Behavioral Health Initiative for Older Adults and People with Disabilities
Systems Changes Needed to Improve Consumer Outcomes: Recommendations for Policy Makers

The following recommendations were developed by the Portland State University Institute on Aging based on our analyses of the evaluation data (i.e., stakeholder surveys, Behavioral Health Specialists' quarterly reports, training evaluations, complex case consultation reports, recommendation survey for Behavioral Health Specialists), with the aim of improving outcomes for older adults and people with physical disabilities.

1. **Keep the focus on meeting consumers' needs and achieving consumer outcomes:**
   Older adults and people with physical disabilities who have behavioral health needs are recognized as a priority population and they:

   Have greater access to services
   - Have timely access to a full range of services
   - Have access to effective behavioral health programs/services
   - Receive services from providers who are knowledgeable and skilled in BH

   Are more knowledgeable
   - Are more likely to seek advice, help to better understand their symptoms
   - Have information about behavioral health promotion

   Receive appropriate support
   - Have their signs and symptoms recognized as behavioral health needs
   - Are less likely to experience eviction
   - Have reduced lengths of stay in hospitals or emergency departments
   - Experience successful resolution

2. **Change policies that encourage siloed thinking and practice.** One indicator of the need for this change is the significantly worsened score for the item, "Old resentments between agencies get in the way of progress" in the stakeholder survey data. The following actions address needed policy and practice changes to reduce siloing at the state and local levels.

   <u>State-level policy and practice change with local input</u>:

   a. **Make meaningful changes in how services for people with complex needs are conceptualized, funded, and implemented**. Many of the consumers who are the focus of the BHI have complex health, behavioral health, and ADL needs that cannot be met by any one agency, let alone one discipline. Therefore:
      i. **Develop an integrated interagency response** that can be initiated by any of the participating agencies to ensure that consumer needs determine services received.
      ii. **Use "braided" or "global" funding strategies** so that each agency (e.g., OHA, CCOs, APD, other agencies) contributes a portion of funds to support the needed array of services.
      iii. **Promote and employ an interdisciplinary team approach** to supporting older adults and people with disabilities who have a behavioral health condition.
      iv. Develop mechanisms so that participating agencies can **provide the in-home services** needed by many older adults and people with disabilities.
      v. **Design and conduct pilot programs** using these approaches, possibly through the use of waivers. Examples: Support MH beds in APD facilities; allow and support ADL care in MH residential care settings.
      vi. **Encourage needed changes in Medicare** by charging the BHI Advisory Council to work with our federal congressional team and statewide legislative advocacy groups to obtain needed increases in reimbursement rates and expansion of the list of credentialed providers permitted to claim reimbursement.

b. **Promote interagency efforts to support consumers** by developing models of interagency agreements and memoranda of understanding for (a) establishing a common understanding of HIPAA and shared language and processes for collective assessment and help for consumers with multiple and complex needs and (b) training staff in implementing agreements.
c. **Include representatives from the BHI**, including Behavioral Health Specialists and key stakeholders, **in statewide conversations to address issues related to housing, integrated services, and transportation** to ensure that the unique needs of older adults and people with disabilities who have BH needs are met.

Local policy and practice change with support from state agencies:

d. **Prioritize bridge building** in local communities to help agency/organization leaders and staff understand each other's services, resources, and challenges. The following approaches have demonstrated success in many local communities:
   i. Increased emphasis on face-to-face meetings (e.g., stakeholder planning meetings; complex case consultation; cross-agency training) that help each provider understand the others' systems, including services offered and eligibility requirements. *Keep the focus on meeting the needs of consumers.*
   ii. Increased emphasis on building personal relationships. Several Specialists already spend dedicated time in several different agencies. Agencies could also designate staff to serve as liaisons to the BHI.

3. **Strengthen the infrastructure** of the Behavioral Health Initiative for older adults and people with disabilities. To assure continued growth and development of BHI programs and to recruit and retain qualified staff:

   a. **Change the formula for assigning Specialists** from one focused on population (e.g., 30,000 older adults for each Specialist) to one that emphasizes geographical area, as well. More FTE is needed in rural communities, especially in frontier counties, where the proportion of older adults exceeds the state average and rates of suicide are high. The current formula results in dramatically fewer services available per capita in rural areas because of travel time and the multiple communities covered. FTE for specialists should be added and not transferred from more urban areas.

   b. **Provide FTE for part-time administrative support to assist Specialists** in activities such as meeting preparation (e.g., arranging space, follow-up with participants) and training (e.g., correspondence with speakers, finding venues, publicity).

   c. **Make Specialists' positions permanent**, which will contribute to the recruitment and retention of Specialists and encourage long-range planning and engagement with stakeholders.

   d. **Provide additional resources to support the development of materials** for training, marketing (including public awareness campaigns), orientation, and community development.

4. **Continue to develop a knowledgeable, informed workforce on consumer issues** through training that:
   a. Is focused on the needs of underserved populations and best practices for meeting those needs
   b. Promotes the integration of health, APD and BH services
   c. Leads to continued engagement of participants in the Initiative (e.g., training that leads to providers willing to accept Medicare reimbursement and participate in complex case consultations, training, and other collaborative efforts).
   d. Is mandated by individual agencies (with encouragement from State agencies) for their staff, including community-based long-term services, long-term care, behavioral health organizations, and health care clinics.

5. **Promote the value of good behavioral health practices and planning to the general public** (e.g., educate the public about the importance of social connections and the need for proactive planning for these in retirement and when declines in health and abilities are being experienced).