Older Adult Behavioral Health Investment Initiative

BUILDING PARTNERSHIPS FOR
OLDER ADULT BEHAVIORAL HEALTH

Final Report prepared by Portland State University Institute on Aging

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Diana White, PhD
Project Director

Linda Dreyer, MSW, MPH, Co-Project Director, shared her knowledge and experience with multiple large-scale cross-agency collaborative endeavors. In this project, she led activities related to community capacity building, including developing tools and planning the learning sessions. Linda also supervised graduate students working on community capacity activities and those developing the community awareness training modules. Linda was critical in developing the Companion Guides and reviewed and edited almost everything. She also assumed an OABHS interviewer role when Alan DeLaTorre left the project.

Natasha Spoden, MS, Project Manager, was absolutely the perfect person to manage the disparate parts and massive details that comprised this effort. She organized meetings and training events, was an excellent communicator and problem solver, and generally kept the project on track. Natasha became the main contact person for the Older Adult Behavioral Health Specialists (OABHS) throughout most of the Project, and was greatly appreciated by them. Natasha also managed all of the technical arrangements for production of training videos, from finding actors, to scheduling filming and narration, to final editing, pressing DVDs, and getting them posted onto You Tube. She probably committed all materials to memory as she reviewed them to assure no mistakes remained.

Litxia Barnett, Candace Lewis-Laietmark, and Lu Pang, graduate research assistants, all assisted in gathering resources for the *Participant Companion Guides* at the beginning of the project. They worked on the community awareness modules and helped assemble materials for the training and learning sessions, where they also provided staff support. All have now completed their MPH degrees and carry with them expertise and appreciation for issues facing older adults with behavioral health needs.

Alan DeLaTorre, PhD, participated in community capacity building activities, especially contributing to development of the county profiles. With Julie Reynolds, he conducted interviews with OABHS following each of the training and learning sessions. At training sessions, Alan was the go-to IT person. He led sessions, including the popular exploration of "sensory kits." He provided much of the technical assistance to OABHS between sessions.

Sheryl Elliott, MUS, was the lead in developing the *Participant Companion Guides*. These guides were used to supplement the videos and PowerPoint slides for modules designed for aging services and behavioral services providers. The *Participant Companion Guides* resource information from credible sources and included links to fact sheets, prevalence data, prevention, evidence-based assessment and screening tools, evidence-based treatment and practice, and materials for the general public including

brochures and pamphlets. Early in the process, she supervised graduate students who helped to locate resources for these guides.

LeAnne Fettig is the administrative coordinator for the Institute on Aging. She kept us in supplies, kept our spirits up, and has managed the website.

Serena Hasworth, BS, undergraduate and graduate research assistant, was critical to the successful completion of the needs assessment that launched this project. She scheduled and assigned interviews, conducted interviews, and participated in group discussions to analyze findings. After moving on to other projects, she returned at the end of the project to support the team's final meeting to review and analyze OABHS feedback and lessons learned from the project. She kept notes and asked clarifying questions, and provided a summary of the discussion.

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Aubrey Limburg, BA, did whatever we asked quickly and well with good humor, from assembling training materials and staffing training sessions, to formatting documents and fixing PowerPoint slides, to finding visual images we could use without infringing on copyright. Aubrey also provided staff support at all training and learning sessions.

Julie Reynolds, PhD was our resident expert on rural issues, having lived and worked in rural communities throughout her life. We relied on her insight and experience. Julie conducted the evaluation of each of the learning and training session. She also interviewed OABHS following each of our scheduled training events to obtain feedback and learn how they were applying the content. She took the lead in developing the module focused on behavioral health and advance care planning.

Megan Rushkin, MPH, began her work with the project as a graduate research assistance working on the community capacity building activities. Working with Linda and Alan, she produced county profiles for all of the areas served by the OABHS. Following graduation, we were pleased to have Megan join the team to continue work on community capacity building activities, provide technical assistance, and send materials to OABHS via email and zip drive as they were completed. Megan also managed the online survey of OABHS and picked up many of the project management duties after Natasha left the project.

Kristen Swafford, PhD, RN, CNS, joined the team in July 2015 and was the lead developer for the modules designed for the primary care audience. Kristen's wealth of experience and knowledge were critical to the successful completion of this vital component of our work. We all benefit from her deep commitment to care and support of older adults and her faith in the ability of OABHS and primary care providers to work together on behalf of older adults.

Older Adult Behavioral Health Investment Initiative
August 2014 – March 2016
Final Report prepared by Portland State University Institute on Aging

Introduction

This report describes the development and implementation of the Older Adult Behavioral Health Initiative focusing on the work of Portland State University (PSU) Institute on Aging. In July 2014, the Oregon Health Authority contracted with PSU to conduct a needs assessment and report findings to the Mental Health Budget Note Committee. Subsequently, PSU was charged with developing a training program and preparing a new cadre of workers, Older Adult Behavioral Health Specialists (OABHS), to build capacity in communities throughout Oregon to address unmet needs. "Behavioral health" the term used in this initiative, includes definitions and services related to both mental health and addictions and substance misuse.

This report briefly summarizes the Budget Note report[1] and details PSU's activities related to training and development of the OAHBS role. The final segment includes lessons learned and recommendations for continued evaluation and development of the initiative. The summary of this report is presented in Appendix A.

Budget Note Report:
State of Older Adult Behavioral Health Services, 2014

In July 2014, PSU was asked to conduct a needs assessment and prepare a report for the Senior Mental Health Budget Note Committee. Our charge was to identify:

- the scope of the problem meeting the mental health needs of older adults in Oregon
- how coordination of services currently works
- gaps in services
- solutions for addressing gaps (with an emphasis on the role of a "Senior Mental Health Specialist")
- rural and urban differences
- overall recommendations

[1] White, D., Dreyer, L., Reynolds, J., Scannell, A., & Worthington, S. (August, 2014). *Senior Mental Health Investment.* Portland State University Institute on Aging. https://www.pdx.edu/ioa/sites/www.pdx.edu.ioa/files/Senior%20Mental%20Health%20Report%208-15-15%20%281%29%20%283%29.pdf

As described in the budget note report, 35 stakeholders representing aging services, mental health services, health services, advocacy organizations, and quality improvement were interviewed. Participants included those with a statewide focus, as well as those with a local agency or community focus. Rural areas of the state were represented among those interviewed. Findings highlighted several problems, including:

- *Fragmented Systems. A*gencies work in silos with different funding priorities, eligibility requirements, and knowledge base.
- *Mental/behavioral health needs of older adults <u>are not a priority</u>* in any agency; existing services are not tailored to the population
- *Knowledge gaps are pervasive* about aging, available community resources, best practices, and mental/behavioral health
- *Resources and funding are limited.* The question of who pays for services is often not known and is contentious among those seeking to provide or obtain services.

Several recommendations emerged from the interviews. The key recommendation was to establish a cadre of Senior Mental Health Behavioral Specialists (now called "Older Adult Behavioral Health Specialists"). The role of the OABHS that has emerged over the past 18 months is consistent with the recommendations. The role has been further delineated into three major job functions: Coordination, training, and complex consultation. Below are the key stakeholder recommendations grouped by the job functions.

<u>Coordination</u>

- Build partnerships and bridge gaps between service sectors
- Coordinate and leverage resources
- Address behavioral health needs in both urban and rural communities

<u>Training</u>

- Develop preventive care services and outreach for early diagnosis and intervention
- Provide sustained, cross training in aging and behavioral health at all levels and all systems
- Identify successful treatment models to address multiple mental health needs.

<u>Complex Case Consultation</u>

- Provide oversight and/or consultation on complex cases
- Promote independence, dignity, and choice while balancing issues of risk and safety

The stakeholders interviewed for the budget note report stressed the importance of the coordination and training job functions of the OABHS. Stakeholders did not want the OABHS to provide direct clinical services because they felt it would be impossible to both carry a case load and do the important work of building new systems and greater expertise within communities. Sharing expertise within the community through complex case consultation was viewed as an appropriate role alternative.

Recommendations also stressed the need for an infusion of resources and a high level of commitment to this initiative, especially in support of the OABHS. The committee recommended 2 dedicated staff at the state level (one in OHA and one in APD) who could model and support bridging services gaps. The Advisory Committee also recommended that the OABHS be housed in Aging and Disability Resource Connection (ADRC) offices.

Outcomes. The Oregon State Legislature funded the Older Adult Behavioral Health Investment initiative. Nirmala Dahr was named the statewide coordinator within the Oregon Health Authority. A similar position was not created within APD to maximize the number of OABHS in the field. Positions were created for 24 OABHS who are located in communities throughout Oregon. Contractors for the OABHS program are evenly divided between non-profit organizations and county government agencies. The positions were distributed according to population. OABHS serve between one country (n=15) and six or seven counties (n=2). Several of the OABHS work out of behavioral health clinics and have work spaces within aging services agencies.

The first 12 OABHS were hired between May and July 2105 with an additional 9 between July and October 2015. As of March 2016, 23 of the 24 positions were filled (one person resigned in December 2015 to take another position). Most OABHS have graduate degrees in social work or psychology (or related fields). Most have extensive clinical experience in behavioral health; three had extensive experience working in aging services. Few had experience with community capacity building or large systems change. See Appendix B for more detailed descriptions of the OABHS.

PSU was awarded a contract in October 2015 to develop a training program to support the mission of the OABHS. First, PSU developed a training program that OABHS could use in their communities to meet the training goals of the project. Based on budget note recommendations, the training program had three distinct audiences: 1) behavioral health and aging services providers, 2) primary care providers, 3) the general public. Second, PSU developed a series of learning sessions for the OABHS to enhance their abilities to address community capacity building activities related to coordination and complex case coordination.

OABHS were interviewed or surveyed after each learning session to identify how implementation was going, their successes and ongoing needs, and how the learning sessions could be improved. In February, OABHS were invited to participate in an anonymous online survey. Questions asked specifically about OABHS evaluation of the training, materials, and technical assistance provided by PSU.

The remainder of this report focuses on the accomplishments related to the work of PSU in partnership with the OABH initiative incorporating feedback from phone interviews and the online survey. We begin with an account of community capacity building activities followed by a description of the training program.

Older Adult Behavioral Health Specialists Roles

Community Capacity Building

Community capacity building is defined as *the ability of community partners to make a difference over time and across different issues.* The budget note workgroup assumed that the OABHS would play a major role in engaging their local partners in the process of identifying gaps in services, potential solutions and system improvement efforts. Such efforts are required to optimize coordination of services.

Using the recommendations from the budget note report, PSU developed a conceptual framework to guide capacity building in OABHS communities (see Figure 1). Although the OABHS had solid clinical skills related to behavioral health and aging, fewer had experience with community development work needed to build capacity. To provide support to the OABHS, PSU developed resource materials and offered three learning sessions focused on different aspects of capacity building.

Figure 1: Community Capacity Building Model

Learning Session 1. Identifying Gaps in Services

This learning session was presented in June 2015. The conceptual framework was introduced as well as three tools the OABHS could use to identify gaps in services and to begin working with stakeholders in their communities to determine how best to address the gaps. The first tool was a set of profiles for each county or cluster of counties served by an OABHS. County Health Rankings & Roadmaps data were used as the primary source. The profiles illustrated the prevalence of various mental health conditions or disorders among older adults in a given geographical area compared to the rest of the state. OABHS used them in interactions with community partners to build awareness of the need for improved behavioral health services. They could also be used to monitor changes in prevalence over time as the national county health ranking data are updated. All of the profiles are available on the PSU website, https://www.pdx.edu/ioa/oregon-county-profiles-of-older-adult-behavioral-health-specialist-service-areas.

As of February 2016, all of the 15 OABHS who responded to this question in the online survey reported using their county profiles when working with community partners. Most (12) indicated they would continue to use them and over half reported the profiles had been helpful or very helpful in building community capacity.

The second tool was a stakeholder interview guide to assist specialists in the initial steps to get acquainted with individual community partners and to learn from them about what older adult services and supports existed. The one-on-one interviews provided an opportunity for community partners to talk frankly about gaps in services, and barriers and opportunities for coordination. OAHBS were encouraged to talk with as many partners as possible and look for common themes. The intent was for OABHS to summarize and present the themes in a community-wide meeting. Partners would then be able to use this information to prioritize and develop a community-wide approach to addressing the most important gaps or problem areas. The stakeholder interview guide can be found Appendix C.

The online survey indicates this tool was used widely. Of the 15 OABHS who responded to questions about the interview guide, all indicated they used it as is or with some modifications. Eleven found it helpful or very helpful and nine will continue to use it.

The third tool was a community capacity assessment form. This tool parallels the conceptual framework and was developed to help OABHS and stakeholders track progress over time. It contains six questions specific to each domain in the conceptual framework. The response scale ranges from 1 to 12, with four anchor points. These are: *we haven't started yet, we could do more, we have a good start,* and *we're doing this well.*

We suggested that OABHS ask community partners to complete the assessment after they presented their summary of the community partner interviews at a community partner meeting and that they repeat the assessment at regular intervals after that.

To demonstrate its use, we asked the OABHS who attended the learning session to complete the assessment for their communities and asked them to complete it again at the last learning session six months later. Recall that only a minority of OABHS had been hired at the time of the first learning session. Results indicated progress in all six domains (see Figure 2)

Figure 2: Community Capacity Assessment Form

△ = Learning Session 1 ○ = Learning Session 3

Older Adult Behavioral Health Community Capacity Assessment – June 23-December 1, 2015

Questions to Consider	We haven't started yet	We could do more of this	We have a good start on this	We're doing this well	Notes/comments
1. Are stakeholders from local organizations working effectively together to improve coordination of services?	1 2 3	4△ 5 6○	7 8 9	10 11 12	LS1 average score: 4.29 LS3 average score: 6.29 **Difference: 2.00**
2. Are you including the needs, preferences and opinions of consumers, family members and advocacy groups in planning and delivering services?	1 2△3	4 5 6○	7 8 9	10 11 12	LS1 average score: 2.57 LS3 average score: 6.12 **Difference: 3.55**
3. Are you using a systematic process to identify gaps in services or problem areas and address them?	1 2△3	4 5 6	7○ 8 9	10 11 12	LS1 average score: 2.7 LS3 average score: 7.22 **Difference: 4.52**
4. Are gaps in services or problem areas being addressed with evidence-based programs?	1 2△3	4 5 6○	7 8 9	10 11 12	LS1 average score: 2.5 LS3 average score: 6 **Difference: 3.50**
5. Are direct service staff increasing their knowledge levels about older adults with behavioral health disorders or conditions?	1 2△ 3	4 5 6○	7 8 9	10 11 12	LS1 average score: 2.24 LS3 average score: 6.26 **Difference: 4.02**
6. Are direct service staff using "best practices" to screen, assess and treat older adults with behavioral health disorders or conditions?	1 2△ 3	4 5 6○	7 8 9	10 11 12	LS1 average score: 2.18 LS3 score: 5.96 **Difference: 3.78**

Fourteen of the OABHS reported using the assessment tool. Some used it as part of their stakeholder interview process. Others used them at community meetings. About half found it helpful or very helpful in building capacity and the same number plan to use it in the future or use it regularly. PSU provided technical assistance to the OABHS who used the assessment tool by tallying and reporting overall scores. We anticipate that this tool will become more useful as the OABH initiative develops and more attention is given to collecting evidence of its success.

Learning session 1 evaluation. Participants attending Learning Session 1 indicated that the learning objectives had been met. One a scale of 1=strongly disagree and 4=strongly disagree, scores ranged from 3.08 to 3.32. Using the same rating scale, scores were also positive with respect to organization (2.48), knowledge of presenters (3.64), and the facility (2.44).

Learning Session 2. Building Collaborative Relationships

This session was intended to guide the OABHS from gathering information about existing resources and gaps in services to more active involvement in developing collaborative relationships to address these gaps. First, OABHS shared what they had learned from their community partner interviews. PSU offered tools for supporting formal or semi-formal agreements for working together, including data sharing agreement and a participation agreements forms.

Guest speakers gave presentations on building collaborative relationships. Maureen Nash, MD, MS, FAPAA, presented strategies for engaging primary care providers in this work. Dr. Nash is Medical Director of Providence ElderPlace, serves on the Advisory Committee for the OABH Initiative, and participated in the development of the training program. Laurel Singer, MS, LPC, Director of the National Policy Consensus Center at PSU presented on improving coordination of services among stakeholder agencies through facilitation. Finally, a panel of experts talked about different levels of primary prevention. They provided information on falls, chronic illness self-management, Aging & Disability Resource Connections mental health programs, and the Assertive Community Treatment program.

Learning session 2 evaluation. Results of the evaluation were similar to Learning Session 1, though ratings of meeting session objectives were somewhat lower (range 2.9 – 3.4). Organization of the training, knowledge of presenters, and the facility were all rated at 3.5, using the same 4-point rating scale used previously, indicating overall improvement in the organization and delivery of the learning session.

Learning Session 3. Collaboration and Capacity

This final learning session continued to build on the previous sessions. Ms. Singer provided more guidance on building collaborative partnerships. Kristen Swafford, PhD, RN, continued the discussion about building collaborative relationships with primary care providers. As described below, Dr. Swafford developed training materials and resources to assist OABHS in their training roles with primary care providers. After these sessions, PSU staff stressed the role of data and evaluation to track progress toward capacity building and generally meeting the goals of the initiative. OABHS generated items that could be used in future evaluation when they were asked to describe “what success will look like” for each of the six domains in the conceptual framework. The day ended with a panel of individuals who had been involved with the development of the initiative through state and local agencies, and advocacy groups. They each described their vision of success.

Learning session 3 evaluation. The range of scores related to meeting learning session objectives ranged from 3.1 – 3.5, somewhat higher than in previous sessions. Ratings of organization and presentation were also higher (3.6 – 3.7).

Training Role

A trained and knowledgeable workforce is the cornerstone of community capacity. We now turn to PSU's tasks in developing training materials to support the OABHS training function. Specifically, we provided tools to help OABHS to increase knowledge of those providing direct services (e.g., aging services, behavioral health services, and health care services) and to promote use of evidence based screening, assessment, and treatment of older adults with behavioral health needs. Ultimately, more knowledgeable community partners will be able to help their communities to implement evidence-based programs incorporating these practices.

Based on the budget note report data, knowledge gaps are pervasive. Three target audiences were identified: aging and behavioral health services providers, primary care providers, and the general public. OHA also specified training was needed for PASRR Level II assessors to address changes being made at the federal and state levels as well as to increase their knowledge of behavioral health needs of older adults. OHA's priority was to start with a training program for aging and behavioral health services providers. We begin this section, therefore, with a description of that program.

Training for Aging and Behavioral Health Services Providers

Planning. In conducting the original needs assessment, PSU asked stakeholders to identify additional people who could provide further insight and direction in understanding the behavioral health needs of older adults, including training needs of those who provide a range of community services. We interviewed as many of those individuals as we could reach and who were available to talk with us. Drawing from the many stakeholders we interviewed, we convened a meeting of professionals to assist in planning the training program. Participants had expertise in both behavioral health and aging; they represented different disciplines and worked in different settings. We asked them to identify the specific topics that should be covered in the training program. We also wanted their views about format and mode of delivery, knowing that a web-based component was needed to ensure the training resources were widely available. We had a one-time opportunity to produce a comprehensive training program that needed to extend beyond the contract. In other words, conducting a one-time or a series of stand-alone workshops would have limited value. Not everyone could attend, even if delivered in multiple communities and such training would not be available to support newly hired staff once the contract ended. We felt strongly that whatever we produced needed to be of use for several years.

The planning committee met in December 2014 and made recommendations related to the training content. First, the committee wanted an emphasis on how most older adults experiencing aging to debunk myths that depression and other behavioral health conditions are typical of old age. Second, services systems need to learn about each other. Because agencies

tend to work in silos, service providers often know very little about others who might be caring for an individual or could be providing services to help a client. Third, case presentations are an effective way of learning and the committee strongly encouraged their use. During the meeting, small groups worked to develop the framework for what became four case-based modules. These modules examine major behavioral health conditions where older adults, or younger adults with coexisting behavioral and health needs, often fall through the cracks because aging services, behavioral health services, and primary care providers are not working together. These topics included anxiety, depression, dementia associated with a long-term chronic physical illness, substance abuse, suicide risk, and schizophrenia, a common serious mental illness. During this meeting, participants commented that advance care planning and end-of-life care can be especially challenging for those with behavioral health needs. Therefore, the group recommended that the training include a module on advance planning and end-of-life care for people with behavioral health needs.

Although the planning committee recognized the need for web-based training, particularly in rural communities and in agencies where scheduling training is difficult, many participants stressed the limitations of that approach. People benefit from opportunities to meet with experts and discuss training content with respect to their own work experiences. In addition, participants stressed the need for cross-agency training, viewing this as key to improved service coordination.

Out of this discussion, a hybrid training program was envisioned: web-based materials moderated or facilitated in person by the OABHS, in partnership with local experts when appropriate or possible. To support learning, the committee recommended that resource materials be developed to support the training. This was the framework for development of the 8-module series developed for behavioral health and aging services providers. This series was supported by guides to assist OABHS to plan training, facilitate discussion, and identify credible resources to supplement the training program. This process also guided the specific content developed for a primary care audience.

Production. During December 2014 – January 2015, the four clinical modules were outlined and scripts prepared. Three consultants were engaged, two had been part of the planning committee (Liz Bartell and Maureen Nash) and the third (Judy Hart) was recommended by another member of the planning committee. The consultants reviewed the scripts and proposed content. Modifications were made based on their reviews. In March 2015, working with the Oregon Health Science University simulation laboratory, we recruited 8 actors and filmed the case presentations. We also filmed the three consultants who portrayed various roles related to aging services, behavioral health services, and primary care. The three consultants modeled multidisciplinary communication and team meetings. PowerPoint slides were created to provide definitions, prevalence data for the condition(s) of interest, evidence-based screening tools, evidence-based treatment, and resource information. Each of the clinical modules was reviewed by the consultants and the materials revised accordingly. After pilot testing (see below), content was developed further, additional edits were made, and then the modules were professionally narrated.

As production progressed with the clinical modules, work on the remaining four modules was ongoing. The introductory module was developed to highlight the everyday experience of older adults, providing well-established research on the general experience of well-being and emotional health of the vast majority of older adults. This was illustrated by a diverse group of older adults who agreed to be interviewed on camera about their lives, including a typical week, surprises about their own aging, pleasures and challenges of getting older, and what they wanted health and social services providers to know.

Two modules focused on the service system. Module 2 described behavioral health (for aging services providers) and module 3 presented information about aging services (for behavioral health providers). The intent was to provide staff in each system with basic information about the other to promote communication and understanding between the two systems. Experts representing each system were interviewed on videotape to provide information about the needs and challenges of supporting older adults with behavioral health problems. Although video clips were not used in the modules, these interviews provided valuable insight into issues that community service providers experience and were quoted in the final product. The final module addressed issues surrounding advance care planning and end-of-life support.

Pilot test and final products. The eight modules were pilot tested in May with the nine OAHBS who had been hired, their supervisors, and supervisors from all other community mental health programs who were in the process of recruiting and hiring OAHBS. Participants provided feedback on both the content and format of the training modules, which was used to revise the modules. Revisions included reediting some of the video to reduce redundancies and making improvements to the power point slides related to prevalence, screening, and treatment of specific disorders. The revised modules were reviewed again by the three consultants and final edits made. A professional narrator was engaged to narrate the 7 of the 8 modules in July. All seven modules were completed for presentation in August 2015 to OABHS (now numbering 19) and aging services partners from their communities. Each module was presented in its entirety (Modules 2 and 3) or in part (Modules, 1, 4-7). We modeled training and provided an opportunity for OABHS and their partners to use the discussion guides, and try out experiential activities related to the modules.

The eighth module, addressing advance care planning and end-of-life care, was drafted but not in final form until later that fall. It also went through a process of review and revision using experts in the field. The final narration was completed in the fall of 2015. Each video was closed-captioned and each final module was recorded onto separate ***DVDs.*** A set of DVDs was given to each of the OABHS at the final Learning Session in December. The modules are also available via YouTube on PSU's website. They will be posted on an OHA website once a web page for the OABH Initiative is developed.

Between May and August, PSU developed supplementary materials for the modules to support the training role of the OABHS, as had been suggested by the planning committee. First was a ***Companion Guide*** for each module. Several OABHS had little prior training experience, so the *Companion Guides* provided tips for organizing and conducting a successful training events.

When conducting the pilot tests, OABHS had expressed skepticism about the clinical modules, specifically whether a multi-disciplinary team existed or could be created, or whether they would find an audience that did not already know the material. Some disagreed with the approaches to the cases portrayed in the videos, and some felt the scenarios were too simplistic. We anticipated that local audiences might have similar reactions, so the second part of each *Companion Guide* was a list of 7-10 questions the OABHS could use to facilitate discussion to get beyond the immediate reaction of "this can't happen here" or "that is not how we do things," and get into deeper discussion about the needs of the community and how aging services and behavioral health could address them together.

We also understood very well that the OABHS needed additional resources so that they could tailor training to their communities and go beyond the materials contained in the modules. The led to the development of a second set of materials for each module, ***Participant Companion Guides.*** Unlike the *Companion Guide,* a document for OABHS to use in planning and conducting training, the *Participant Companion Guides* were developed as a resource for both OABHS and those who attended the OABHS training sessions. We visualized the *Participant Companion Guides* as a handout or as materials that could be easily accessed on line. *Participant Companion Guides* for each clinical module contained information from reliable sources on the topics addressed in the module. This included links to fact sheets; information on disease prevalence; presentation and adverse effects; prevention; screening; evidence-based practice and treatment; brochures, pamphlets, and booklets; and journal articles. Modules 2, 3, and 8 (i.e., *Behavioral Health Service System, Aging Services System, Advance Care Planning*) also contained information about services and how to access them.

Additional tools and resources prepared for each module included ***evaluation forms*** the OABHS can use with participants in their training to track participant satisfaction with the training and their self-assessed knowledge gains. Information related to ***Continuing Education*** was distributed. PSU obtained approval for continuing education credit for each module from the National Association of Social Workers (NASW). Each module was awarded one credit and this approval extends through May 2017. When OABHS present the training modules using the DVDs, participants can receive CEU credits. Materials provided to OABHS included the CE approval letter, roster to record attendance, the NASW evaluation form, and certificates specific to each module.

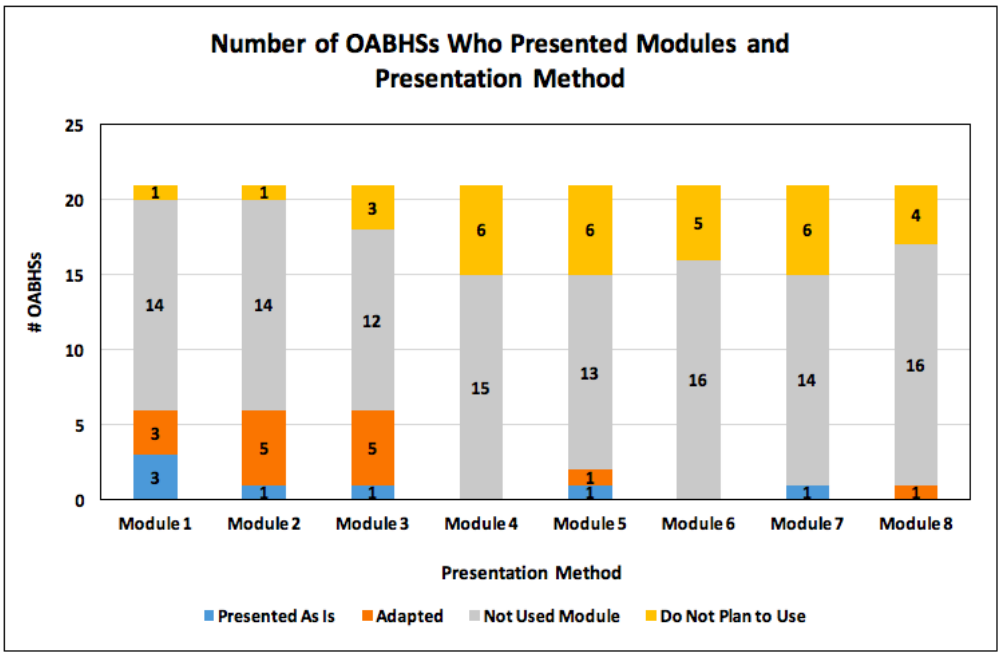
Finally, copies of the ***PowerPoint slides*** complete with notes were made available to the OABHS so that the OABHS could select, edit, or adapt slides to meet their community and audience needs. All of these materials were provided to OABHS via Google Drive, zip drive, and the Institute on Aging webpage.

Use of aging services and behavioral health service provider modules. Some of the OABHS consistently have been critical of the training products, particularly the videos. Many felt they were too basic and covered too much information. A few OABHS said their community partners were not interested in the topics covered by the modules and many wanted to develop their own training. We believe that the OABHS who have limited experience partnering

with aging services providers over-estimated the amount of behavioral health knowledge this group of professionals have. We believe that as the OABHS work more closely with this target audience, the use of the modules may increase.

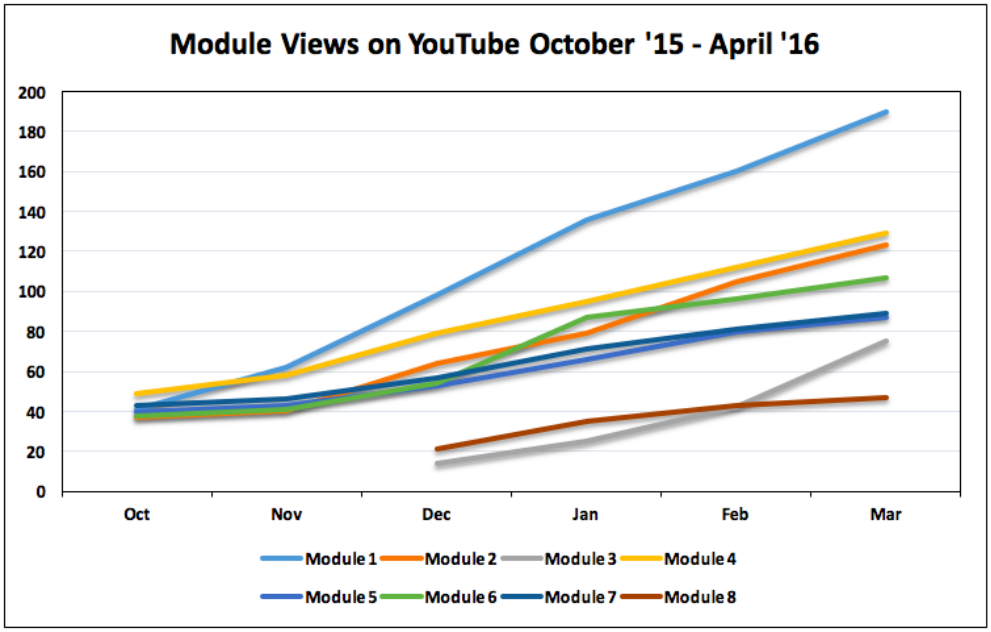
Some of the criticisms about the modules are a product of developing the training without involving OABHS in their initial development. As described earlier, PSU was working to complete the modules before the first OABHS were hired. Just over one-third of the OABHS had been hired by the time we our contract required us to conduct the pilot test; the majority of OABHS had not been hired.

Figure 3: OABHS Use of Modules



In the online survey, we asked OABHS whether they had used the training modules, whether audiences were from the same or different agencies, and their ratings of the usefulness of the modules. As indicated in Figure 3, OABHS are just beginning to use the modules. Six OABHS had used the first three modules as is or had adapted them, two had presented Module 5, and one each Modules 7 and 8. We must emphasize that OABHS have been engaged in other important training activities which are not reflected in this report. We are reporting only on training materials developed through the PSU contract. As indicated by YouTube views of the Modules (see Figure 4]), interest in the Modules appears to be growing. As of April 2016, Module 1 had nearly 200 views and the rest between 42 and 125.

Figure 4: Module YouTube Views



It appears that most (59%) of the training using the modules is being done with a mixed audience from different agencies. This was one of the goals for the training program. In addition, those who use the modules are finding them useful or very useful in generating interest in the community about older adult behavioral health needs, helping participants focus on solving problems (as opposed to complaining about the lack of support from one agency or another), and for increasing knowledge within the community.

Many more of the OABHS have used the *Participant Companion Guides* than have used the videos. The most common reasons for using them include: to identify websites (11), to prepare training (10), to locate screening tools (9), or to locate evidence-based best practices (8). Other reasons include preparing for a stakeholder meeting, looking up information for a complex case, and answering questions for a stakeholder. Two-thirds of the OABHS reported that the *Participant Companion Guides* are very useful and another 17% find them useful as reflected in the comment below.

> *The participant companion guides are incredible. These have really simplified my process for preparation related to meetings and trainings.*

Training for Primary Care Providers

A second target audience for the OABH Initiative is primary care providers (PCPs). Beginning July 2015, we engaged Kristen Swafford, PhD, RN, CNS, to take the lead in developing training modules and informational materials for PCPs. Dr. Swafford has extensive background in geriatric mental health, both as a mental health provider and as a nurse. Working with PCPs from the planning committee and the PSU project team, Kristen developed five modules:

- *Toward Integrated Care: Anxiety*
- *Geriatric Depression Care*
- *Geriatric Substance Use Disorders: An Invisible Epidemic*
- *Late Life Suicide Prevention*
- *Behavioral and Psychological Symptoms in Dementia*

Modules were reviewed by PCPs from the planning committee as well as by selected OABHS with content expertise in a particular module. Modules range in length from 15 to 20 minutes. Like the community service provider modules, these modules are posted on the project website. One version of each training module is a narrated video; it can be used for independent learning. PowerPoint slides with scripts are also available for the OABHS to use in conducting in-person training with PCPs and/or their office staff; PowerPoints can be adapted as needed. This latter approach is recommended. We heard consistently from the physicians and other PCPs involved in this project that PCPs need the information and need to partner with OABHS and other community members to address the complex care needs of their patients. With mandates to Coordinated Care Organizations and requirements of the Affordable Care Act, PCPs have new incentives to learn about the behavioral health issues faced by their older patients and to partner with OABHS in addressing them.

Kristen Swafford presented two of these modules to the OABHS at Learning Session 3 in December 2015. She also led a discussion on strategies for reaching PCPs, such as getting on the program for medical grand rounds, doing in-services at PCP clinics and private offices, and inviting PCPs to participate in multiple disciplinary teams virtually or in person. At the time of the online survey, only a few of the OABHS had begun working with PCPs. Therefore, it is too soon to determine the usefulness or effectiveness of these tools.

In addition to the videos, Dr. Swafford and project staff developed multiple support materials. Some of these materials have been laminated and are available to distribute to PCPs for use in their clinics. Others (i.e., the talking points) are to support OABHS in making the case to PCPs to work in partnership to address issues older adults with behavioral health needs experience. These materials include:

- Alternatives to Beers Criteria High-Risk Medications in Older Adults
- Alternatives to Beers Criteria Potentially Harmful Drug-Disease Interactions in Older Adults
- Comorbid Physical Conditions and Late Life Depression

- Differential Diagnosis VINDICATE
- Medications Causing Depression and Anxiety
- Substance Abuse
- Talking Points: Demographics
- Talking Points: Rationale

Most of these materials are posted on the PSU project website.

Community Awareness Modules

The budget note workgroup stressed the importance of prevention. Prevention is a part of all modules developed for community services providers and PCPs. Another important vehicle for prevention is to increase awareness in the general public about the risks of poor behavioral health and what they can do to prevent it for themselves and for other members of their families and communities. Thus, the general public was a third target audience for the training program.

The project team developed three modules for this population. These are brief PowerPoint presentations focusing on alcohol use, anxiety, and social isolation. These modules were designed to be delivered informally to small groups, incorporating discussion and information sharing. As with the other modules, OABHS are encouraged to adapt the materials and add resource information specific to the communities. Companion Guides were developed for each module to support OABHS in planning and delivering the training. The modules and *Companion Guides* are available on the project website.

PASRR Training

The PSU contract required training to providers who administer Level 2 Preadmission Screening and Resident Review (PASRR) assessments. PASRR 2 assessments are conducted when PASRR 1 screening indicates a behavioral health issue might be present. Regulations governing PASRR have changed recently. In addition, not all PASRR 2 assessors have a background in care of older adults. Therefore, the PASRR training included updates on PASRR and information on care of older adults. Specific topics were:

- *Nuts and Bolts of PASRR*
- *Is it Dementia, Delirium or Depression?*
- *What Happens to that Pill After it is Taken? Pharmacokinetics and Pharmacodynamics Made Easy*
- *Enhancing Well-Being: Medications and Beyond for Elders Living with Mental Illness*
- *Creating Opportunities for Transitions*

Fifty-five people attended the training, including at least four of the OABHS who do PASRR 2 evaluations in their communities. Evaluations from the training indicate increased knowledge as reported by the participants (see Appendix D). The highest levels of beginning knowledge were for the presentations by Glenise McKenzie (*Is it dementia, delirium, or depression?)* and by Lynda Crandall (*Beyond Medications for elders living with mental illness).* The highest level of ending knowledge was for McKenzie. The largest increases in knowledge came from the Simonson presentation *(What happens to that pill after it is taken?*), where pre-presentation knowledge was about 2.5 and increased to almost 4.

Complex Case Consultation

Discussion of the complex case consultation (CCC) role of the OABHS was incorporated into PSU's various learning sessions and training materials. As indicated previously, most of the OABHS are clinicians and had already been knowledgeable about managing and working with people with complex mental health needs and age-related health conditions. Our training and interactions with OABHS confirmed that CCC contributes to community capacity building. By providing CCC, OABHS are engaging with community partners and building relationships. The OABHS were also learning first-hand about the gaps in the service system and what needed to be addressed through training, coordination, and other community-wide efforts.

Providing CCC also give the OABHS opportunities to provide "just in time" education to providers in the course of their consultation. Several OABHS developed training to address gaps outside of the CCC sessions. We anticipate that these efforts to increase knowledge and engage community partners will result in a more informed provider community that can address complex care issues on their own in or in routine collaboration with others, independent of OABHS direct support. In addition, as the community becomes for knowledgeable we expect an increase in community-wide efforts to prioritize and address the key issues that emerge from CCC and develop a more informed provider workforce.

Tracking Success

The OABH Initiative is ambitious and complex. Beyond the individual efforts of the OABHS, the Initiative requires ongoing commitment from state agencies and the Oregon legislature to meet its goals. Data collection and evaluation are critical for providing the information needed to continue to improve services and inform policy. With that in mind, at the last learning session we asked the OABHS to reflect on what success would look like in their communities.

First, we seated OABHS according to their interests and strengths with respect to domains in the conceptual framework of community capacity building (Figure 1). Group assignments were based on interviews conducted with the OABHS after each of the previous

learning sessions. For example, those especially interested in needs and preferences of consumers, family members, and advocates and were doing work in this area were seated together. Similarly, those who had been especially active in identifying gaps in services in their communities sat together as well. In all, the OABHS were arranged in five groups. Only the domain, "Evidence-based programs are being implemented" was not represented in the original grouping because fewer communities had developed capacity to do this type of work.

Second, we provided information about indicators of success, including "soft" and "hard" indicators. Examples of hard indicators include that multidisciplinary team meetings are held regularly, and that people with complex health and behavioral health needs have fewer and shorter hospitalizations. Examples of a soft indicators is the perception that community partners are "playing nice" with each other, and that the community is not letting people with multiple and complex needs fall through the cracks. We also talked about measurement and the need to look at indicators systematically as a way to collect evidence of success and identify areas in need of continuing improvement.

Finally, we asked each group to spend some time discussing what success would look like in their domain of expertise and how they would know they were making progress. Their task was to generate indicators that would reflect progress and success. Project staff sat at each table taking notes. OAHBS then moved to a different table of their choice where they repeated the exercise within a different domain. All domains were represented in this second round of discussion. Project staff remained at the table adding notes.

A summary of indicators of success and ways to identify progress created by the OABHS is presented in Table 1. These indicators could be especially helpful in developing tools to evaluate the program.

Lessons Learned from OABHS

Following completion of the learning sessions and online surveys, the project team met to review the body of information collected from the OABHS over the course of our work with the OABH Initiative. Below we describe themes that emerged related to the OABHS role, job satisfaction, and OABHS needs moving forward. This information will be useful as the program grows and new OABHS are hired.

OABHS Role

Job preparation. The first theme was job preparation. How well prepared an OABHS felt was influenced by the match between *job expectations* and the realities of the job. Incongruities occurred when the original job description did not meet the intent of the job. For example, if an OABHS expected to provide direct service, the need to limit practice to consultation was frustrating. This frustration contributed to ongoing dissatisfaction with the

role for some OABHS. With the evolution of the program, expectations and job responsibilities have become more consistent and aligned. Although this is less likely to be an issue in the future, it is important to keep job descriptions clear and accurate.

Table 1. Indicators of Success by Domain

How Will We Know We Are Successful?

- Identifying and addressing gaps in services or problem areas
  - Stakeholders meeting regularly and working collaboratively
  - Systematic documentation of gaps in services and solutions
  - Relevant stakeholders regularly attend/participate in MDTs/consultations
  - Community stakeholders are coming together to develop and implement quality improvement projects
- Direct service staff increased knowledge
  - Use of supportive, professional language
  - Increase in appropriate referrals
  - Increased use of best practices (e.g., screening, treatment-including medications)
  - Decrease in complex case consultations [providers able to address issues themselves and with other stakeholders]
- Best practices in screening, assessment, and treatment
  - Increased use of evidence-based screening and assessment tools
  - Increased use of treatment best practices (e.g., appropriate use and reduction of misuse of therapies, cognitive-behavioral therapy)
  - Screening and assessment data used routinely to plan appropriate treatment
- Evidence-based programs are being implemented
  - Programs are widely available in communities to address specific behavioral health needs
- The needs, preferences and opinions of consumers, family members and advocacy groups are included in the planning and delivery of services
  - Consumers, family members, and advocates are well represented in stakeholder groups
  - Consumers, family members, and advocates are fully involved in all aspects of community development
- The coordination of services among stakeholder agencies is improving
  - Stakeholders are familiar with the services of others in the community
  - Stakeholders routinely share information about services and resources with each other

Prior work experience contributed to OABHS' sense of role preparation. Almost all came to the role from a mental health clinical background, including work on a geriatric psych unit,

long-term care case management or care coordination, participating on a multidisciplinary team or providing complex case consultation, and working in programs related to specific behavioral health needs such as substance abuse. Nearly all of the OABHS felt this clinical experience was necessary. Other prior work experience identified as helpful by one or two of the OABHS included public speaking, working with CCOs, and living in the community where they were working. A small minority of OABHS had experience with community development, which contributed to their preparation for the role.

Although prior clinical experiences in behavioral health were viewed as important job preparation, we feel that this focus may have limited the overall direction of the program. In the future we encourage inclusion of those with different professional experiences. For example, if some of the OABHS had had most of their experiences in aging services, they could have helped their peers to gain greater understanding of the aging services system. Similarly, those with a gerontological nursing background could have helped with entre into health care systems and contributed to understanding specific information about the linkages between health conditions and well-being. Importantly, having peers in the OABHS network from multiple disciplines and work experiences could contribute to the necessary and complex work of multi-disciplinary and multi-agency collaborations.

Skills needed. All of the OABHS described the need to develop new skills. A few described adapting their clinical skills and applying them to systems-level work. Because a primary OABHS role is to help bridge service systems, all OABHS needed to learn a significant amount of information about at least one new system of care (e.g., aging services, primary care). For example, although most OABHS had worked with older adults, they generally were less familiar with aging services than they were with behavioral health services. They needed to learn new acronyms, definitions of services, and become more knowledgeable about needs of older adults beyond mental health, including conditions common in old age (e.g., dementia, other chronic disease) and the implications of those conditions in supporting older adults appropriately (e.g., pharmacologic and medication considerations with older adults).

Most OABHS had not been involved in community development prior to this position. They considered it necessary to acquire skills in public relations and in forming liaisons with community partners. Communication skills were necessary and included being able to succinctly describe the OABH Initiative (i.e., “elevator speech”) and making cold calls to begin the process of promoting the initiative and developing relationships with stakeholders. Most OABHS needed to develop training and workforce development skills, confirming the appropriateness of PSU’s approach to supporting the OABHS.

Job Satisfaction

Almost all of the OABHS described multiple sources of job satisfaction. Those sources varied by specialist. All elements of the three OABHS job functions were associated with job satisfaction for at least some of the OABHS.

Providing complex case consultation (CCC) was identified most often as a major source of satisfaction. In some cases, CCC provided opportunities for OABHS to work with an interdisciplinary team. Many other OABHS embraced the process of *developing relationships* in the community, including networking, working with stakeholders and doing outreach. One individual especially enjoyed the opportunity to work in a rural community. Opportunities to *provide training* was valued by some OABHS.

Working at the *systems level* was rewarding. This was highlighted by some of the OABHS who had not expected to do this work and were first reluctant to assume this responsibility. This work, whether expected or not, represented an opportunity to build something new. Successfully navigating the job was accompanied by a sense of personal development as OABHS' skills and knowledge grew alongside the program.

The opportunity to learn more skills was a plus for some of the specialists. These individuals liked the challenges of becoming trainers, learning a new service system, working with primary care providers, or engaging in system change. *Being a resource* for others, whether for other providers, older adults, or the community at large, was common across these elements. The work itself was perceived as meaningful work that will make a difference for older adults. The opportunity to work with others who also like to work with older adults was gratifying. This occurred within OABHS' communities and also with their OABHS peers.

As described below, some people did not like the "roadmap" that was developed as common reporting tool. At the same time, many others liked the structure and clarity of role that it represents and at least one person named it as a source of job satisfaction.

Challenges

Sources of job dissatisfaction. The OABHS have encountered many challenges, some of which contributed to job dissatisfaction. Many are common to new programs and are likely to resolve as the OABH Initiative gains experience and traction within their communities. One of the OABHS described this as "building a plane in the air." The most frequent issue of concern noted by OABHS was that expectations have been inconsistent and ever-changing. Similarly, we heard comments about a general lack of structure or clear focus at the state level or from the contract agencies where the OABHS were housed. Often this was related to the mismatch between job requirements and OABHS expectations as described above. As in a previous example, a few OABHS expected to be doing direct services; their communities and contracting

organizations had those same expectations. The inability to pursue this work or limiting services to complex case consultation has been dissatisfying for at least one OABHS. Other OABHS were surprised at the emphasis on training or on engaging primary care providers or on targeting adults with disabilities. Although, most of the OABHS understand these challenges are a part of new program development, changing expectations or perceptions of changing expectations remain difficult to navigate for some.

A few OABHS pointed out that their position can be isolating. In most communities, the OABHS is the only one who holds the position. As a result, they have no peers with whom to share the work or to identify solutions to local issues. Networking and problem solving with other OABHS is valued, and is viewed as an opportunity to build a peer network. In learning session evaluations, networking was consistently identified as one of the most helpful aspects of the day. Now that the PSU contract for training is complete, a few OABHS indicated that few opportunities are available to build on these valued peer relationships. A challenge going forward will be to maintain consistent contact with other OABHS. It is difficult to get people together because of the rural nature of this state. A few OABHS requested more time and flexibility during regularly scheduled peer networking calls to increase opportunities to share information and lessons learned. Another possible solution is to develop smaller networks of OABHS. Some OABHS are already doing this. The OABHS in the Portland metropolitan counties work together and the OABHS who work in the Greater Oregon Behavioral Health Inc. (GOBHI) region also are in frequent contact.

In addition to challenges related to expected job functions, some of the OABHS expressed frustration with the reporting requirements. Although many specialists find the "roadmap" reporting form to help clarify job functions and expectations, others find them burdensome. Flexibility has been added to the roadmap which will help OABHS report on activities unique to the needs of their communities. Some felt it will be challenging to meet some of the documentation requirements because of limited responses by stakeholders in their communities, especially from primary care providers (PCP). PCPs are often hard to reach and have limited time available for OABHS. Some CCOs are focused on children and to date are not responsive to efforts to work on an initiative specific to older adults and people with disabilities.

Resource challenges. The lack of resources available for serving older adults with behavioral health needs is well documented and remains a major challenge for OABHS even as they work to build community capacity. Lack of housing is especially problematic. So too, is the lack of referral options, particularly for qualified therapists and clinicians who are willing to serve a Medicare or Medicaid population. Community health workers who could support people in their homes or in community-based care settings are underused or unavailable in most communities. Resources are particularly limited in rural areas. Furthermore, many of the OABHS specialists are covering large geographical areas with a wide range of needs and resources.

Confidence in the OABH Initiative

The OABHS were asked about their level of confidence that the Initiative would meet specific goals. Nineteen OABHS responded to this question on the online survey. The goals and ratings of confidence are listed in Table 2 in order of confidence. The rating scale was 1=not at all confident to 4=very confident. OABHS were most confident (3.1) that community stakeholders would come together to improve coordination of services. They were also confident (3.0) that community stakeholders would gain the knowledge they need about older adults with behavioral health needs. The OABHS are all actively pursuing these aspects of community development.

OABHS were least confident about goals that require deeper systems changes. Specifically, they were least confident ("a little confident; 2.3) that evidence-based practices would be used routinely to screen and assess older adults with behavioral health needs or that the needs of older adults with behavioral health needs would be addressed in all areas of the state. Routine and assessment using evidence-based practice tools requires practices changes within health care and social services systems. Similarly, lower levels of confidence that services will be available state-wide speak directly to the resource challenges described above. This is seen in many rural parts of the state, but even in more urban and resource-rich areas, many segments of the population do not have access to services because of eligibility criteria or lack of qualified providers.

Table 2. OABHS Confidence in the Ability of the OABH Imitative to Meet Program Goals

Goal	**Average** (1= not at all confident; 4=very confident)
1. Community stakeholders coming together to improve coordination of services.	3.1 Range: 2-4
2. Community stakeholders are gaining the knowledge they need about older adults with behavioral health needs.	3.0 Range 2-4
3. Community stakeholders are working together to implement evidence-based programs to support older adults with behavioral health needs.	2.7 Range 1-4
4. The needs, preferences, and opinions of consumers, family members, and advocacy groups are included in all aspects of planning and delivering services.	2.6 Range 1-4
5. Systems are being put in place to support older adults with multiple needs	2.4 Range 1-4
6. Evidence-based practices are being used routinely to screen and assess older adults with behavioral health needs	2.3 Range 1-4
7. The needs of older adults with behavioral health needs are being addressed in all areas of the state.	2.3 Range 1-4

Ongoing Support Needs

In the final interview with OABHS, we asked "Moving forward, what support do you need (want) from your immediate supervisor? State Coordinator? Community partners/stakeholders?" Below we present responses. Where appropriate, we also include information from past interviews and comments from the online survey.

Support from community partners. The OABHS have made substantial progress in strengthening community partner relationships and developing new partners. To build and sustain the momentum, they need the community to be engaged and enthusiastic. Stakeholder buy-in is needed, particularly from primary care providers. Buy-in is demonstrated through a commitment of time and resources to work on common problems and to engage in mutually agreed upon improvement projects.

OABHS need community support for training. Agencies can make staff available for training, especially cross agency training to help agencies build understanding of each other's services and the complex needs of clients. In-kind support, such as space or co-trainers are other examples of community support for training. Building on complex consultation efforts is another way to demonstrate support. This can be done by making referrals to the OABHS for complex case consultation, supporting development of multidisciplinary teams, and participating on teams. To address needs identified through complex case consultation and assessment, community agencies need to work toward increasing flexibility in programming and strengthening the workforce. One example provided was to increase the use of community health workers.

Support from supervisors. Supervisors support OABHS in many important ways. Where support is strongest, supervisors support autonomy and creativity of the OABHS and are also available as a sounding board for prioritizing tasks and problem solving. The supervisor can serve as an advocate for the initiative at both the local and state level. Locally, supervisors can facilitate work of the OABHS by providing introductions to key stakeholders and supporting OABHS efforts to develop or strengthen relationships with agencies and individuals. Supervisors can also serve as liaisons to relevant state agencies in making the case for policy changes to support OABH Initiative goals. By understanding and embracing this Initiative, supervisors can help assure fidelity to the overall program.

Administrative support from the state. OABHS need support from OHA and the State Coordinator. This includes timely communication and availability when OABHS request technical and other types of support. OABHS reported a range of experience and levels of satisfaction with the support they receive.

Many of the OABHS value opportunities to meet with their peers. OABHS consistently reported that the PSU learning sessions were valuable for this reason. Although peer meetings are still held regularly, most OABHS attend by phone. Most cannot attend in person because of

distance and investment of time and other resources. It is challenging to provide opportunities for dialogue in this situation. Regardless of meeting format, however, OABHS would like to have more time in these meetings devoted to sharing experiences and engaging in shared problem solving. At the suggestion of one of the OABHS, a Wiggio account was created so that OABHS could share information and documents with each other. According to the online survey, however, only a minority of OABHS use this method for peer communication.

Many of the OABHS indicated a need for more consistency in direction for OABH Initiative priorities. This reflects the challenges described above by the OABHS who expressed dissatisfaction with lack of clarity or changing program priorities. Although the roadmap was helpful in specifying priorities for some, others indicated they still had need for more direction in tracking and reporting on their work. As is commonplace in state-wide initiatives, a tension exists between having metrics that provide data that can be compared across agencies and having metrics that provide sufficient flexibility for capturing each community's unique needs, priorities, and activities to address those needs. The roadmap seeks to provide this framework and it appears that the state and OABHS are developing consensus on the overall approach.

Recommendations for future OABHS

Over time, OABHS will move on to other positions and new OABHS will be hired. We have already seen some attrition as OABHS have left for other jobs or are planning to leave because of the challenges inherent in a start-up position. OABHS made several recommendations for the next generation of specialists. The first was to get to know the community and its resources at the very beginning, and to recognize that it takes time to learn about and become a part of a community. Learning about systems outside of mental health and talking directly with older adults were examples given of ways to get to know communities better. This is consistent with approach presented in Learning Session 1.

OABHS stressed the importance of maintaining a local focus and responding to needs identified by the local community rather than imposing plans on the community. The county data was mentioned as a way to inform a community-level effort. The ability to take on simple and tangible projects and goals with community partners was highlighted. New OABHS are cautioned not to promise the community that they can solve problems. Instead, they need to keep the focus on working with community partners to determine what they can do together. Such efforts are consistent with Learning Sessions 2 and 3.

The need for OABHS to keep learning was highlighted. In addition to learning about the community, OABHS need to learn about the Medicare and Medicaid systems. They also need to be skilled in meeting the training needs of community partners and other stakeholders. The ability to organize and provide cross-training is a part of this. This is consistent with the training related to the modules developed for this initiative.

In addition to skills and abilities, OABHS identified other traits that are important for job success, including flexibility, openness to others, and tolerance for ambiguity. Passion for the Initiative was highlighted as well. This is demonstrated through advocacy for the program, immersing oneself in the materials that have been developed for the initiative, and understanding the roadmap.

Finally, new OABHS are encouraged to seek support for themselves as needed. This includes adopting a continuous learning approach, asking for clarification from the State Coordinator and partner agencies as needed, and to "know your worth" in negotiating compensation.

Summary and Recommendations

Summary of Activities and Products

PSU Institute on Aging received a contract from the Oregon Health Authority to support the establishment of the Older Adult Behavioral Health (OABH) Initiative. In July and August 2014, PSU Institute on Aging conducted a needs assessment reported its findings to the Oregon Health Authority and the Budget Note Committee. Findings included a description of the stakeholder's views about the role of a "Senior Mental Health Specialist," which became "Older Adult Behavioral Health Specialists" (OABHS).

Between September and December 2015 PSU assembled a team, met with stakeholders, and outlined a training program that would address the key gaps and priorities identify through the Budget Note report. The training program was designed to support OABHS to provide training within their communities. The training program had four parts, each targeting a different audience: Aging and behavioral health services providers, primary care providers, the general public, and PASRR II assessors.

PSU also identified professional development needs to support OABHS. This included workshops to present training materials developed for each audience. These were held in May and August 2015. For OABHS to be successful, they had to be skilled in community capacity building. To support this key function, PSU developed and presented three Learning Sessions highlighting different aspects of community-capacity building. These were held in June, October, and December 2015.

In the first five months of 2015, PSU developed a training curriculum for **aging and behavioral health providers**, developed scripts and produced video materials for four clinical modules, and outlined resource materials, including companion guides to support OABHS training roles and participant companion guides which contained resource information relevant to each module. The clinical modules addressed the most common behavioral health issues facing older adults and those with chronic disabilities. In addition, four other modules were

produced that addressed the everyday experience of aging as told by over a dozen elders, basic information about the aging services and behavioral health services systems, and advanced care planning and end-of-life care. The National Association of Social Workers awarded one hour of continuing education (CEU) credit for each module (8 total).

The final products included eight video-taped modules (available on DVD and YouTube), eight companion guides and participant companion guides, information regarding CEUs, and power point slides. All materials went through multiple peer review and editing processes. The modules were pilot tested in June 2015 and revised. Seven of the eight modules were completed in August and presented to the OABHS and aging services providers invited by the OABHS. The final module was completed in the fall of 2015.

In May 2015, under the supervision of PSU team leaders, three graduate research assistants in community health began to develop materials appropriate for the **general public**. In addition to power point slides, a companion guide was developed for each module. Three modules were developed over the course of the year and addressed social isolation, anxiety, and alcohol use.

In July 2015, work began on training modules specific to a **primary care provider** audience. Five modules were developed and made available in two forms: power point slides which could be modified as needed by OABHS, and a narrated version that could be presented as is. Topics included anxiety, depression, substance use, late life suicide prevention, and behavioral and psychological symptoms in dementia. As with other modules, many support materials were collected or developed to support PCPs and support use of evidence-based best practices.

Planning began for PASRR II training in January 2015 and a workshop was presented in March 2016.

All of the modules and materials developed were distributed to OABHS in multiple formats. All are available on the PSU project website: https://www.pdx.edu/ioa/serving-older-adults-with-behavioral-health-needs-training-youtube-links-companion-guides

Recommendations

We cannot overstate the importance of the OABH Initiative nor its complexity. It is an ambitious and timely program. Research has demonstrated consistently that integrating health and behavioral health care services benefits patients and clients. The same is true for addressing both behavioral health and aging-related functional decline. Not only do such efforts improve the quality of life for those in need of multiple services, they also improve quality of care, offer providers more resources to support their patients and clients, and reduces health

care costs caused by health disparities and high unnecessary utilization of health and medical services.

For the most part, OABHS are addressing many of the gaps in knowledge and in access to services that were described in the initial Budget Note Report. They are in the process of bringing key community partners together to make care of older adults with behavioral health needs a priority across agencies, and they are increasing the knowledge of their community partners through complex case consultation and training. Many of the OABHS are helping to bridge local service systems that in the past have "not played nice" together or have operated on parallel tracks to the detriment of those in need of services.

We have encouraged OABHS to work with their community partners representing different service systems to develop community priorities and begin an improvement project to meet mutually agreed upon needs. Success of such an endeavor will enrich relationships and make it more likely for partners to work together on future improvement projects. This process will take time and must be supported for multiple years.

Recommendation 1. This is an ambitious and complex initiative that will take many years to bring to fruition. Sustained commitment through policy and funding is needed at the very highest levels of state government to meet initiative goals.

Recommendation 2. Building on the work to date, OABHS and community partners should embark on specific community improvement projects to address priority community needs. These projects will:

a. serve as laboratories for exploring new ways for community partners to work together to meet common goals.
b. provide much needed data to inform policy makers as they set practice and funding priorities.
c. provide "success" stories others can use and adapt as a basis for their own improvement projects.

Recommendation 3. In addition to reporting on the scope of activities related to their job functions, data is needed to help understand how the initiative is affecting community partners (e.g., an increase in appropriate referrals, increased ability of aging services providers to support people with behavioral health needs, increased ability of behavioral health providers to support clients with ADL needs, reduction in emergency department use for housing people with behavioral symptoms because they cannot find services). <u>State leaders, including leaders in state agencies and professional associations, need to strongly encourage local partners to participate in such data collection.</u>

OABHS cannot address all of the issues identified in the budget note report by themselves. Fragmented systems at the state and national levels remain major barriers that directly impact local communities' abilities to address complex needs. Agencies with a stake in supporting older adults and people with disabilities who have a combination of poor health,

age-related impairments, and behavioral health conditions have different funding streams and eligibility requirements.

Recommendation 4. Strengthen cross agency advocacy for the OABH Initiative at the state level (e.g., APD, OHA, Health Transformation). For example:

- Mandate and/or provide incentives for AAA, CMH, APD field offices, CCOs, and other key partners to support and participate in cross agency training
- Model collaboration at the state level. Establish workgroups representing state agencies and OABHS who can identify new ways to bridge silos and address issues such as those raised by OABHS and aging services providers at the project Learning Sessions.
- Explore Medicaid waivers or advocate at the national level to make financing services more flexible across agencies.

These next set of recommendations build upon the lessons learned through observations by PSU project staff and OABHS feedback.

Recommendation 5. Review job descriptions regularly, especially as new OABHS are hired, to make sure that expectations are clear and agreement exists between the State Coordinator, the contracting agency, and the OABHS who is assuming the job.

Recommendation 6. Support and strengthen peer networking among OABHS to facilitate sharing ideas, lessons learned, and to provide mutual support. Involve OABHS in planning activities during to regularly scheduled peer network meetings to optimize opportunities to share information or work in collaboration on issues of interest. Consider supporting smaller groups of OABHS who work in similar types of regions or are addressing similar behavioral health issues. Perhaps smaller groups could more easily meet in person or by phone and still experience the benefit of regular contact with another OABHS.

Recommendation 7. Expand job recruitment to include people with professional backgrounds beyond behavioral health, including aging services, community and public health, community development, nursing, and health education. The knowledge, skills and abilities associated with these different disciplines could broaden combined experiences that OABHS bring to the position and enrich peer learning.

The training program developed by PSU focused on community capacity building and creating training materials to help address the most common behavioral health needs found in older adults and adults with chronic mental illness. Some Advisory Committee members argued that the PSU materials lacked a critical focus on adults with disabilities. Our emphasis, based on initial interviews with Budget Note advisory committee members, other stakeholders, the planning committee guiding training development, and OHA guidance, was on older adults. This was appropriate and necessary given the short timeline for developing and distributing materials designed for different audiences (aging services, behavioral health, primary care, and the general community). Although our focus was primarily on older adults with behavioral

health issues, many of the concepts and materials developed cross population boundaries. This is particularly true for the community capacity building focus. That said, we recognize more work needs to be done to develop training materials that focus on the needs of adults with disabilities.

> **Recommendation 8.** Invest in the development of training materials specific to adults with disabilities. Whereas PSU developed the training program prior to OABHS being hired, now that they are in place, it is important to include interested OABHS with expertise in adults with disabilities to participate in the development, review, and testing of these materials.

Appendix A

OLDER ADULT BEHAVIORAL HEALTH INVESTMENT INITIATIVE

AUGUST 2014 - MARCH 2016

INTRODUCTION

The Oregon Health Authority contracted with PSU to conduct a needs assessment and report findings to the Mental Health Budget Note Committee in August 2014. The role of the Older Adult Behavioral Health Specialist that has emerged is consistent with the recommendations from that report. The role has been further delineated into three major job functions:

Coordination

- Build partnerships and bridge gaps between service sectors
- Coordinate and leverage resources
- Address behavioral health needs in both urban and rural communities

Training

- Develop preventive care services and outreach for early diagnosis and intervention
- Provide sustained, cross training in aging and behavioral health at all levels and all systems
- Identify successful treatment models to address multiple mental health needs.

Complex Case Consultation

- Provide consultation on complex cases
- Promote independence, dignity, and choice while balancing issues of risk and safety

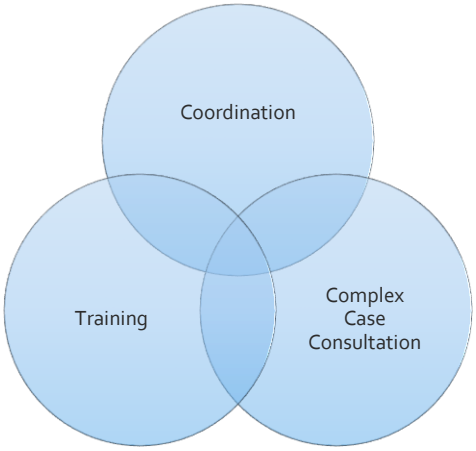


Figure 5: Role of OABHS

TRAINING DEVELOPED BY PSU

Subsequently, PSU was charged with developing a training program to prepare Older Adult Behavioral Health Specialists (OABHS) for their roles through community capacity building efforts. Training modules were created for three distinct audiences:

- **Behavioral health and aging services providers**
  - *The Everyday Experience of Aging*
  - *Behavioral Health Partners*
  - *Aging Services Partners*
  - *What's Happening with Gladys?*
  - *Bill's Search for Lois*
  - *Has Anyone Seen George?*
  - *We Have Another Call About Nell*
  - *Behavioral Health Issues and Advance Care Planning*

- **Primary care providers**
  - *Toward Integrated Care*
  - *Geriatric Depression Care*
  - *Geriatric Substance Use Disorders*
  - *Late Life Suicide Prevention*
  - *Behavioral and Psychological Symptoms in Dementia*

- **The general public**
  - *Is Anxiety Affecting Your Health?*
  - *Is Alcohol Affecting Your Health?*
  - *Is Social Isolation Affecting your Health?*

Supplementary materials were developed, including ***Companion Guides*** which assist OABHS in presenting the modules. ***Participant Companion Guides*** provided resources from reliable sources on the topics addressed in modules. Materials specific for the primary care providers' audience were compiled and distributed.

PSU developed a series of learning sessions for OABHS to support community capacity building skills and abilities:

- **Learning Session 1: Identifying Gaps in Services**
  Tools were introduced to help OABHS work with community stakeholders to identify and determine how best to address the gaps in services:
  - Community profiles
  - Stakeholder interview guide
  - Community capacity assessment form

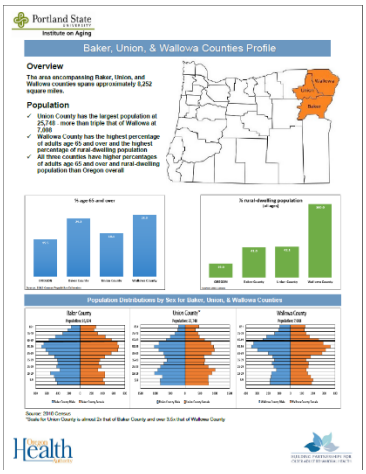


Figure 6: Community Profile

- **Learning Session 2: Building Collaborative Partnerships**
  This session was intended to guide the OABHS in developing collaborative relationships to address these gaps.

- **Learning Session 3: Collaboration and Capacity**
  This final learning session continued the theme of collaborative partnerships, including working with primary care providers. Content also focused on "What will Success Look Like?" OABHS generated items that can be used in future evaluation.

SUMMARY OF KEY RECOMMENDATIONS

Systems

- The OHBS Initiative is complex and ambitious; it requires sustained commitment through policy and funding at the highest levels of state government to meet initiative goals.

- OABHS and community partners should embark on specific community improvement projects to address priority needs. Such projects will serve as learning laboratories and provide much needed data to inform policy.
- Cross agency advocacy for the Initiative is needed at State and Local levels.

OABHS

- Review job descriptions regularly, especially as new OABHS are hired, to ensure that expectations are clear and agreement exists between the State Coordinator, the contracting agency, and the OABHS who is assuming the job.
- Support and strengthen peer networking among OABHS to facilitate sharing ideas, lessons learned, and to provide mutual support. Involve OABHS in planning activities to optimize peer networking opportunities.
- Expand job recruitment to include people with professional backgrounds beyond behavioral health, including aging services, community and public health, community development, nursing, and health education.

Access Training Materials and Reports:

https://www.pdx.edu/ioa/serving-older-adults-with-behavioral-health-needs-training-youtube-links-companion-guides

Appendix B
Summary of Older Adult Behavioral Health Specialist (OABHS) Characteristics

Hire dates:

- 12 OABHSs were hired between May and July, 2015
- 9 OABHSs were hired between July and October, 2015
    - 1 OABHS hired in July resigned in December, 2015 to take another position related to aging and mental health
    - 1 OABHS hired in November resigned in December, 2015
- 4 OABHS were hired between October and December, 2015

Position titles:

- OABHS were given various job titles:
    - Older Adult Behavioral Health Specialist (n=7)
    - Clinical Services Specialist (n=4)
    - Senior Mental Health Specialist (n=2)
    - Older Adult Behavioral Health Coordinator (n=3)
    - Older Adult Behavioral Health Program Coordinator (n=2)
    - Mental Health Services Coordinator (n=1)
    - Seniors Mental Health Coordinator (n=1)
    - Older Adult Behavioral Health Regional Coordinator (n=1)
    - Older Adult Behavioral Health Coordinator (n=1)
    - Older Adult Systems of Care Coordinator (n=2)
    - Senior Older Adult Specialist (n=1)

Contractors:

- 12 OABHSs were hired through contracts with non-profit organizations, including:
    - Greater Oregon Behavioral Health, Inc. (GOBHI) (n=4)
    - Klamath Basin Behavioral Health (n=1)
    - Options for Southern Oregon, Inc. (n=2)
    - Rogue Valley Council of Governments (RVCOG) (n=1)
    - Trillium Behavioral Health (n=2)
    - Wellness and Education Board of Central Oregon (WEBCO) (n=2)

- 12 were hired through contracts through agencies within county government agencies, including:
    - Clackamas County Health, Housing & Human Services (n=1)
    - Coos County Health and Wellness (n=1)
    - Linn County Health Services (n=1)
    - Linn County Mental Health (n=1)
    - Multnomah County Aging, Disability, and Veterans Services (n=2)
    - Multnomah County Mental Health and Addictions Services Division (n=2)
    - Polk County Behavioral Health (n=1)
    - Washington County Disability, Aging, & Veterans Services (n=1)
    - Washington County Mental Health (n=1)
    - Yamhill County Adult Behavioral Health (n=1)

Number of counties served:

- 15 OABHSs were hired to serve single-county areas
- 2 OABHSs were hired to serve two-county areas
- 5 OABHSs were hired to serve three-county areas
- 1 OABHSs was hired to serve a six-county area
- 1 OABHSs was hired to serve a seven-county area

Workspaces (different than/additional to contracting organization):

- Several OABHSs utilize workspaces different than or in addition to their contracting organizations:
    - Linn County Mental Health
    - Home office
    - Senior Center
    - Polk County Behavioral Health & Northwest Senior and Disability Services (NWSDS) - Dallas
    - Trillium Behavioral Health, Disability Services, ADRC Sr. Connections
    - GHOBI offices in Roseburg and The Dalles
    - Yamhill County Residential & Outreach Services and NWSDS - McMinnville
    - Clackamas County Behavioral Health, and DHS/ADP offices - Oregon city, Canby, Estacada, Milwaukie
    - Oregon Cascades West Council of Governments - Albany, Linn-Benton Counties and Oregon Cascade West Council of Governments - Toledo, Lincoln County

Education:

- 11 OABHSs have degrees in social work (MSW / LCSW)
- 14 OABHSs have Masters Degrees in Psychology-related fields, and 1 OABHS is currently working toward a Masters in Psychology
- 2 OABHSs have PHDs
- 1 OABHS has an MBA

Work experience:

- 3 OABHSs list experience working in aging services
- 18 OABHSs list experience working in behavioral health services
- 4 OABHSs list experience working in addictions
- 8 OABHSs list experience working in care coordination

Misc.:

- 1 OABHS has extensive experience working with LGBT older adults
- 1 OABHS lists extensive experience with PASRR
- 1 OABHS has extensive experience working in primary care settings
- 17 OABHSs specifically list experience in direct service with older adults, whereas all 24 OABHSs relate to their experience with direct service with individuals with behavioral health needs in general
    - Reinforces the common concern that OABHS appear to share about the lack of direct service in their new positions
- 4 OABHSs list experience directly relevant to community capacity building:
    - "has worked at bridging partnerships between mental health agencies and facilities…participated in a community evaluation process"
    - "cultivated community partnerships as a QMHA for Enhanced Care Outreach Services (ECOS)"
    - "worked collaboratively with other community-based organizations to develop programming and support services specific to those living with early stage memory loss"
    - "the liaison for APD and collaborates and coordinates care between the two agencies when an individual's need overlaps…experience in quality assurance."

Appendix C
Community Stakeholder Discussion Guide

Purpose: To assist local Older Adult Behavioral Health Specialists collect information from colleagues and other community leaders to improve their knowledge of local behavioral health care resources for older adults.

- **Phase 1: initial meeting to build relationship, gain information about agency**
- **Phase 2: follow up for more detailed questions, are we meeting with the right people in their agency?**

Opening script:

- Focus on integrating services.
- How do you define older adults? Age? Disability?
- Do people know the term Behavioral Health and what it implies as "services": therapy, skills training, case management, socialization, substance abuse, education/psychoeducation groups, support groups, respite, discharge social workers, screenings, etc.

Thank you so much for meeting with me. Our discussion will help me as I begin my new position as an Older Adult Behavior Health Specialist here in [community]. I would like to know your views about the strengths of behavioral health care, the gaps between need and access to services, and your recommendations for improving services.

Interview guide

1. What types of behavioral health services does your agency/organization provide to older adults?
   - *Do people know the term "behavioral health", is the community still using "mental health"?*
   - What types of services does your agency/organization provide to older adults?
   - If not specific programming for older adults, how are older adults utilizing current services? How do older adults typically access/utilize the services you offer?

2. What do you think are the major gaps in services for older adults in this community? [Probes: Mental health resources? Who gets missed/falls through the cracks?]
   - What issues/challenges does your agency come across with older adults?(i.e. complications with older adults)
   - How are older adults falling through the cracks? Not getting the services they need?

3. What are the major barriers to bridging these service gaps? [Probes: Competing agency goals? Geographic distance?]
   - What is your opinion of why these gaps aren't fixed?
   - We talked about some gaps/issues/challenges, what are the barriers to solving those issues?

4. What are the opportunities for bridging these gaps? For example, which agencies work well together (this does not have to be specific to aging and behavioral health)? [Probes: Formal services e.g., clinics, AAAs, CCOs? Informal services/voluntary groups e.g., churches, neighborhood associations?]
   - Have you had any success in address these issues/gaps/barriers?
   - If yes, how?
   - If no, what was missing?

- What partners do you work with in the community? Who do you partner with most frequently? Who would you like to & why? Who don't you partner with and why?
- Identifying system blocks

5. I will be convening a meeting of representatives from key organizations and community leaders to address the behavioral health needs of older adults in our community. To help ensure success, who do you think needs to be invited? Initial phase.
   - Vary for each county
   - Who do you feel it would be helpful to talk to?

6. What recommendations do you have for me in my role of Older Adult Behavioral Health Specialist?
   - As we move forward with this process, do you have any recommendations/suggestions?

Thank you for your time!

Date: _____

Community Stakeholder Name: _____

Stakeholders' agency/organization: _____

City/county:

_____

Contact information:

Phone _____

Email _____

Appendix D
PASRR Participants' Reports of Knowledge Before and After the Training

	BEFORE today	AFTER today
Nuts & Bolts Of PASRR (Edward Kako, MSc, PhD)		
a. Explain the basics of how PASRR works	2.78	3.71
b. Explain the use of Level I screens and Level II determinations	2.64	3.53
c. Describe the use if categorical determinations	2.29	3.60
d. Discuss person-centered PASRR	2.67	3.96
Is it Dementia, Delirium or Depression? (Glenise McKenzie, PhD, RN)		
a. Identify risk factors for delirium, dementia, and depression in older adults	3.07	4.18
b. Discuss differences between delirium, dementia, and depression in older adults	3.18	4.11
c. Recognize the utility of common tools for assessing patients with delirium, dementia, and depression	3.07	4.11
What Happens to that Pill After it is Taken? (William "Si" Simonson, PharmD, CGP, FASCP)		
a. Describe how normal age-related changes influence the action of medications	2.65	3.95
b. Identify at least three medication classes that may be involved in interactions	2.65	3.95
c. Discuss at least two medication-related syndromes that may affect behavior	2.73	3.95
Enhancing Well-Being: Medications and Beyond for Elders Living with Mental Illness (Lynda Crandall, RN, GNP)		
a. List at least 3 elements of well-being	3.31	4.09
b. Describe the assessment process used to address symptoms often described as "behavior challenges" or "behavior problems"	3.11	3.87
c. Discuss at least 3 methods to individualize a treatment/care plan	3.38	4.18
d. Describe at least 2 non-drug strategies to address behavioral presentations in persons living with mental illness	3.40	4.09
Creating Opportunities for Transition (Christina D Jarmillo)		
a. Discuss the philosophy behind Diversion and Transition	2.36	3.02
b. Describe community based care choices	2.53	3.20
c. Explain the role of the Transition Coordinator	2.33	3.09