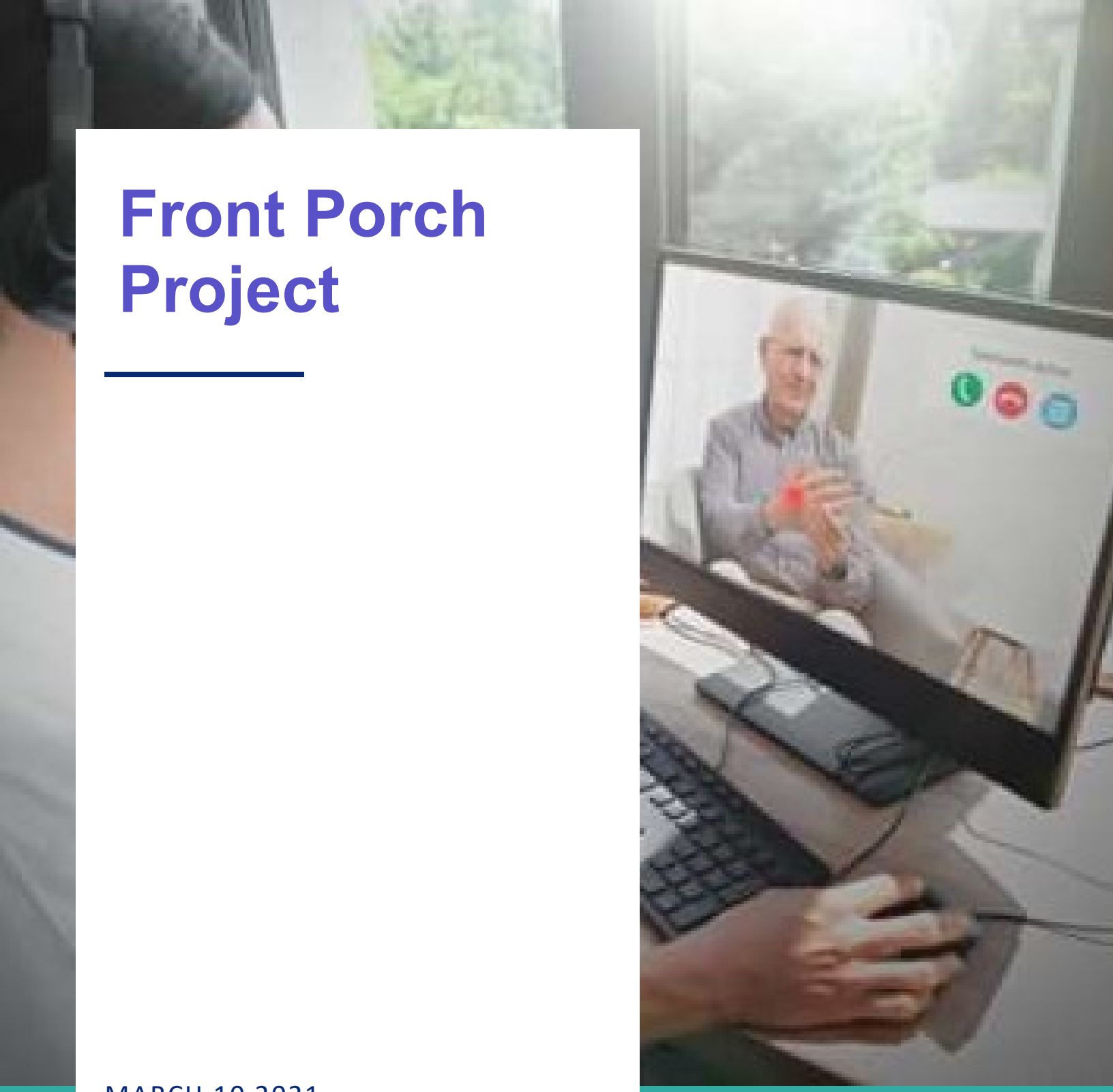

Front Porch Project

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SSG SILVER

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Front Porch Tele-Mental Health Project

Year End Report

The Front Porch tele-mental health project is a mental wellness program designed to provide mental wellness service to seniors residing in independent living communities. Many seniors have limited access to needed behavioral health services or low utilization rates for traditional mental health services due to mobility challenges, stigma, and accessibility of culturally and linguistically appropriate services. The purpose of the project is to demonstrate the effectiveness of video conferencing and tele-mental health services ("virtual counseling sessions") as a strategy for addressing the mental health needs of underserved older adults by addressing the barriers related to accessibility and privacy. Tele-mental health is an emerging strategy that has shown promise in recent years in addressing these barriers albeit older adults may require additional technical assistance to navigate this tool. Through this project, SSG SILVER and Front Porch strive to explore the usage of technology to empower older adults to live well, especially in their later years. We believe that this project will be the cornerstone for future mental health services in terms of its boundless utilization of mental health services to promote the mental wellness of the elderly.

SSG SILVER has collaborated with Front Porch to provided tele-mental health services to Front Porch Communities since 2014. Due to the onset of COVID-19 pandemic, this service delivery model was shifted to primarily telephonic from tele-mental health format to ensure appropriate social distancing and ultimately the health and safety of staff and residents. The coordinators from both Front Porch communities and the SSG SILVER team have worked closely to connect residents to the services and to ensure the quality of care. SSG team's bilingual therapists provided services in various languages including in English, Spanish, and various API languages (Mandarin, Cantonese, Tagalog, and Korean). Aside from language, the clinical team strived to provide culturally appropriate services including addressing culturally specific concerns and stigma related to the utilization of behavioral health services. The following report was created by the SSG team to document the progress of this project at the end of the project year.

"The project contributes explored innovative uses of technology to empower individuals to live well, especially in their later years."

Total number of clients served and hours of service provided

By the completion of the project year, a total of 24 residents were referred by Front Porch community resident coordinators for behavioral health services. Of those referred, more than 60 percent of the residents participated in the program (15 residents) and a total of 115 sessions were provided. Compared to previous years, residents demonstrated a higher level of service participation over a longer period of time with 62.25% of residents completing more than 3 sessions.

Among the 15 residents who participated in ongoing sessions, 5 received services in a language other than English (i.e., Mandarin, Cantonese, and Spanish). As a result of the in-language support received by the residents, the residents became more aware of their behavioral health needs and the availability of in-language behavioral health services. Further, it was identified that three of the five residents was suffering from behavioral health symptoms that required higher level of care. Therefore, they were connected to in-language behavioral health services via SSG SILVERs DMH contracted programs.

	Total Number of Referrals	Total Number of Session Completed
Lutheran Tower Total	17	89 sessions
Emmerson Village Total	2	13 sessions
Good Shepherd Total	5	13 sessions
Total	24	115 sessions

Pre- and Post-Survey Data

To assess the effectiveness of the intervention, the PHQ-9 was selected as a pre-and post-evaluation tool at the onset of the program. However, when the service model was modified and services began to be delivered primarily via the telephone, it became evident that administering this tool would be difficult. Residents expressed difficulty following the survey questions citing difficulty hearing and or challenging with following the instructions for the survey. Among all 25 referrals, only two residents were able to finish their pre PHQ 9 screen with clinicians by telephonic directions. Numerous residents requested the stop of the PHQ 9 screen or refused the screen complaining about their frustration. Also, many cases were closed because the resident stopped responding to clinician's calls, which contributes that clinicians did not have the opportunity of performing post-survey.

In terms of the communication limitation via telehealth method for older adults, it is suggested that the pre-survey (PHQ 9) could be a part of the intake procedure performed by the resident coordinators to get better data analysis through the interactive administration of the survey. Also, the clinicians must be responsible to perform the post-survey by tele-session or coordinate the survey with resident coordinators regardless of how many sessions they've provided.

Analysis of Cost Savings

Tele-mental health service has started with the expectation that it could bring a variety of cost savings from receiving services where you are without travel to receive mental health services. Of course, it is an excellent service for older adults who have a limitation of physical conditions and travel limitations, but it was a great opportunity to reduce the cost of the resident and/or the service providers.

The two of three front porch communities are located far from the metro LA area where the most mental health services are clustered. In terms of travel distance and the cost of travel, a round trip to Lutheran Tower is about 55 miles. A roundtrip to Emmerson Village in Pomona is about 70 miles. It costs $ 31.63 per visit for Lutheran Tower; $40.25 per visit for Emmerson Village. It takes relatively little time to travel to Good Shepherd about 15 miles from the clinic and costs $8.63 per round trip since the apartment is located in south LA. Travel cost is calculated by applying the average mileage cost in California in 2021 ($0.575 per mile).

Regarding total travel times for the project, a total of 13756 min or 229 hrs of travel time to communities are saved. It was calculated actual travel times to the communities through Google Maps during the work hours. There were three options for travel and chose the middle number among three for both miles and travel time. The longer the distance, the more cost savings appear to be. Please refer to the table below. Also, there is the date of the cost savings per community (Appendix 1, 2, and 3) and total savings (Appendix 4) are presented at the back of this report for your reference.

	Travel Times Saved	Travel Miles Saved	Saved Mileage Expense
Lutheran Tower	10324 min	4675 miles	$2,688.13
Emmerson Village	1924 min	630 miles	$523.25
Good Shepherd	1508 min	195 miles	$112.13
Total	13756 min (appx. 229 hrs.)	5360 miles	$3,323.51

Anecdotal data on the impact of services

Residents with high adherence to the tele-mental health service have expressed their satisfaction for the service through the service compliance and maintain the motivation of the service. A few testimonies of successful service have been presented in the half-year report. Once again, It is important to present the cases here to demonstrate the impact of services is and to present the direction of the future project.

The first case is a resident who was experiencing difficulty with the end-of-life of her care recipient, who she has cared for many years. She experienced difficulty coping with the loss of a loved one as well as facing the challenges of the pandemic. Through the program, she was able to receive supportive counseling to help her address her symptoms of depression and anxiety. In addition, she

gained support to help her navigate and address her own health needs. The resident was also able to examine her relationship with her estranged mother who lived far away. Through counseling, the resident reconnected with her mother and was able to discuss end of life issues that, without guidance, would have been a challenging conversation to have. At the end of her participation, she was referred for follow up care via a DMH contracted agency.

Next, is a resident who was referred to the project with a pre-existing mental health diagnoses. The resident was evaluated by a psychiatrist and was under medication treatment. This resident was not eligible for the project because of the severity of her mental health diagnosis. The team discussed the possible risk for providing telehealth service for the resident in-depth. It was decided to accept her as a part of an engagement to refer to one of the potential DMH mental health programs because the team learned the resident and her family have never found about the existence of consistent mental health service in their native languages. She was monolingual Chinese and needed to receive psychiatric support, but had no resources for mental health services in her area. During the project, the resident was open to mental health services and had reduced a significant amount of stigma regarding the mental health service. This positive outcome occurs after a few sessions she engaged in. SSG team made a referral this resident to field-based DMH mental health service, including clinician's visit, for her continuous treatment in her native language.

These two examples have shown the possibility of getting closer to emotional wellness services through exposure to mental health services throughout the project. Also, It is reminded that residents learned that the benefits of receiving mental health services through the project are greater than the stigma of mental health services.

Challenges of the Service

At the beginning of the COVID-19 Pandemic, Front Porch telehealth service was modified to primarily telephonic services to ensure proper social distancing and thus the overall health and safety of staff and residents. In some ways, this change made it much more accessible as it was directly connected to residents without the setup process of the telehealth device, but in other ways, more effort or multiple attempts of clinicians was required to connect with the residents. It is learned that the coordination from both Front Porch and the SSG team is very important to prevent that residents lose their motivation to receive telehealth services. Also, clinicians promptly need to respond to the referral and any difficulty to make appointments with residents. Then, both side coordinators could figure it out as soon as possible to make residents on the board without losing them. Closer support for the appointment coordination by resident coordinators is essential to deliver the appropriate service on time without the loss of the clinician's time. Many residents did not answer the calls and the voice messages made by clinicians. Clinician's multiple attempts (approximate 3-4 times) were necessary to make the first appointment. Residents were not able to respond even after names and numbers of clinicians were provided in voice messages. It could be their difficulties to follow up with voice messages. If a resident was not able to pick up multiple calls, the hearing issues of residents also seem to have contributed to this.

In addition, as reported previously in the mid-year report, some residents applied for telehealth service without a proper understanding of the program. Residents did not always understand the difference between a friendly caller and therapeutic services. Some did not recognize that they were speaking to trained clinicians but rather believed they were receiving informal check–in or friendly calls. It should be determined how to overcome the limitation of understanding wellness counseling services on residents. Residents required additional education on the purpose and benefits of the telehealth sessions during the initial calls. Many did not fully understand the services that they had enrolled in. Then some residents declined the service at the first contact.

As above, through the things we have learned while working on the project over the past year, the telemental health project will be able to develop in a direction that can benefit more and more residents if the team closely communicates with one another (resident coordinator, program coordinator, and clinicians).

Conclusion

The Front porch project has contributed to the exploration of innovative uses of technology to empower elderly individuals to live well with the emotional support that they need. This project will be the innovative foundation for future telemental health services In that individuals can receive the same quality of mental health service beyond the various limitations of the elderly.

For this project year, the front porch telehealth service, which was originally intended to be provided by using a telehealth device was changed into a telephone counseling service due to the COVID 19 pandemic and has been finished for a year successfully. It contribute to the shorter process of making an appointment for residents, but clinicians were forced to receive less helps or support with making appointments from coordinators since resident coordinators were allowed to visit residents on a very limited basis. Nevertheless, the project showed positive results. It has been a support for participated residents to overcome without being isolated in the limited social interactions caused by the pandemic. The achievements shown by the data above illustrate these well. With these achievements, we believe that the front porch service model can be developed and used in the future to give more service wellness service or mental health service opportunities to the elderly population who has many challenging restrictions for the service.

Appendix 1

	ID	Number of Session Completed	MHS Expense	Travel Miles Saved (55 miles per R trip)	Saved Mileage Expense	Travel Time Saved (116 min per R trip)
Lutheran Tower	1	4	$ 595.20	220.00	$126.50	464
	2	1	$ 148.80	55.00	$31.63	116
	3	1	$ 148.80	55.00	$31.63	116
	4	17	$ 2,529.60	935.00	$537.63	1972
	5	4	$ 595.20	220.00	$126.50	464
	6	1	$ 48.80	55.00	$31.63	116
	7	13	$ 1,934.40	715.00	$411.13	1508
	8	4	$ 595.20	220.00	$126.50	464
	9	20	$ 2,976.00	1100.00	$632.50	2320
	10	5	$ 744.00	275.00	$158.13	580
	11	3	$ 446.40	165.00	$94.88	348
	12	1	$ 148.80	55.00	$31.63	116
	13	1	$ 148.80	55.00	$31.63	116
	14	6	$ 892.80	330.00	$189.75	696
	15	1	$ 148.80	55.00	$31.63	116
	16	2	$ 297.60	110.00	$63.25	232
	17	5	$ 744.00	275.00	$158.13	580
Total		89	$ 13,243.20	4895.00 miles	$2,814.63	10324 min

Appendix 2

	ID	Number of Session Completed	MHS expense	Travel Miles Saved (70 mile per R trip)	Saved Mileage Expense	Travel Time Saved (148 min per R trip)
Emmerson Village	1	3	$ 446.40	210.00	$120.75	444
	2	10	$ 1,488.00	700.00	$402.50	1480
Total		13	$ 1,934.40	910.00 miles	$523.25	1924 min

Appendix 3

	ID	Number of Session Completed	MHS Expense	Travel Miles Saved (15 mile per R trip)	Saved Mileage Expense	Travel Time Saved (48min per R trip)
Good Shepherd	1	2	$ 297.60	30.00	$17.25	232
	2	3	$ 446.40	45.00	$25.88	348
	3	6	$ 892.80	90.00	$51.75	696
	4	1	$ 148.80	15.00	$8.63	116
	5	1	$ 148.80	15.00	$8.63	116
Total		13	$ 1,934.40	195.00 miles	$112.13	1508 min

Appendix 4

	Number of Referrals	Number of Session Completed	MHS Expense	Travel Distance Saved	Saved Mileage Expense	Travel Time Saved
Lutheran Tower	17	89 sessions	$13,243.00	4675 miles	$2,688.13	10324 min
Emmerson Village	2	13 sessions	$ 1,934.40	630 miles	$523.25	1924 min
Good Shepherd	5	13 sessions	$ 1,934.40	195 miles	$112.13	1508 min
Total	24	115 sessions	$17,111.80	5360 miles	$3,323.51	13756 min (229 hrs.)

Appendix 5

	Total Referrals (cases)	**Declined at the first contact**	**More than 3 times Support received**	**Successful Higher Level MH referrals**	**Bi-lingual services**
Lutheran Tower	17	6	10	2	3 / Spanish & Cantonese
Emmerson Village	2	0	2	1	1 / Mandarin
Good Shepheard	5	2	3	0	1/ Spanish
Total	**24**	**8**	**15**	**3**	**5**