confirmed as a rare, fatal brain disorder. The illness was devastating both to his physical and mental functioning. Caring for her husband with the multiple medical problems associated with his disease became a tremendous burden for Rosalee. She eventually moved him to a nursing home.

"After Art died I had this ongoing movie in my head of the last days of his life," says Rosalee. "On the day Art died I was at the funeral home to finalize things. My daughter was with him. She called and said, come back, Art's going. I hit every red light on the way back and I got back just after he finished his last breath. He was gone. I couldn't get away from that movie in my head. Art had been dead for two years when I saw an announcement about the grief study."

"After the death of her husband Rosalee became frozen in grief, and she never talked to anyone about it," says Dr. Iglewicz, adding that "she did beautifully in the study." "The movie stopped and the grief became less intense," says Rosalee.

Translating Research to Practice

"I believe it is not enough to just develop and test interventions," says Dr. Jeste. "We have to see if they are useful in everyday practice." Therefore, UCSD has partnered with the San Diego County Public Mental Health System, which provides care for about 40,000 adults. "Our studies have shown that the interventions we've developed are indeed practical."

In addition, Hartford Scholars are participating in efforts to translate research to practice. For example, Ipsit V. Vahia, MD, Assistant Professor, Department of Psychiatry, University of California, San Diego, and a Hartford Scholar, studies late-life schizophrenia and successful aging. "I'm in the unique position of being able to apply my research findings to the patients I see in the clinic," says Dr. Vahia. Many people believe that if they have the burden of a diagnosis like bipolar disorder or schizophrenia this is an impediment to aging successfully.

Dr. Vahia translates his research findings into reassuring messages for his patients. "I'm able to tell them that coping with bipolar disorder is not that different from coping with something like diabetes or hypertension," says Dr. Vahia. "They are different illnesses, but on a day-to-day basis it comes down to taking medications every day. A simple statement like that can make a big difference to their morale, and they leave feeling better, which is ultimately our goal."

RESEARCH

University of Pittsburgh
Hartford Center of Excellence in Geriatric Psychiatry

My mother was always very pleasant. After she fell and broke her leg she was taken to the emergency room and then to surgery. When she woke up after the surgery she was almost a completely different person. My mother has always been able to filter what she was thinking, which diminished a bit with the Alzheimer's disease, but the filter was completely taken away with the delirium. She became incredibly agitated and angry.

When I called the hospital they told me she threw a water container across the floor and she was yelling at people. When my brothers and I went into the room she stared at us and said very nasty things, cursing and swearing. My mother never swore. It was upsetting and scary. First we thought it was caused by the anesthesia and it would wear off. Then we thought she had plummeted quickly into another stage of Alzheimer's.

Dr. Solai, the psychiatrist who was treating her in the nursing home before the fall, adjusted her medications, and now we're noticing that she's more alert. She's sweet and loving again. Even though she has Alzheimer's disease, she's still there. A lot of people misunderstand Alzheimer's disease. It's not like the disease is diagnosed and the person's mind is completely gone. It's sort of bittersweet, because they're not the person they used to be, but you can enjoy who they are, and my mother is very special.

–Lisa, daughter of Patty

Patty

Patty, 77 years old, was brought to my attention by the nurses at Masonic Village because of increased confusion. It was clear she had dementia. I spoke to Patty, to her nurses, and to her daughter Lisa to get some background information. We did a routine workup, including blood tests, urine tests, and a medication review. Initially she was taking Benadryl for itching. Benadryl is not a good medication for an older adult because it tends to increase confusion. We took her off of that. Patty was also depressed about being in the nursing home, so I started her on an antidepressant. At about this time she had a fall and sustained a fracture, which is a risk factor for delirium. She was put on pain medication in the hospital, which further contributed to her confusion. I knew that her mental state after the surgery was not her normal state. We had to manage her pain, but also be judicious about the dose of the pain medication, so she would not get confused. I also noticed she was placed on a medication for incontinence during the hospitalization, which can contribute to delirium. I had to stop that drug. We also identified and treated a urinary tract infection. There are multiple possible reasons for delirium and the management is an ongoing process.

Working with the nurses and the family we tried behavioral approaches to treating Patty's delirium like redirecting her and engaging her in activities to keep her busy. Patty likes one-on-one attention and did her best during those times. She was still screaming and yelling profanity, so I added a small dose of an antipsychotic medication. As the pain from the surgery subsided we switched her to non-sedating pain medicines. She's still forgetful from the dementia, but she's more alert, interactive, and not as anxious.

Lalith-Kumar Solai, MD
Assistant Professor of Psychiatry
Department of Psychiatry
University of Pittsburgh
Hartford Center of Excellence in Geriatric Psychiatry

Patty enjoys visits from her psychiatrist, Dr. Lalith-Kumar Solai.

"I've found that the amount of education needed by the nursing home staff on mental health issues is very high."

Dr. Lalith-Kumar Solai
Assistant Professor of Psychiatry
Department of Psychiatry
University of Pittsburgh

Lisa (top, right) travels once a month to visit her mother Patty at the Masonic Village Nursing Home, where she receives expert care. Staff members (above, and right) work with Dr. Lalith-Kumar Solai in handling mental health issues.

"My mother has always been able to filter what she was thinking, which diminished a bit with the Alzheimer's disease, but the filter was completely taken away with the delirium."

Lisa, daughter of Patty

University of Pittsburgh Hartford Center of Excellence in Geriatric Psychiatry

Designated as a John A. Hartford Foundation Center of Excellence in Geriatric Psychiatry in 2004, the University of Pittsburgh's Department of Psychiatry houses one of the nation's largest divisions of geriatric psychiatry, with an international reputation as a research leader for the study of mood and cognitive disorders in older adults. The University of Pittsburgh's Department of Psychiatry trains 20 percent of the nation's academic geriatric psychiatrists.

Through a grant to the American Federation for Aging Research, Inc. (AFAR), the Hartford Foundation provides funding for the Hartford Geriatric Psychiatry Fellowship Program, which offers academic geriatric psychiatrists the option to pursue one of two career paths: physician researcher or physician educator. Physician researchers generate new knowledge about mental health care for older adults and investigate new models of care. Physician educators teach generalist physicians and other health care providers appropriate models of geriatric care and disseminate new models of care that emerge from research.

Up to 50 percent of older surgical patients experience delirium.

Lalith-Kumar Solai, MD, Assistant Professor of Psychiatry, Department of Psychiatry, University of Pittsburgh, was a Hartford Geriatric Psychiatry Fellow (2005-2007), and chose the path of physician educator, with a focus on delirium in older adults. His interest in delirium began several years ago when he was providing psychiatry consultation services to several hospitals. He noticed that a large number of older adult patients were hospitalized with delirium that had not been diagnosed by their primary care providers or by emergency room staff.

To quantify his observations, Dr. Solai conducted a study of older adult patients who came to the emergency department at two community hospitals and were identified as having delirium. Previous studies have shown that about 10 to 15 percent of older adults who go to an emergency room have delirium. "We found that only one to two percent of the charts showed any documentation of delirium," says Dr. Solai. Many cases were obviously being missed. With funding as a Hartford Fellow, Dr. Solai responded to his findings by creating

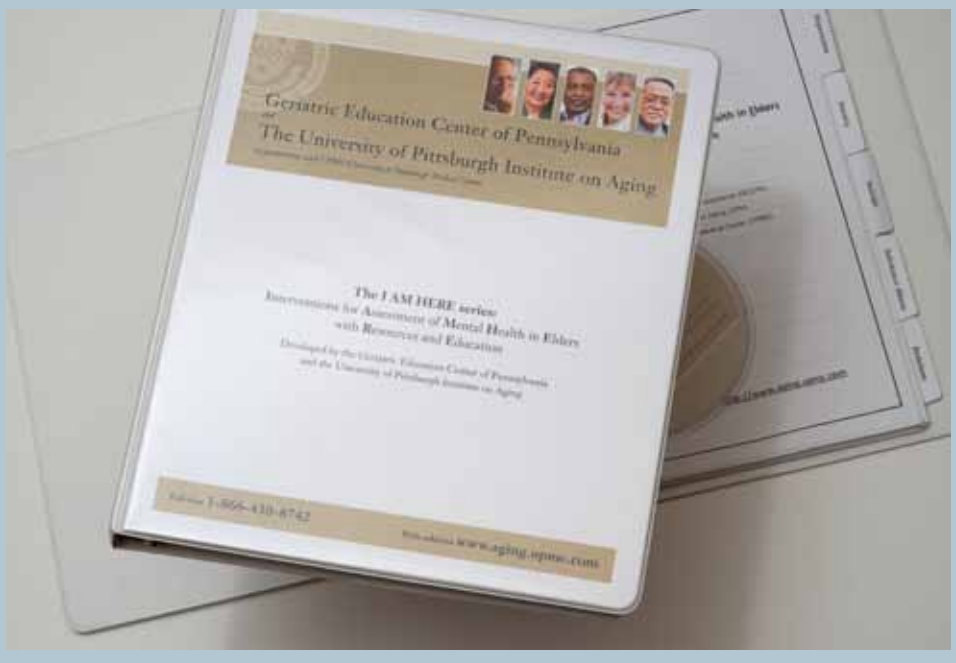
a Web-based teaching module for emergency physicians and nurses on identifying and treating delirium (see Resources, inside back cover).

"Through this work I have been identified as the local expert on delirium," says Dr. Solai. At the University of Pittsburgh School of Medicine he gives lectures on delirium to medical students and to residents in psychiatry, surgery, anesthesiology, and other specialties. Dr. Solai also provides clinical services to nursing homes. "I've found that the amount of education needed by the nursing home staff on mental health issues is very high," says Dr. Solai. To address this, he created a training module on late-life mental health issues, such as dementia, delirium, and depression, which is targeted to nursing home staff, including nurses, aides, social workers, physical therapists, and occupational therapists.

Prevention and Treatment of Depression in Older Adults

A major research focus of the University of Pittsburgh Center of Excellence in Geriatric Psychiatry is the prevention and treatment of depression in older adults.

"The connections between depression and physical disability and the connections between depression and mild cognitive impairment (MCI) or dementia are at the heart of what is unique about mental illnesses in older adults," says Charles F. Reynolds III, MD, Director of the Hartford Center of Excellence in Geriatric Psychiatry, and University of Pittsburgh Medical Center Endowed Professor in Geriatric Psychiatry. Close to half of older adults with major depression have MCI. (A person with MCI has noticeable memory problems and may later develop Alzheimer's disease



The "I AM HERE series" was developed by Dr. Lalith-Kumar Solai to teach nursing home staff about late-life mental health issues.

or other types of dementia.) Dr. Reynolds notes that depression is now recognized as a risk factor for dementia, doubling the chances for dementia in later life. Older adults living alone with few social resources are at risk for depression.

Psychosocial issues, such as bereavement, can set the stage for depression or complicated (prolonged) grief (see page 50). Some specific medical problems have been shown to be highly associated with depression, such as stroke and disability secondary to a heart attack or chronic obstructive pulmonary disease.

"We are challenged by these complexities and want to sort them out in ways that are helpful to patients and their caregivers," says Dr. Reynolds. Several new studies have been launched at the University of Pittsburgh to develop a menu of strategies that will help protect older adults from becoming depressed.

At the core of much of the experience of depression in older adults is a sense of helplessness, of no longer being able to cope. Therefore, one of the strategies involves teaching older adults and their caregivers better coping and problem-solving skills. Another intervention is a brief behavioral treatment for insomnia because insomnia is a risk factor for depression. "In older adults we often see particularly difficult and profound sleep disturbances," says Dr. Reynolds. Another set of interventions relates to exercise. "All of these interventions help to enhance a sense of control over one's life," says Dr. Reynolds.

Depression doubles the risk for dementia and Alzheimer's disease.

A Commitment to Education

In addition to research, the University of Pittsburgh Department of Psychiatry is also committed to providing quality education on important topics in geriatric mental health. With a grant from the National Institute of Mental Health, they created a series of documentaries on late-life mental health intended to inspire students across disciplines. The series is titled "Caring for Those Who Cared for Us" (see Resources). Topics include complicated grief, late-life suicide, minority elders and mental health, and successful aging.

Accomplishments of Hartford Fellows

Attracting new researchers and educators in geriatric psychiatry is a critical priority as the number of adults over age 65 steadily grows. Both the University of California, San Diego, and the University of Pittsburgh have made great strides in recruiting and advancing the careers of promising geriatric psychiatrists, which ultimately will improve mental health care for older adults.

University of California, San Diego
Hartford Center of Excellence in Geriatric Psychiatry

Since 2004, 21 UCSD Hartford Scholars have been supported, including several who have both MD and PhD degrees. They have been extremely successful. Several of them are on the full-time faculty at UCSD or other major medical institutions. Almost all of them have published research papers and several of them have obtained funding as independent investigators. "This is a boon not just for us at UCSD but for the entire field of geriatric psychiatry," says Dr. Jeste.

Some Hartford Scholars have been involved in modifying the curriculum for the UCSD Medical School to include more geriatrics and geriatric psychiatry. Dr. Alana Iglewicz is particularly interested in finding ways to inspire more medical students to specialize in geriatric medicine and geriatric psychiatry. She is working with the leaders of the UCSD Hartford Center of Excellence in Geriatric Pyschiatry to systematically study barriers to entering these specialties as well as programs for drawing more students to them.

University of Pittsburgh
Hartford Center of Excellence in Geriatric Psychiatry

All of the Hartford Geriatric Psychiatry Fellows funded at the University of Pittsburgh are now full-time academic geriatric psychiatrists. They are emerging as highly valued leaders in the department and are active in mentoring the next generation of students. The Fellows on the physician researcher track have all received National Institutes of Health grants. The Fellows on the physician educator track have also been very productive, creating programs to help clinician educators and recruiting medical students into geriatrics. The fellowship in geriatric psychiatry offered at the University of Pittsburgh trains three to five new geriatric psychiatrists annually.

POLICY

Hartford Geriatric Social Work Faculty Scholars Program
Hartford Doctoral Fellows in Geriatric Social Work program

"Since its earliest history social work has been involved with social policy and mental health practice, emphasizing the promotion of the general welfare of vulnerable people, such as the elderly," says Barbara J. Berkman, DSW/PhD, Director of the Hartford Geriatric Social Work Faculty Scholars Program.

The Faculty Scholars Program, funded by the John A. Hartford Foundation since 1999 with a total of $24.3 million, has supported over 120 social work faculty who address issues around aging. A companion program, the Hartford Doctoral Fellows Program, funded by the John A. Hartford Foundation since 2000 with a total of over $10 million, has provided dissertation support and professional development opportunities to over 100 social work doctoral students.

Hartford-funded social work faculty and doctoral students are continuing the long-standing tradition of influencing health policy through their research and advocacy work for older adults with mental health issues.

POLICY

I just do the best I can. You know, it's hard for me 'cause I can't get around very well. But, you do what you gotta do. It's hard. Like, not too long ago I, even thought there was nobody here but me 'cause the provider wasn't here at that particular time in the evening, I fell out of the bed. And then I couldn't get up and it was hard. And I finally figured a way to get up. I finally did get up on my bed and that's the way I made it up but… see I don't have anyone in the afternoon. I just have someone in the mornings.

(Sometime later Bertha was hospitalized for several weeks with pneumonia and congestive heart failure. The hospitalization marked a significant deterioration in her health, one that she struggled to recover from.)

This is hard to explain, but the illness and going to the hospital, it did something to my depression, I am very depressed after that, it did something to me, and I get very sad and very lonely and I can't tell you why, but I just get those feelings…I didn't recognize being here, I didn't have the comfortable feeling of being home, I don't understand myself, but I've been feeling that way since I've been home and I'm trying to get back to feeling normally, like I had.

–Bertha

"Bertha" – A Case Study

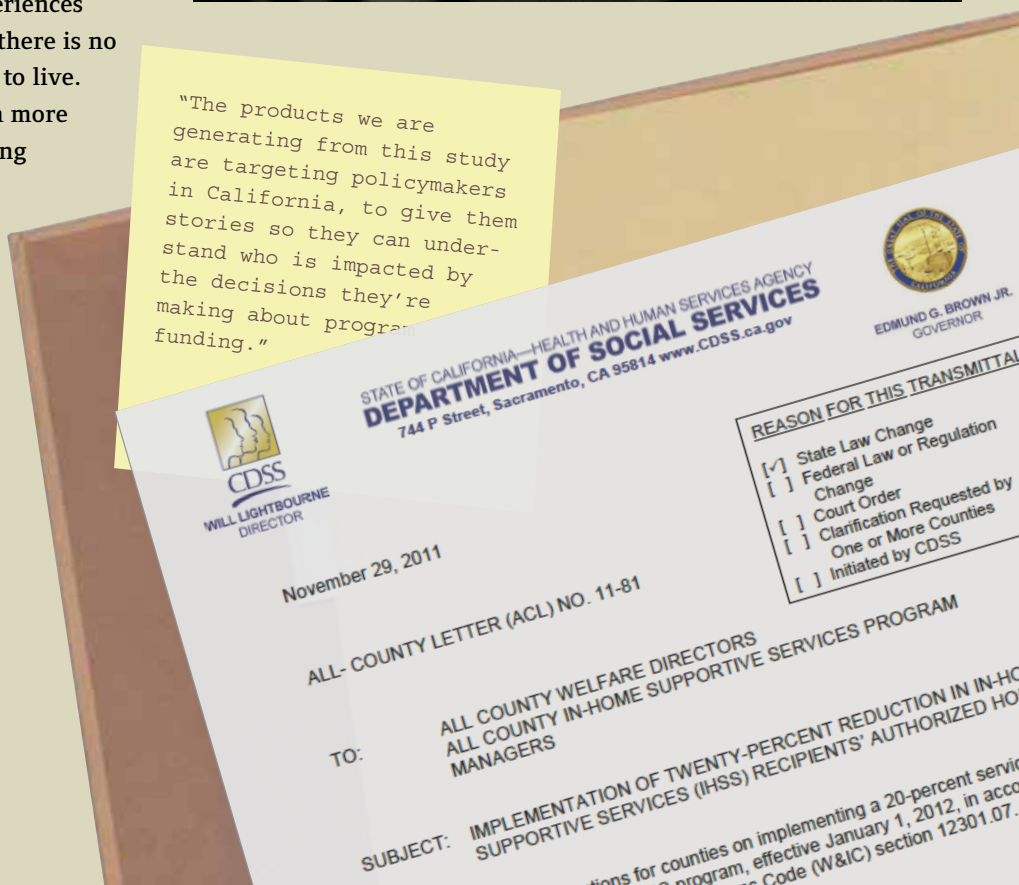
by Kathryn G. Kietzman, PhD, MSW
Hartford Social Work Doctoral Fellow
Research Scientist
University of California, Los Angeles
Center for Health Policy Research

Bertha is a 78-year-old woman who receives home care services from the publicly funded In-Home Supportive Services (IHSS) program. She struggles with diabetes and mobility problems from chronic knee pain. She needs help with housework, preparing meals, shopping, and laundry. Bertha's needs vary throughout the day but she is alone in the afternoons. She tries her best to adjust and does very little once her caregiver has left for the day.

Bertha's hospitalization and health deterioration resulted in some temporary and long-term changes to the types of supports she receives. Bertha needs more personal help with bathing and grooming, which her IHSS caregiver provides. Informal supports are limited for Bertha.

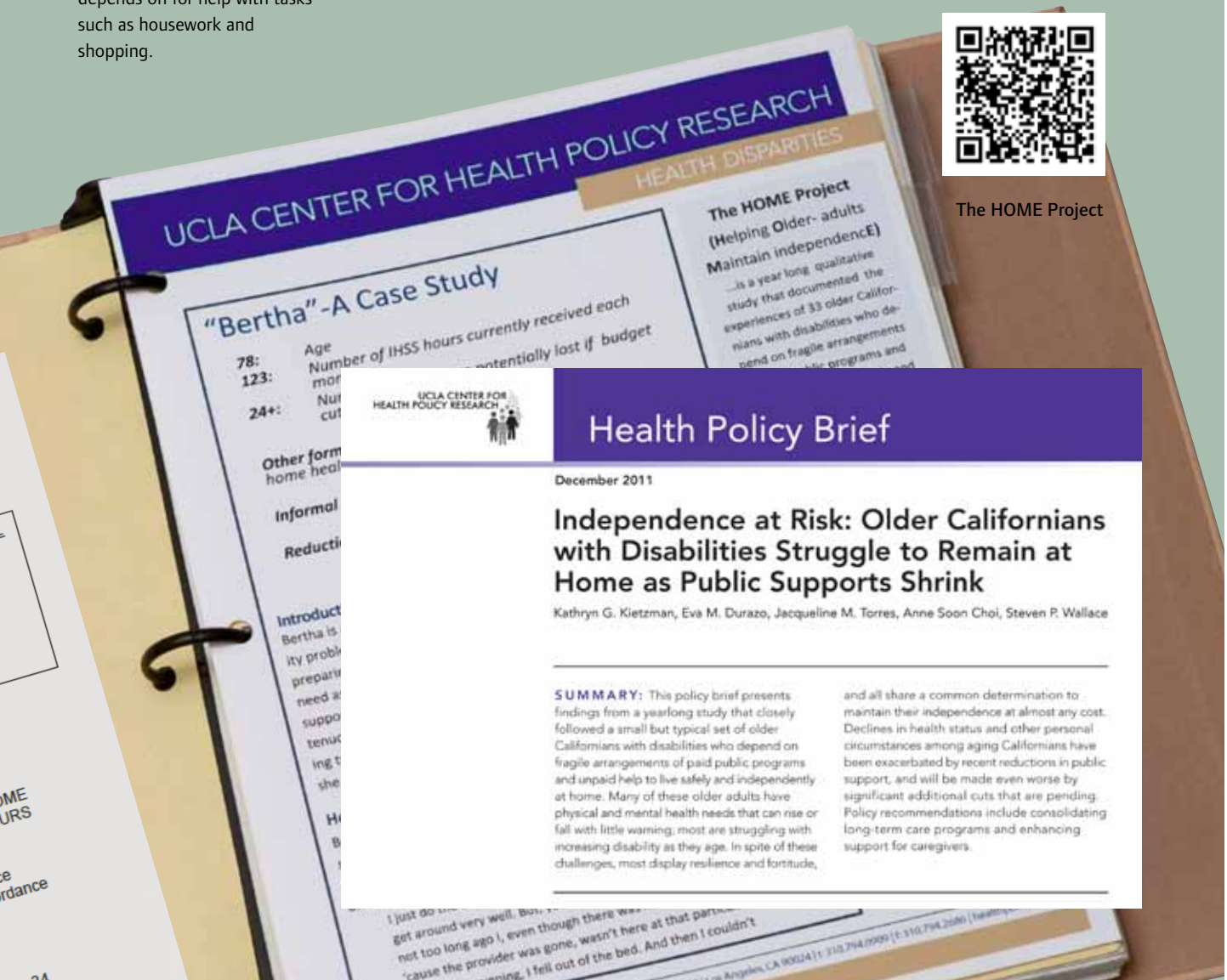
With her declining health, Bertha has become increasingly isolated, which can lead to depression. Despite the limited social supports and challenges she experiences living at home with a disability, there is no other place Bertha would choose to live. Bertha's caregiver provides much more than just doing chores and running errands. The caregiver provides motivation and companionship to help Bertha start her day and get through the afternoons when she is alone.

Kathryn G. Kietzman, PhD, MSW



Proposed budget cuts would eliminate 24 hours per week of caregiver services that Bertha depends on for help with tasks such as housework and shopping.

The HOME Project (Helping Older adults Maintain IndependencE) is a year-long study that documented the experiences of 33 older Californians with disabilities who depend on fragile arrangements of paid public programs and unpaid help to live safely and independently at home.
It was supported by a grant from The SCAN Foundation in 2011.



The HOME Project

"A 20 percent cut in caregiver hours would be devastating to disabled seniors' health and well-being."

Kathryn G. Kietzman, PhD, MSW
Hartford Social Work
Doctoral Fellow
Research Scientist
University of California,
Los Angeles
Center for Health Policy
Research

Social Workers as Public Health Policy Advocates

To improve mental health care for older adults it is necessary to develop and implement proven treatments, and to provide more comprehensive education for health care providers. But there is one more piece that must fall into place, and that is policy. "Evidence-based interventions must become imbedded in systems of care, and there must be mechanisms to reimburse for them," says Philip McCallion, PhD, ACSW, Professor, School of Social Welfare, University at Albany, State University of New York, and a Hartford Geriatric Social Work Faculty Scholar.

For this reason, the Hartford Geriatric Social Work Faculty Scholars and Hartford Doctoral Fellows in Geriatric Social Work are encouraged to become involved in policy work by Dr. Berkman and James E. Lubben, DSW, MPH, The Louise McMahon Ahearn Chair, Boston College, and Director of the Doctoral Fellows Program.

Hartford Geriatric Social Work Initiative

One area in which Hartford-funded Scholars and Fellows are making an impact relates to policies that help older adults continue to live safely at home. Home health care has grown rapidly during the past two decades, enabling many older adults to live independently. Medicare is the largest single payer of the annual $57.6 billion in home care services in the United States, providing home-based services to over 15 million older adults with acute illness, chronic medical conditions, and disability. Some state-funded programs pay for caregiver services for low-income older adults with disabilities.

Depression is common among homebound older adults, affecting 13 to 27 percent of older adults receiving home care. Yet depression often goes unrecognized and untreated in this group. A range of factors account for this, including the stigma around mental health conditions, financial difficulties, and transportation problems. In some cases, addressing physical limitations, social isolation, and medical problems can help alleviate depression.

Older adults with medical conditions such as heart disease have higher rates of depression than those who are medically well.

Helping Low-Income Seniors Remain at Home

Kathryn G. Kietzman, PhD, MSW, Research Scientist, UCLA Center for Health Policy Research, and a Hartford Social Work Doctoral Fellow (2006-2008), wants to make sure older adults receive the services they need to live independently while maintaining both their physical and mental health. For example, a study she and her colleagues conducted was influential in stopping, for now, the state of California from cutting funding to a crucial program for low-income seniors.

The study, called the HOME Project (Helping Older adults Maintain IndependencE), documented the experiences of 33 older Californians with disabilities who depend on home care services through the state-funded program In-Home Supportive Services (IHSS). The study was supported by a grant from The SCAN Foundation. "The written materials we are generating from this study are targeting policymakers in California, to give them stories so they can understand who is impacted by the decisions they're making about program funding," says Dr. Kietzman.

The SCAN Foundation

In a recent survey, only 37 percent of older adults reported that they had been asked about their mood by their doctor or health care provider in the past year.

Bertha is one of the 33 older adults in the study and one of over 400,000 low-income Californians who depend on support from an IHSS caregiver for help with personal care (such as bathing), domestic tasks (such as meal preparation), and other assistance (such as transportation to medical appointments).

Like many people in her situation, Bertha struggles with both physical and mental health issues. "Not only was she coping with the physical recovery process (after hospitalization for pneumonia and congestive heart failure), but she also faced emotional challenges," wrote Dr. Kietzman in the case study of Bertha. "A hospitalization can cause significant disruptions to the physical and emotional well-being of older adults." Dr. Kietzman and her colleagues found that mental health issues were relatively common among the participants in the HOME study, and that having assistance from a caregiver was essential to maintaining their overall physical and mental health.

When a $100 million cut in funding (which would result in a 20 percent reduction in the number of caregiver hours) was proposed by the California state legislature, Dr. Kietzman and her colleagues took

action. “In the long run, this could cost the state more, because ailing seniors will increasingly end up in expensive emergency rooms, hospitals, and nursing homes,” says Dr. Kietzman.

Dr. Kietzman’s colleague Steven P. Wallace, PhD, Associate Director, UCLA Center for Health Policy Research, used data from the HOME study in a lawsuit, which helped to convince a judge to issue a temporary restraining order to prevent the funding cuts. (The final outcome has not yet been determined.) “It’s an interesting example of how research, in this case in the words of the individuals affected, can be used to inform policy,” says Dr. Kietzman.

Dr. Kietzman’s background as a Social Work Scholar and as an Atlantic Philanthropies-funded Health and Aging Policy Fellow (2008-2010) in the office of United States Senator Debbie Stabenow of Michigan helped to prepare Dr. Kietzman for her current career in health policy. In 2008 when health care reform was being debated in Congress, Senator Stabenow wanted to make sure that mental health issues were not neglected in the discussions. She gave Dr. Kietzman the task of working with organizations with an interest in mental health (such as the American Association for Geriatric Psychiatry and the American Psychological Association) to draft legislation to establish a national network of centers of excellence for the treatment of depression and bipolar disorders.

“I worked on reconciling the varied interests among the groups because their support was important for moving the legislation forward,” says Dr. Kietzman. “Senator Stabenow was dedicated to making it a bipartisan bill, recognizing that depression and other mood disorders affect everyone,” says Dr. Kietzman. These efforts paid off. The bill received bipartisan support in both the Senate and the House of Representatives and was ultimately incorporated into the overall health care reform bill (the Patient Protection and Affordable Care Act). Congress has not yet appropriated the funding.

“Because the policy process is so dynamic and unpredictable, efforts to influence policy must be continuous to find the windows of opportunity essential for advancing change,” says Dr. Kietzman.

The Atlantic Philanthropies Health and Aging Policy Fellows Program

A Small Change Makes a Big Difference

In the state of Missouri an older adult Medicaid recipient who experiences major depression for the first time is now eligible to receive mental health services. Before 2010 this was not the case. In the past, Medicaid would pay for treatment only for people with a history of serious persistent depression. Making this change took a year of effort on the part of James Cook, PhD, Project Coordinator, Missouri Institute of Mental Health, University of Missouri-St. Louis, with assistance from Hartford Doctoral Fellow Leslie K. Hasche, PhD, who is now a Hartford Faculty Scholar at the University of Denver, Graduate School of Social Work.

"Making this policy change means that an older adult doesn't have to wait through one episode of depression before receiving services for a recurrence."

Dr. Leslie K. Hasche
Hartford Faculty Scholar
University of Denver
Graduate School of Social Work

This impacts low-income older adults who require in-home services because of health problems and functional disabilities. They are eligible for Medicaid but they were not being seen by community mental health agencies unless they had a documented history of depression. Dr. Hasche performed literature reviews and helped Dr. Cook write issue briefs. She provided findings of a study she participated in which found that 25 percent of older adult Medicaid recipients had significant depression but low use of mental health services.

Integrating Mental and Physical Health Care Services

Zvi D. Gellis, PhD, Director and Associate Professor, Center for Mental Health & Aging, School of Social Policy & Practice, University of Pennsylvania, and a Hartford Faculty Scholar (2002-2004), is also dedicated to influencing social and health policy. His work is focused on the mental health care needs of older adults who are homebound and receiving home care services for chronic medical conditions.

In 2002 when Dr. Gellis was an assistant professor at the University at Albany – SUNY and a Hartford Faculty Scholar he found that home health care staff (nurses, physical therapists, and occupational therapists) recognized that many older adults they cared for had depression or anxiety, but the staff members did not have the knowledge or training to know how to help. Dr. Gellis and his colleagues responded by developing a depression care model, called DART-HOME (Depression Assessment Referral and Treatment in Home Care) to screen and treat late-life depression in homebound older adults.

The DART-HOME Model

When Dr. Zvi D. Gellis wanted to test the feasibility of the DART-HOME model, an intervention aimed at improving the recognition and treatment of depression in homebound older adults, he reached out to Sr. Jean McGinty, RN, MS, Director of St. Peter's Home Health Care Program in Albany, New York. This became the site for the study.

In conducting the research, a nurse performing initial assessments of recipients of home health care services asked questions about depression and anxiety. A high score triggered a visit from the social worker, Cindy Jordan, LCSW (above and right), for further evaluation. Patients were divided into two groups. One group received depression education, problem-solving skills, help with scheduling activities and weekly telephone calls for six weeks. The other group received the usual care.

The dramatic improvement in depression scores among patients receiving the intervention convinced Sr. McGinty to require this depression screening tool for all home care patients. "Ultimately, Medicare made a similar change in their assessment tool, and we were ready," says Sr. McGinty.

Dr. Zvi Gellis reviews study data with Sr. Jean McGinty.

Using this model, a visiting nurse making an initial visit to an older adult receiving home care services asks questions about depression and anxiety in addition to the usual battery of questions used for assessment. If the answers indicate the person may have depression or another mental health issue, a social worker visits to more thoroughly assess the patient, use evidence-based therapies for depression, and make any necessary referrals.

In studies of the DART-HOME model, this intervention significantly reduced depression scores, increased treatment satisfaction, and improved problem-solving skills. A majority of patients (63 percent) reported that they preferred talking with a social worker about their depression than taking an antidepressant medication.

As a result of this research and his other work, Dr. Gellis was appointed by New York Governor George Pataki in 2005 to sit on the Governor's Interagency Planning Council for Health and Mental Health Services for Older Persons. The council recommended that the New York State Office of Mental Health establish demonstration sites across the state to provide training on how to integrate a depression assessment and screening model into a variety of agencies and health care settings that serve older adults (including hospital clinics, geriatric outpatient centers, nursing homes and visiting nurse agencies).

Only nine percent of licensed social workers identify aging as their primary field of practice.

Dr. Gellis is not alone in advocating for the integration of mental and physical health care services for older adults. As a result of a large body of work, the Centers for Medicare and Medicaid Services (CMS) was persuaded in 2008 to make changes to their procedures. When a Medicare beneficiary begins receiving home care services, the first step involves an assessment, usually by a nurse. CMS requires that the nurse complete a questionnaire called the Outcome Assessment Information Set. This assessment now includes a two-item Patient Health Questionnaire as a screen for depression. If the patient answers yes to these two questions, a longer assessment tool can then be used.

Dr. Gellis's current research is looking at taking the DART-HOME model and moving it into the realm of home telehealth technologies. "Instead of going to the home, the nurse uses the telephone and Web-based communication systems to interact with the patient," says Dr. Gellis.

CONCLUSION

Elizabeth, Vernon, Maria, Roberto, Mignonne, David, Kenneth, Rosalee, Patty, Lisa, and Bertha generously shared stories with us about their very personal experiences. They did so because they hope it will raise awareness about mental health issues faced by older adults and ultimately help others who struggle with depression, anxiety disorder, bipolar disorder, schizophrenia, complicated grief, delirium, and other mental illnesses.

As funders, health care providers, families and caregivers, health policy makers, and academicians, we can't let them down. The discouraging statistics about assessment and treatment of mental illnesses in older adults highlighted in this report can and must be recognized.

We hope this report inspires health care practitioners, policy makers, and funders to be attuned to the issues of mental health in older adults. We also hope that this report provides some information and resources to help identify mental illness and find appropriate treatment.

"Older people are an invaluable resource for the society in terms of their wealth of experience and wisdom," says Hartford grantee Dr. Dilip Jeste. Therefore, we must do a better job of improving both physical and mental health care for our aging society.

2011 Aging and Health Grants

In 2011, the John A. Hartford Foundation awarded two grants under its Aging and Health program representing $1.4 million in new commitments. Authorizations for new programs or large renewal grants are described here.

The Foundation made $19.6 million in payments to existing grants in 2011. A Summary of Active Grants can be found on page 74.

Foundation-Administered Grant
New York, NY
Communications & Dissemination Initiative Expansion Renewal
John Beilenson
$1,258,800, Three Years

The Hartford Foundation Communications and Dissemination Initiative Expansion will build on previous communications work with Strategic Communications and Planning (SCP), a socially responsible consulting firm specializing in work with nonprofit organizations, foundations, and government initiatives. This grant will allow the Foundation to continue to raise awareness of and increase support for education and service innovations in geriatrics and gerontology that improve the quality of care for older adults. The Foundation's Communications and Dissemination Initiative has been funded since 1999 to provide training, consultation, and media outreach for grantees and staff to help them successfully promote and communicate their work to diverse audiences. For more information on Strategic Communications and Planning, please visit: www.aboutscp.com.

Grantmakers in Aging
Arlington, VA
Core Transitional Support
John Feather, PhD
$140,000, Two Years

This funding from the Hartford Foundation will help provide stability to Grantmakers in Aging (GIA) during its current period of leadership change and geographic relocation. It will enable the organization to develop a long-term plan covering strategy, operations, and finance and will allow the organization to broaden its base of stakeholders and reach out to members directly and immediately at the start of 2012. To learn more about GIA, visit: www.giaging.org.

Financial Summary

On December 31, 2011, the Foundation's investment portfolio was valued at approximately $478 million, versus $498 million at the end of 2010. Spending for grants, administrative expenses and taxes totaled $25.0 million. Total return on the investments, income plus realized and unrealized capital gains, was 1.0 percent. Audited financial statements were not completed in time for this printing, but will be available on the Foundation's Web site.

The Foundation's investment objective continues to be securing maximum long-term total return on its investment portfolio in order to maintain a strong grants program, while assuring continued growth of its assets at a level greater than the rate of inflation.

The broad U.S. stock market finished 2011 with a modest positive return, while international equity markets suffered all year from the sovereign debt crisis with a double-digit decline. The S&P 500 gained 2.1 percent, the MSCI EAFE Index declined 11.7 percent, and emerging markets plummeted 18.2 percent. Despite a volatile year for global markets, the Foundation's portfolio fared relatively well––mainly driven by the strong performance from private equity and real estate investments––compared to the foundation and endowment plans in the Northern Trust universe. The Foundation's portfolio has remained liquid and defensively positioned, providing it with the ability to meet ongoing spending needs and to withstand dramatic swings in the financial markets.

At the end of the year the Foundation's asset mix was 43 percent marketable equities, 16 percent fixed income, and a total of 41 percent in private equity and real estate funds, compared with 48 percent public equities, 12 percent fixed income and 40 percent in non-marketable alternatives as of the end of 2010.

As of December 31, 2011, Cubic Asset Management, Lateef Investment Management, Neuberger Berman – The Bolton Group, Integre Advisors, Newport Asia and Westwood Global Investments manage the Foundation's long-only equity investments. Chilton Investment Company, Convexity Capital Management, Habrok Ltd., Hayman Capital Management, New Providence Asset Management, Pennant Capital Management, Scout Capital Fund and York Capital Management manage the marketable alternatives. In addition, the Foundation is an investor in venture capital funds managed by Oak Investment Partners, Brentwood Associates and William Blair Capital Partners. Private equity partnerships are managed by GCP Capital Partners, Angelo, Gordon &Co. and Brentwood Associates. Real estate investments consist of funds managed by TA Associates Realty, Angelo, Gordon & Co and Heitman/JMB Advisory Corporation.

As the investment landscape continues to grow more complex and volatile, in order to best meet the fiduciary obligation, the Foundation has engaged New Providence Asset Management, an independent registered investment advisor, to assist in overseeing the day-to-day management of the endowment since the beginning of 2009.

The Finance Committee and the Board of Trustees meet regularly with New Providence to review asset allocation, investment strategy and the performance of the individual investment advisors and funds. Northern Trust Corporation is the custodian for all the Foundation's securities. A complete listing of investments is available for review at the Foundation offices.

Summary of Active Grants

		Balance Due January 1, 2011	**Grants Authorized During Year**	Amount Paid During Year	Balance Due December 31, 2011
AGING AND HEALTH					
ACADEMIC GERIATRICS & TRAINING					
American Academy of Nursing *Nursing Initiative Coordinating Center and Scholar Stipends Renewal* Patricia G. Archbold, DNSc, RN J. Taylor Harden, PhD, RN	Washington, DC	$8,269,331		$2,407,274	$5,862,057
American Academy of Nursing *The John A. Hartford Foundation Geropsychiatric Nursing Collaborative* Cornelia Beck, PhD, RN Kathleen C. Buckwalter, PhD, RN Lois K. Evans, PhD, RN	Washington, DC	391,858		357,818	34,040
American Association of Colleges of Nursing *Ensuring the Advanced Practice Registered Nurse Workforce is Prepared to Care for Older Adults - Phase II* Geraldine Polly Bednash, PhD, RN	Washington, DC	553,539		289,741	263,798
American Association of Colleges of Nursing *Enhancing Gerontology Content in Baccalaureate Nursing Education Programs* Geraldine Polly Bednash, PhD, RN	Washington, DC	83,112		83,112	
American College of Cardiology Foundation *Development and Dissemination of a Curriculum in Geriatric Cardiology* Susan Zieman, MD	Washington, DC	84,122			84,122
American Federation for Aging Research, Inc. *Centers of Excellence in Geriatric Medicine and Training National Program Office* Odette van der Willik	New York, NY	7,380,160		3,640,339	3,739,821
American Federation for Aging Research, Inc. *Paul B. Beeson Career Development Awards in Aging Research Partnership* Odette van der Willik	New York, NY	6,130,263		1,175,578	4,954,685
American Federation for Aging Research, Inc. *Medical Student Training in Aging Research Program Renewal* Odette van der Willik	New York, NY	527,532		187,444	340,088
American Geriatrics Society, Inc. *Geriatrics for Specialists Initiative: Increasing Geriatrics Expertise for Surgical and Related Medical Specialties* John R. Burton, MD	New York, NY	2,704,574		300,968	2,403,606
American Geriatrics Society, Inc. *Geriatrics for Specialty Residents Program* Ronnie Ann Rosenthal, MD	New York, NY	719,535		132,779	586,756

		Balance Due January 1, 2011	**Grants Authorized During Year**	Amount Paid During Year	Balance Due December 31, 2011
Arizona State University *Center of Geriatric Nursing Excellence* Colleen Keller, PhD, RN	Tempe, AZ	$ 496,184		$ 194,077	$ 302,107
Association of Directors of Geriatric Academic Programs *Geriatrics Leadership Development Initiative–Phase III* Laura Mosqueda, MD	New York, NY	641,595		252,215	389,380
Association of Directors of Geriatric Academic Programs *Chief Resident Immersion Training in the Care of Older Adults* Sharon A. Levine, MD	New York, NY	165,552		165,552	
Association of Professors of Medicine *Integrating Geriatrics into the Specialties of Internal Medicine* Kevin P. High, MD, MSc	Alexandria, VA	1,842,668		308,472	1,534,196
Baylor College of Medicine *Center of Excellence in Geriatric Medicine and Training Renewal* George E. Taffet, MD	Houston, TX	16,888		16,888	
Community College of Philadelphia *Fostering Geriatrics in Pre-licensure Nursing Education: Phase II* M. Elaine Tagliareni, EdD, RN	Philadelphia, PA	254,701		139,516	115,185
Council on Social Work Education *National Center for Gerontological Social Work Education Renewal* Julia M. Watkins, PhD	Alexandria, VA	1,025,284		512,625	512,659
Foundation for Health in Aging Inc. *Hartford Geriatrics Health Outcomes Research Scholars Renewal* Eric A. Coleman, MD, MPH	New York, NY	246,370		100,345	146,025
Gerontological Society of America *Hartford Geriatric Social Work Faculty Scholars Program and National Network* Barbara J. Berkman, DSW	Washington, DC	5,401,238		1,424,560	3,976,678
Gerontological Society of America *Hartford Doctoral Fellows in Geriatric Social Work Program Renewal* James E. Lubben, DSW, MPH	Washington, DC	2,060,898		849,579	1,211,319
Johns Hopkins University *Center of Excellence in Geriatric Medicine and Training Renewal* Samuel C. Durso, MD, MBA	Baltimore, MD	24,205		24,205	

		Balance Due January 1, 2011	**Grants Authorized During Year**	Amount Paid During Year	Balance Due December 31, 2011
New York Academy of Medicine *Hartford Partnership Program for Aging Education Adoption Initiative Continuation* Patricia J. Volland, MSW, MBA	New York, NY	$ 865,362		$ 581,632	$ 283,730
NLN Foundation for Nursing Education *Fostering Geriatrics in Pre-licensure Nursing Education: Phase II* M. Elaine Tagliareni, EdD, RN	New York, NY	169,895		95,995	73,900
Oregon Health & Science University *Center of Geriatric Nursing Excellence Renewal* Theresa A. Harvath, PhD, RN, CNS	Portland, OR	430,973		146,452	284,521
Pennsylvania State University *Center of Geriatric Nursing Excellence* Ann Kolanowski, PhD, RN	University Park, PA	358,758		129,346	229,412
Research Foundation of the City University of New York *Evaluating the Hartford Geriatric Nursing Initiative* Shoshanna Sofaer, DrPh	New York, NY	279,446		136,458	142,988
Rhode Island Hospital *Brown University Center of Excellence in Geriatric Medicine and Training* Richard W. Besdine, MD	Providence, RI	85,355		85,355	
University of Arkansas for Medical Sciences *Center of Geriatric Nursing Excellence Renewal* Claudia J. Beverly, PhD, RN	Little Rock, AR	393,925		116,613	277,312
University of California, San Francisco *Center of Geriatric Nursing Excellence Renewal* Margaret I. Wallhagen, PhD, GNP	San Francisco, CA	370,685		124,137	246,548
University of Iowa *Center of Geriatric Nursing Excellence Renewal* Janet K. Specht, PhD, RN	Iowa City, IA	411,889		168,957	242,932
University of Minnesota *Center of Geriatric Nursing Excellence* Jean F. Wyman, PhD, APRN, BC	Minneapolis, MN	461,564		160,085	301,479
University of North Carolina at Chapel Hill *Center of Excellence in Geriatric Medicine and Training Renewal* Jan Busby-Whitehead, MD	Chapel Hill, NC	37,500		37,500	
University of Pennsylvania *Center of Geriatric Nursing Excellence Renewal* Eileen M. Sullivan-Marx, PhD, CRNP	Philadelphia, PA	423,901		162,089	261,812
University of Utah *Center of Geriatric Nursing Excellence* Ginette A. Pepper, PhD, RN	Salt Lake City, UT	432,559		181,371	251,188

		Balance Due January 1, 2011	**Grants Authorized During Year**	Amount Paid During Year	Balance Due December 31, 2011
University of Wisconsin *Center of Excellence in Geriatric Medicine and Training* Sanjay Asthana, MD	Madison, WI	$ 55,283		$ 55,283	
Wake Forest University Health Sciences *Center of Excellence in Geriatric Medicine and Training* Jeff D. Williamson, MD, MHS	Winston-Salem, NC	97,702		26,016	$ 71,686
Total Academic Geriatrics & Training		$43,894,406		$14,770,376	$29,124,030
INTEGRATING & IMPROVING SERVICES					
AARP Foundation *Professional Partners Supporting Family Caregiving - Phase II* Susan C. Reinhard, PhD, RN	Washington, DC	$ 484,770		$ 207,470	$ 277,300
International Honor Society of Nursing Foundation, Inc. *Geriatric Nursing Leadership Academy Implementation* Patricia Thompson, EdD, RN	Indianapolis, IN	502,208		329,466	172,742
Johns Hopkins University *Enhancing the Quality of Medical Home Services* Bruce Leff, MD	Baltimore, MD	647,655		232,454	415,201
Johns Hopkins University *Translating Research into Practice: The Johns Hopkins Home Hospital* Bruce Leff, MD	Baltimore, MD	97,149		97,149	
Mount Sinai Medical Center, Inc. *Center to Advance Palliative Care: Advancing the Palliative Care Field* Diane E. Meier, MD	New York, NY	360,689		141,151	219,538
Oregon Health & Science University *Dissemination of Care Management Plus: Information Technology Tools for the Care of Seniors* David A. Dorr, MD, MS	Portland, OR	541,068		400,301	140,767
Paraprofessional Healthcare Institute, Inc. *Challenge Grant: Expanding PHI's Work to Improve Care for Elders* Steven L. Dawson	Bronx, NY	400,000		161,287	238,713
Paraprofessional Healthcare Institute, Inc. *The Nurse as Supervisor of Direct-Care Staff* Sara Joffe	Bronx, NY	72,000		72,000	
Partners in Care Foundation, Inc. *Preventing Medication Errors: Evidence-Based Medication Management Intervention* W. June Simmons, MSW	San Fernando, CA	87,764		87,764	

		Balance Due January 1, 2011	**Grants Authorized During Year**	Amount Paid During Year	Balance Due December 31, 2011
University of Colorado Denver *Building the Capacity to Disseminate the Care Transitions Intervention on a National Scale* Eric A. Coleman, MD, MPH	Denver, CO	$ 555,116		$ 410,040	$ 145,076
University of Colorado Denver *The Practice Change Fellows: An Interdisciplinary Leadership Program to Improve Health Care for Older Adults* Eric A. Coleman, MD, MPH	Denver, CO	189,921		189,921	
University of Washington *Improving Depression Care for Elders - IMPACT Model Dissemination* Jürgen Unützer, MD, MPH, MA	Seattle, WA	350,802		328,700	22,102
Visiting Nurse Service of New York *The Geriatric CHAMP (Curricula for Home Care Advances in Management and Practice) Program as a Framework for Geriatric Home Care Excellence Expansion* Penny Hollander Feldman, PhD	New York, NY	445,111		307,011	138,100
Total Integrating & Improving Services		$4,734,253		$2,964,714	$1,769,539
AGING & HEALTH-OTHER					
American Federation for Aging Research, Inc. *Kensington-Hartford Travel Awards in Geriatrics* Stephanie Lederman	New York, NY	$ 20,960		$ 20,960	
American Geriatrics Society, Inc. *Establishing a Geriatrics Workforce Policy Studies Center to Support Advocacy for Improved Geriatric Health Care* Nancy E. Lundebjerg, MPA	New York, NY	301,286		167,910	$ 133,376
The Foundation for the LSU Health Sciences Center *Rebuilding Geriatric Medicine and Training at Louisiana State University: A Response to the Flooding of New Orleans* Charles A. Cefalu, MD, MS	New Orleans, LA	233,805		134,410	99,395
George Washington University *Advancing Aging and Health Policy Understanding Renewal* Judith Miller Jones	Washington, DC	323,415		177,627	145,788
Grantmakers in Aging *Core Transitional Support* John Feather, PhD	Alexandria, VA		$ 140,000		140,000
Tides Center *Eldercare Workforce Alliance* Nancy E. Lundebjerg, MPA	San Francisco, CA	235,766		111,537	124,229
Total Aging & Health-Other		$1,115,232	$ 140,000	$ 612,444	$ 642,788

		Balance Due January 1, 2011	**Grants Authorized During Year**	Amount Paid During Year	Balance Due December 31, 2011
PARTNERSHIP FUND					
American Federation for Aging Research, Inc. *2011 Annual Awards Dinner* Stephanie Lederman	New York, NY		$ 8,600	$ 8,600	
Community College of Philadelphia *4th Annual Pathways Breakfast Guide Sponsorship* Elise Morgan	Philadelphia, PA		9,500	9,500	
Gerontological Society of America *2011 Annual Meeting Support* James Appleby, RPh, MPH	Washington, DC		4,300	4,300	
New York Academy of Medicine *2011 17th Annual Gala Sponsor Package* Jo Ivey Boufford, MD	New York, NY		7,000	7,000	
New York University *The John A. Hartford Foundation Doctoral Research Seminar in Geriatric Nursing* Terry T. Fulmer, PhD, RN	New York, NY	$ 25,000		25,000	
New York Womens Agenda, Inc. *2011 STAR Breakfast* Beverly Cooper Neufeld	New York, NY		600	600	
Northwest Health Foundation Fund II *Nurse Funders Collaborative* Judith Woodruff	Portland, OR		30,000	30,000	
United Hospital Fund *Annual Support* James R. Tallon, Jr.	New York, NY		2,500	2,500	
Visiting Nurse Service of New York *2011 Benefit Dinner* John Billeci	New York, NY		12,500	12,500	
Total Partnership Fund		$ 25,000	$ 75,000	$ 100,000	
OTHER GRANTS					
Center for Effective Philanthropy, Inc. *Annual Support* Phil Buchanan	Cambridge, MA		$ 1,700	$ 1,700	
The Foundation Center *Annual Support* Bradford Smith	New York, NY		10,000	10,000	
Grantmakers in Aging *Annual Support* John Feather, PhD	Alexandria, VA		7,500	7,500	
Grantmakers in Health *Annual Support* Lauren LeRoy, PhD	Washington, DC		7,500	7,500	

		Balance Due January 1, 2011	**Grants Authorized During Year**	Amount Paid During Year	Balance Due December 31, 2011
Philanthropy New York, Inc. *Annual Support* Ronna D. Brown	New York, NY		$ 16,600	$ 16,600	
The Philanthropy Roundtable *Annual Support* Adam Meyerson	Washington, DC		1,700	1,700	
Sub-Total Other Grants			**$** 45,000	$ 45,000	
Matching Grants*			1,083,335	1,083,335	
Discretionary Grants**			52,000	52,000	
Grants Refunded or Cancelled		1,254,039	(1,287,943)	(33,904)	
Discounts to Present Value		(1,922,660)	1,247,021		(675,639)
Total (All Grants)		$ 49,100,270	$1,354,413	$19,593,965	$30,860,718

**Grants made under the Foundation's program for matching charitable contributions of Trustees and staff.*

***Grants made under the Foundation's program for charitable contributions designated by staff.*

		Expenses Authorized Not Incurred Jan. 1, 2011	Projects Authorized During Year	Expenses Incurred During Year	Expenses Authorized Not Incurred Dec. 31, 2011
Foundation-Administered Grant *Communications & Dissemination Initiative Expansion Renewal* John Beilenson	New York, NY	$394,425	$1,258,800	$282,354	$1,370,871
To Pursue Selected Activities in the Strategic Plan			189,579	189,579	
Total		**$**394,425	$1,448,379	$471,933	$1,370,871

Application Procedure

The John A. Hartford Foundation's overall goal is to improve the health of older adults by creating a more skilled workforce and a better designed health care system. In order to maximize the Foundation's impact on the health and well-being of the nation's elders, grants are made in two priority areas:

Academic Geriatrics and Training

The Foundation supports efforts, on an invitational basis, in selected academic medical centers and other appropriate institutions to strengthen the geriatric training of America's physicians, nurses, and social workers.

Integrating and Improving Health-Related Services

The Foundation supports a limited number of sustainable efforts to improve and integrate the "system" of services needed by elders and the effectiveness of selected components of care. The emphasis is on nationally replicable models and is typically by invitation.

The Foundation normally makes grants to organizations in the United States that have tax-exempt status under Section 501(c)(3) of the Internal Revenue Code (and are not private foundations within the meaning of section 107(c)(1) of the code), and to state colleges and universities. The Foundation does not make grants to individuals.

Due to its narrow funding focus, the Foundation makes grants primarily by invitation. After familiarizing yourself with the Foundation's program areas and guidelines, if you feel that your project falls within this focus, you may submit a brief letter of inquiry (1-2 pages) that summarizes the purpose and activities of the grant, the qualifications of the applicant and institution, and an estimated cost and time frame for the project. The letter will be reviewed initially by members of the Foundation's staff and possibly by outside reviewers. Those submitting letters of inquiry will be notified of the results of this review in approximately six weeks and may be asked to supply additional information.

Please do not send correspondence by fax or e-mail. Mail may be sent to:

The John A. Hartford Foundation
55 East 59th Street
New York, NY 10022

Detailed information about the Foundation and its programs is available at our Web site, http://www.jhartfound.org.

This 2011 Annual Report is available as a pdf on the John A. Hartford Foundation home page at www.jhartfound.org.

RESOURCES

General

1. Information on aging-related topics, educational programs, research studies, and services for older adults, family and caregivers, professionals in aging, researchers, educators and students
The Aging Institute of University of Pittsburgh Medical Center Senior Services
www.aging.upmc.com

2. The Geriatric Mental Health Alliance of New York is dedicated to advocating for changes in mental health practice and policy that are needed to improve current mental health services for older adults and to develop an adequate response to the mental health needs of the elder boom generation. Their Web site offers many resources and publications: *http://www.mhaofnyc.org/advocacy/geriatric-mental-health-alliance-of-new-york/publications.aspx*

For older adults, their family, and caregivers

1. Mental health information from the National Institute of Mental Health (NIMH)
http://www.nimh.nih.gov/index.shtml

For researchers

1. Research conducted at NIMH and funding information
http://www.nimh.nih.gov/index.shtml

For educators and students in the health care professions

1. Videos on late-life mental health issues, funded by NIMH and created at the University of Pittsburgh Hartford Center of Excellence in Geriatric Psychiatry and the University of California, San Diego, Hartford Center of Excellence in Geriatric Psychiatry
http://www.foxlearningsystems.com/Late-Life/Education.html

2. Curriculm materials from the Geropsychiatric Nursing Collaborative Initiative
www.pogoe.org/series/Geropsychiatric-Nursing-Curriculum-Materials

For health care providers

1. Web-based teaching module, "Delirium in the Emergency Room," for physicians and nurses on identifying and treating delirium (Dr. Lalith-Kumar Solai)
https://cme.hs.pitt.edu/servlet/IteachControllerServlet?actiontotake=loadmodule&moduleid=2941

2. The Hospital Elder Life Program (HELP) is a patient-care program that is designed to prevent delirium among hospitalized older patients. It was developed by Sharon K. Inouye and colleagues at the Yale University School of Medicine.
http://www.hospitalelderlifeprogram.org/public/public-main.php

SUGGESTED READING

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