Evaluation of the Behavioral Health Initiative for Older Adults and People with Disabilities in Oregon

EXECUTIVE SUMMARY
REPORT FOR THE PERIOD
JULY 2017 – JUNE 2019

Background

This report summarizes the findings pertaining to progress toward meeting the goals of the Behavioral Health Initiative (BHI, or the Initiative) for Older Adults and People with Disabilities (July 2017 to June 2019). The goal of the Initiative is "to create greater access to mental health and addiction services geared to the needs of seniors and people with disabilities within the senior/disability and community mental health systems and other public and private mental health and addiction services."[1] Twenty-four Behavioral Health Specialists (Specialists) located in communities throughout Oregon and overseen by the Statewide Director of the Initiative, were hired "to facilitate outreach and services to seniors and people with disabilities experiencing mental health and addiction problems."[2] The three major job functions of the Specialists are to (a) promote collaboration and coordination among core stakeholders and community partners, (b) provide complex case consultation for older adults and people with disabilities who have behavioral health needs, and (c) offer training to support workforce development and community health and wellness promotion.

Data were gathered from the Specialists via quarterly reports, reports on complex case consultations they organized or participated in, and reports on workforce development trainings and community education events they conducted, facilitated, or planned. Data from participants in the trainings were also gathered, and an annual online survey of community stakeholders was conducted. Where possible, changes over time were examined.

Barriers and Gaps in Services

There was considerable agreement between stakeholders and Specialists about the many barriers to serving this population. Stakeholders and Specialists perceived three of the same top five challenges: lack of affordable housing, lack of behavioral health services in long-term

[1] Oregon Legislative Work Group on Senior and Disability Mental Health and Addictions, in cooperation with the Senate Health Care and Human Services Committee. (2013, January 31). *Final Report.* P. 9.
[2] Ibid, p. 10.

care settings, and restrictive eligibility criteria. The two remaining top five barriers identified by stakeholders were the lack of behavioral health programs specific to older adults and people with physical disabilities and the lack of in-home services. As reported by the Specialists, the two remaining top five barriers were distance to services and lack of transportation.

Although still seen as major barriers, several barriers lessened in the last two years. According to Specialists' perceptions, these included the lack of behavioral health programs specific to older adults and people with disabilities, the lack of in-home services, waitlists, the lack of needed services other than those specifically asked about, the lack of credentialed providers willing to accept Medicare reimbursement for behavioral health services, and the lack of personnel with the required expertise to provide quality behavioral health services. Among stakeholders, there was some evidence that distance to services was seen as less of a barrier.

Strategies and Actions for Addressing Barriers

Collaboration and Coordination

There was consistent community partner involvement over time, as reported by Specialists. However, as revealed in the stakeholder survey data, representatives of other community partners such as law enforcement, veterans services, tribal organizations, and faith communities comprised a larger share of respondents; thus, Specialists may be reaching out to previously unconnected community partners.

There were both improvements and downturns in the indicators of collaboration and coordination over time as revealed in the stakeholder survey data. Community partners who attended collaborative meetings showed greater agreement on priorities for addressing gaps. They also reported less competition for stakeholders' time and attention by other projects. At the same time, although a majority of the stakeholders continued to agree that the Initiative was a priority for their organization, this indicator worsened since 2017. There was also a decline in the percentage of stakeholders who reported having participated regularly in discussions or meetings whose primary purpose was to talk about collaboration or coordination of services, and the share of stakeholders who reported having never attended these meetings increased. It is important to note, though, that the sample for the survey was again expanded in 2019, and this may have negatively affected the results, with a larger number of those surveyed likely being more tangentially involved in and perhaps less knowledgeable about the Initiative.

Specialists' reports indicated no change over time in core stakeholders' engagement in coordination activities such as expressing support, having direct involvement, having regular contact with other stakeholders, and agreement on gaps and priorities in behavioral health services for older adults and people with disabilities. **There were several improvements, though, with respect to community partner involvement in community capacity building activities.** Specialists were more likely to report that community partners had formed a cohesive group committed to addressing gaps in services, community partners met often enough to make progress in reducing gaps in services, consumers were well represented at

community partner meetings, coordination among community partners had improved, memoranda of understanding or participation agreements were more likely to be in place, agencies were not working in silos, and turnover in community partner organizations had declined.

Complex Case Consultation

Specialists were involved in a large number of complex case consultations (CCCs): 2,331 between October 2017 and March 2019 (six quarters), or roughly an average of 16 cases per quarter per Specialist. The number of cases per quarter varied considerably by Specialist, however, ranging from a few to over 50.

Many stakeholders (42%), reported involvement in one or more CCCs that had included the Specialist in their community, and 90 percent saw these CCCs as somewhat or very successful in resolving the problems or concerns about the care or treatment plan for the older adults or adults with physical disabilities. Over time there was no statistically significant change in stakeholders' views of the overall success of the CCCs,

The most common actions Specialists reported taking during the CCCs were:

- Assisting with information or referrals to services
- Providing clinical information about the consumer's presenting problems
- Providing additional staff training or coaching
- Providing the consumer and/or surrogate with short-term help in accessing services

The issues addressed in these complex case consultations were indeed complex. Most of the CCCs (62%) involved consumers with five or more issues; half of these cases (or 30% of all cases) had 10 or more issues. Difficulties in navigating the system for the consumer, family members or other supports and complex and/or co-occurring medical conditions were the consumer issues most likely to be reported, followed by the lack of or poor family/natural supports. About one third of cases involved consumers with functional limitations, isolation or loneliness, or difficulties in understanding eligibility for services.

For about half of the cases, a change in residence was recommended. In over half of those cases, however, a change in residence was not obtained either because the option was not available (42%) or the consumer refused (12%). Most of the recommended changes in residential setting were moves to a higher level of care. **In nearly all of the CCCs, the Specialists reported that the community could provide at least some of the resources necessary to address the needs of the CCC consumer.**

Workforce Development and Community Education

Specialists conducted, hosted or planned a large number of training events: 405 community education events and 484 workforce development events between July 2017 and March 2019, for an average of 58 community education and 69 workforce development events (127 training events) per quarter. A wide array of topics was covered (e.g., system navigation, available resources, communicating needs, physical disability/function, and advance planning/end-of-life care) for participants ranging from advocates and consumers to individuals working in behavioral health services, primary care, or local law enforcement.

Most of the stakeholders responding to the online stakeholder survey had attended at least one behavioral health-related in-service and/or training event planned, conducted or facilitated by the Specialist since June 2015, increasing from 62% of stakeholders in 2017 to 74% in both 2018 and 2019. This increase is due in part because participants who took a training evaluation survey were subsequently invited to participate in the stakeholder survey. The most common reasons given for not attending training events were lack of awareness about training opportunities and lack of time; these did not change from 2018. There was some evidence, though, that financial constraints increased as a barrier to attending trainings. Although the vast majority of trainings offered by Specialists are provided at no cost to participants, and only 11 percent of stakeholders reported in 2018 that trainings were too expensive (e.g., due to the cost of travel or time away from work), 30 percent did so in 2019.

The trainings were evaluated very highly by participants with respect to the amount learned, confidence in their ability to use the knowledge gained, the trainings having met their expectations, the usefulness of the information in their work, support by their employer for the topic, preparation for work with or advocacy for older adults and people with disabilities with behavioral health needs, and the trainers' preparedness, knowledge, and responsiveness to their questions.

The trainings continued to be very positively evaluated by the training participants who responded to the follow-up survey two months after the training. The vast majority of respondents reported that their supervisor supported their using the knowledge and skills gained, they had shared information with their coworkers, their agency had the staff and resources needed to apply the information, they were providing better services to older adults and people with disabilities, they were able to use information from the training in their job, their work improved as a result of training, and that the training gave them confidence in their ability to meet the needs of this population. However, among respondents who did not select "not applicable" or "don't know," only one third reported that their agency was using screening or assessment tools they had learned about at the training. This may be because most participants were not in a position to introduce new tools for use in their agencies.

Systems Change

A key element for bringing about systems change and positive consumer outcomes is the availability of a multidisciplinary team (MDT). **There was a slight but statistically significant increase in overall MDT success as reported by Specialists over time.**

Specialists and stakeholders were asked about progress toward achieving various desired outcomes for consumers. The wording of items was not directly comparable for the two groups, however, and many Specialists and stakeholders alike responded that they did not know about the extent to which success had been achieved in a given outcome. Other ways of collecting data about outcomes must be considered, such as interviews with stakeholders and Specialists.

Among the Specialists who responded to questions related to the outcomes of the Initiative, several improvements over time were revealed. These included increased referrals for complex case consultation, greater ease in making referrals, greater willingness among providers to accept Medicare reimbursement for this population, greater access by consumers

and family members to needed services, decline in inappropriate hospitalizations, and greater knowledge of each other on the part of relevant services agencies.

Among the stakeholders surveyed, there was some evidence that some outcomes had worsened over time. There was less agreement that older adults and people with physical disabilities who have behavioral health needs were recognized as priority populations, were more likely to have timely access to the full range of services they need, were more likely to have access to community-based behavioral health programs or services that have demonstrated their effectiveness, and were more likely to receive help from direct service and/or primary care providers with the requisite knowledge and skills. Also, fewer stakeholders in 2019 agreed that community partners were more successful in resolving complex cases.

Stakeholders reported only minimal behavioral health service provision to various groups of older adults and people with physical disabilities who have unique vulnerabilities (e.g., those living in long-term care or community-based care, ethnic minorities, LGBTQ+ populations, veterans, those who are socially isolated, those with serious mental health issues, those with addictions issues). Furthermore, there was some evidence of decline in the provision of behavioral health services to those at risk of behavioral health issues due to isolation. Greater awareness of the extent and effects of social isolation, due to Specialists' efforts to raise awareness and attention in the media, likely contributed to this result. **Again, because of expansion and changes in the sample for the stakeholder survey each year, these findings should be viewed with caution.**

Retention and Recruitment of Behavioral Health Specialists

Behavioral Health Specialists are the backbone of the Initiative. As of June 2019, seven of the original cohort of 24 Specialists remained in their positions. **Progress on the Initiative may be stalled when turnover occurs and vacant positions must be filled.** Moreover, it is unclear whether Specialists "have the authority necessary to assure that system changes can be made to ensure service delivery systems will meet individual needs," as stipulated in the report regarding the Special Purpose Appropriation in 2013 for Senior and Disabled Mental Health Services.[3] Further exploration is needed of the decision-making authority of Specialists and ways to enhance their retention and recruitment.

Recommendations

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

1. Integrate behavioral health (OHA) and aging services (DHS) for older adults and people with disabilities with cross-system care needs.

[3] Report regarding the Special Purpose Appropriation in 2013 for Senior and Disabled Mental Health Services. (2014, August 15). Pp. 2-3.

    a. Acknowledge shared responsibilities for services by executing MOUs at the state and local levels.
    b. Use “braided” or blended funding strategies so that each agency contributes to the needed array of services.
    c. Prioritize building bridges between local agency leaders and their staff to reduce state agency siloes.
2. Elevate older adults and people with disabilities as a priority population in organizations and programs that offer behavioral health services and supports.
    a. Allocate funding for appropriate services.
    b. Support and invest in a knowledgeable and skilled workforce.
    c. Promote program development to enhance access to services and specialized housing.
3. Increase Medicare literacy and promote structural changes.
    a. Allocate funding for technical assistance for providers.
    b. Educate providers on behavioral health billing codes and alternative strategies.
    c. Advocate for increased reimbursement rates and a larger group of qualified professionals who can provide billable mental health services for this population.
4. Consider and address the personnel-related factors that may impact progress.
    a. Assess the factors affecting Specialist turnover.
    b. Identify ways to recruit and sustain a qualified workforce of Behavioral Health Specialists.

Conclusion

Many barriers remain to addressing the behavioral health needs of older adults and people with physical disabilities in the state of Oregon, and there is considerable agreement between stakeholders and Specialists, at least, concerning what these barriers are. At the same time, several barriers appear to have lessened in the last two years, which is good news.

The evidence for progress toward accomplishing the goal of the Initiative is mixed, however. There were both improvements and downturns in the indicators of collaboration and coordination over time. With respect to community partner involvement in community capacity building activities, there were several improvements. Specialists appear to be reaching out to community partners previously unconnected to the Initiative.

Specialists are the backbone of the Initiative, and they are busy! Each was involved in an average of five workforce development or community education events per quarter and an average of 16 complex case consultations per quarter. The trainings they conducted, hosted, or planned were evaluated very highly. They have initiated many unique and innovative programs.

Other reasons for optimism about the prospects for success for the Initiative are the increase in overall success of multidisciplinary teams and improvements in several consumer outcomes as perceived by Specialists over time. Among the stakeholders surveyed, however, there was some evidence that some outcomes had worsened over time. Also, few of the most vulnerable

groups of older adults and people with disabilities were reported by stakeholders as having received behavioral health services, and there was some evidence of decline in service for some, although these results should be viewed with caution given changes over time in the sample for the stakeholder survey.

Clearly, gains have been made. Nonetheless, work remains to be done to address the behavioral health needs of older adults and people with physical disabilities in Oregon. Formal agreements for sharing information and resources and reducing silos between community partners still are needed. Work toward a Memorandum of Understanding between OHA and APD is underway, and similar agreements are in place or are being pursued in some communities at the local level. Ground needs to be made up with respect to elevating older adults and people with disabilities who have behavioral health needs as a priority population. Although progress has been made with respect to getting providers to accept Medicare reimbursement, continued effort is needed to educate federal policy makers about flaws in Medicare reimbursement rates and practices and to inform local providers about alternative billing strategies. Finally, because progress in the Initiative rests heavily on the work of the Behavioral Health Specialists, it is critically important to identify ways to recruit and sustain a qualified cadre of Specialists.