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PSYCHOLOGISTS PROPOSE INTEGRATED-CARE MODEL FOR ELDERS

"Mrs. Garcia's primary care physician may have assumed that because of her age, disability associated with her diabetes was to be expected and that interventions to increase her ability to manage her medications would be ineffective. Mrs. Ruttger's neurologist disengaged once the diagnosis of a progressive neurodegenerative disease was made, and he withdrew from the process of improving her quality of life and that of her caregivers when he determined there was 'no hope, no cure.'

"Perhaps the assumption that older people are physically and mentally frail underlies the persistent deemphasis on prevention of disability that is exacerbated by the structural and financial underpinnings of our healthcare system."

These examples of ageism by medical practitioners are quoted from *Blueprint for Change: Achieving Integrated Health Care for an Aging Population*, a report issued recently by a distinguished task force of the American Psychological Association (APA). The document will be the focus of a major symposium at APA's 116th annual convention in Boston, Aug. 14–17.

ESSENTIAL MODEL

"Developing a model of integrated healthcare is essential as the U.S. population ages, and mental health care providers can make unique and critical contributions to this paradigm," the report states. The document proposes a basic model for interdisciplinary healthcare that includes providers in a range of healthcare professions who should be represented on any eldercare team, such as physicians, psychologists, nurses, physical therapists, pharmacists and social workers.

According to the authors, "In an interdisciplinary team, no one person is designated as 'the leader,' although one person might function as an administrative coordinator." The task force explains that such teams "are characterized by shared leadership and shared power in decision making across all the professions involved in the team." The *Blueprint* adds that such teams have long been used by the U.S. Department of Veterans Affairs and in many long-term care settings or geriatric primary care sites.

"As members of an integrated healthcare team, psychologists are encouraged to offer consultation to family members, significant other close relations and to other professionals," the task force emphasizes. In particular, says the report, psychologists can contribute an understanding of aging and adult development and can clarify which clinical problems might be reversible, such as those caused by other treatments or medications. Also, they can assess mood or anxiety disorders, psychosis and suicidal symptoms, among other mental health issues, as well as address behavioral medicine issues, such as insomnia, pain or difficulties adhering to medical treatment.

The *Blueprint* specifically notes that the contributions of geropsychologists, health psychologists, neuropsychologists and others trained in behavioral medicine "will be particularly welcomed among integrated healthcare teams."

The *Blueprint* was developed as an initiative of Indiana University psychologist Sharon Stephens Brehm, APA's 2007 president. Initiative cochairs were University of Michigan psychologist Toni C. Antonucci and Antoinette M. Zeiss, of the Department of Veterans Affairs in Washington, D.C. The report outlines the challenges and benefits of building interdisciplinary teams to address the specific healthcare needs of older people, "particularly as the baby boom generation ages," the task force notes.

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AGEISM

Brehm explains in the *Blueprint* that her idea for the task force "developed from personal experiences, demographic forecasts and insights by both individuals and organizations that a piecemeal, uncoordinated approach to healthcare for older adults simply does not work."

The authors stress, "Our healthcare system is predominantly individualistic and individual provider-patient based. In a hierarchical resource-limited system, older people are disadvantaged by care [that] is not sensitive to multiple morbidities, life span experiences, fragmented care, marginalization, ageism and stigma, as well as unique characteristics, such as age, gender, class, race, religion and ethnicity."

The report presents eight principles of integrated care, starting with "Principle 1: Integrated Teams Are Sensitive to Ageism and Its Influence on Treatment Decisions." Noting that APA adopted its Resolution on Ageism in 2001 as an association policy, the task force states that "ageism—discrimination against older adults—is widespread in the United States. The statement of principle goes on, "Older adults are viewed stereotypically as (a) alike; (b) alone and lonely; (c) sick, frail and dependent; (d) depressed; (e) rigid; and (f) unable to cope."

The task force underscores that "this pervasive view portrays all older adults in a negative light and ignores the incredible heterogeneity of aging and the strengths and positive attributes of older adults. On an integrated healthcare team specifically, ageism can translate into feelings of hopelessness, the expectation of poor progress, and a lack of quality care provided by the team."

Additionally, the authors write, "Ageism underlies findings such as the underutilization of screening for bone density and cognitive and affective functioning, as well as the overestimation of late-life depression by many health providers who work with older adults. Team members themselves must be cognizant of their own ageist thoughts and beliefs and try to minimize these."

PRINCIPLES

Beside sensitivity to ageism, the Blueprint delineates seven other principles, including the need for members of interdisciplinary teams to:

- Become familiar with the roles of other team members;
- Respect differences in healthcare processes and beliefs among them;
- Be aware of and productively treat conflict among team members;
- Use conflict-resolution skills;
- Be receptive to increasingly diverse forms of communication;
- Be sensitive to issues of multicultural diversity and marginalization; and
- Understand the need to offer ongoing assessment of treatment and its outcomes.

In addition to disseminating the *Blueprint* widely, APA's Committee on Aging will develop factsheets for policymakers, graduate faculty and training directors, and older adults and their families.

APA, through its Office on Aging and Committee on Aging, will reach out to other professions to coordinate their work with APA's own efforts to promote integrated care.

The *Blueprint* is available online at *www.apa.org/pi/aging/blueprint.html*. ❖

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