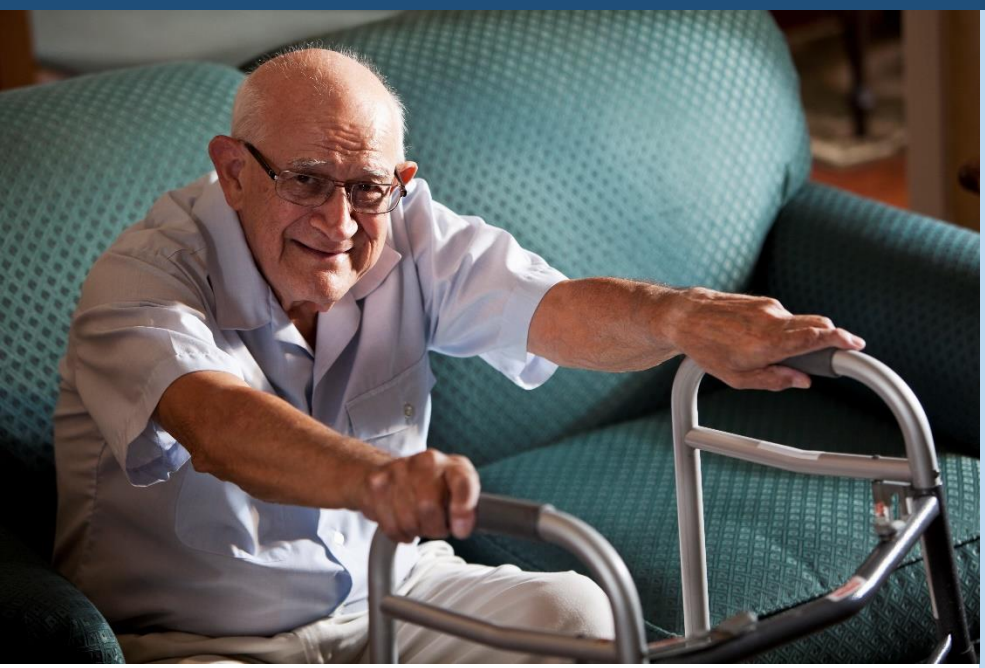
Final Report

2017-2019

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



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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.

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

REPORT FOR THE PERIOD JULY 2017 – JUNE 2019

Background

In 2014 the Oregon legislature allocated funding to the Oregon Health Authority (OHA) for the Behavioral Health Initiative (BHI, or the Initiative) for Older Adults and People with Disabilities. Subsequently, the OHA contracted with the Institute on Aging (IOA) at Portland State University (PSU) to conduct an assessment of the behavioral health needs of older adults and how best to address the gaps. Early in 2015, a Statewide Director, Nirmala Dhar, was named to lead the BHI within the OHA. Community Mental Health Programs and other nonprofit entities were awarded contracts to hire 24 Behavioral Health Specialists (subsequently referred to as Specialists) located in communities throughout Oregon (see Figure 1). Since July 2016, the OHA has contracted with the IOA at PSU to document the activities and accomplishments of the Initiative.[1] The current report describes the evaluation findings from July 2017 - June 2019, with an emphasis on findings pertaining to progress toward meeting the goals and objectives of the Initiative and identifying ways to improve services. When possible, comparisons are made with data from the previous year.

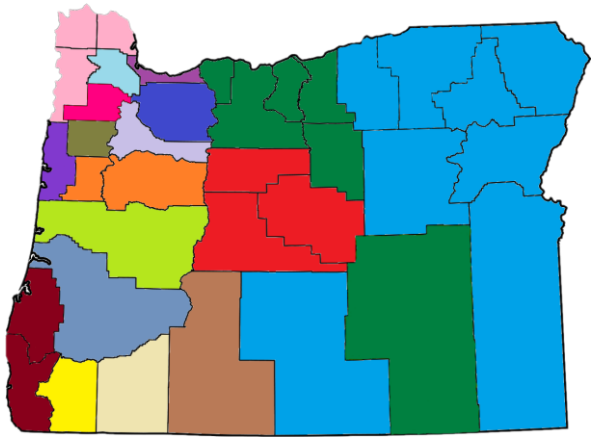


Figure 1. 2019 Behavioral Health Specialist service areas

[1] PSU Institute on Aging (2017). *Evaluation of the Behavioral Health Initiative for Older Adults and People with Disabilities in Oregon, July 2016-June 2017*. This report can be found at https://www.pdx.edu/ioa/more-about-the-program.

Gaps in Services

The needs assessment conducted in 2014 identified a number of issues related to addressing the behavioral health needs of older adults and people with disabilities in Oregon, as presented in Table 1.

Table 1

Gaps in Behavioral Health Services Identified for Older Adults and People with Physical Disabilities as Identified in the 2014 Needs Assessment

Lack of Coordination

- Systems are fragmented
- No one agency willing to take the lead in assessing or coordinating services
- Services are provided in silos; as a result, those with behavioral health needs who also have age-related or disability-related needs are not a priority for any organization.
- Each system (e.g., health system, aging and disability system, behavioral health system) has different requirements and funding sources
- Little information sharing among agencies takes place for those with complex needs
- Those with complex needs are often invisible to multiple service systems until there is a crisis

Lack of Availability

- All health, aging and disabilities, and behavioral health systems are overloaded due to limited resources and funding and lower priority being placed on this population.
- Lack of knowledgeable providers
- Issues of availability are particularly high in rural communities

Lack of Accessibility

- No approved Medicare providers willing to take clients in the area
- Lack of transportation
- Restrictive eligibility requirements
- Issues of accessibility are particularly high in rural communities

Lack of Affordability

- Those who do not qualify for public services often cannot afford to pay out of pocket

Lack of Acceptability

- Stigma associated with behavioral health makes older adults or people with disabilities reluctant to seek out or accept services
- Few services are tailored to the population in terms of service location (e.g., mental health clinics rather than in home or primary care settings) or program design

The Specialists focus on bridging these gaps through their three primary job functions: (1) to promote collaboration and coordination among core stakeholders and community partners, (2) provide complex case consultation for older adults and people with disabilities who have behavioral health needs, and (3) to offer training to support workforce development and increase public awareness of behavioral health issues and resources (see Figure 2).

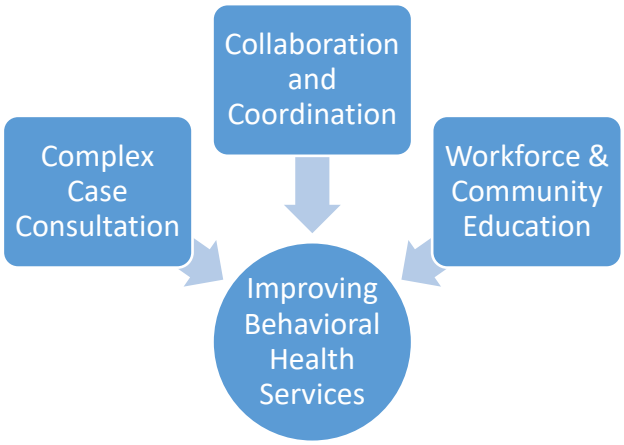


Figure 2. Behavioral Health Specialist job functions

Purpose and Methods

The purpose of the evaluation has been: (1) to systematically collect and analyze data to document the activities and accomplishments of the Behavioral Health Initiative for Older Adults and People with Disabilities and (2) to identify ways to continue to improve behavioral health services for older adults and people with disabilities in Oregon. The evaluation is based on an adaptation of the logic model developed by the research team to guide the evaluation, as shown in the following figure. The data collected have focused on the activities related to the three functions of the Specialists and how these have contributed to better meeting the behavioral health needs of older adults and people with disabilities. Data have also been gathered pertaining to the systems-related changes that have occurred to date resulting from the work of the Specialists and other community partners. The logic model serves as the organizing framework for this report.

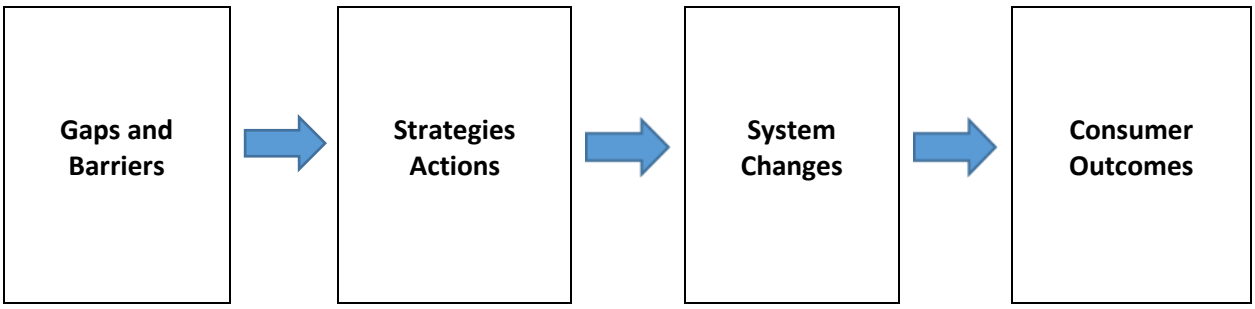


Figure 3. Guiding logic model

Data Sources

Data were gathered from multiple sources using various tools[2] developed by IOA team, as described below. The results of the evaluation to date are presented for each element in the logic model. This report includes data collected in the fiscal year (FY) period 2017-2019 (Years 2 and 3 of the evaluation). When possible, we compare these data with those collected in FY 2016 (Year 1 of the evaluation).

Quarterly Reports. Specialists submit reports quarterly, although some aspects of their job are reported on every six months (every other quarter) instead of quarterly to minimize reporting burden. The Specialists' reports contain information about barriers, collaboration and coordination, and perceived progress in systems changes and outcomes.

Some quarterly reports cover more than one county (e.g., both Linn and Benton). Also, some reports during FY 2017 were not submitted or received due to position vacancies. Nonetheless, the reports submitted for the present evaluation covered from 90 to 100 percent of Oregon's population, depending on the quarter. Several indices using multiple questions were created to measure change in various aspects of the Initiative over time. All statistical tests were conducted using within-county models to ensure comparability over time.

Reports on Complex Case Consultations. Beginning in October 2017, Specialists began recording detailed information about the complex case consultations (CCC) they organized or participated in. This information provides rich data and further insight into the needs of the population and the extensive work of Specialists to address this job function. The data available for this report were reported between October 2017 and March 2019. During this period, Specialists reported on a total of 2,331 complex case consultations. Note that this figure does not correspond to total number of consumers served by Specialists through these consultations, since consumers (and their proxies, or referral source) can receive more than one consultation. The reporting form has been revised and updated multiple times based on Specialists' suggestions and experiences.

Trainings Conducted and Participants' Evaluations of Trainings. Specialists organize two types of training: workforce development and community education events**.** Workforce development trainings are aimed at enhancing the behavioral health-related knowledge and skills of aging services, health services, mental health services, and other professionals. Community awareness events are intended to inform the public about topics related to wellness, healthy aging and behavioral health. In their quarterly reports, Specialists reported conducting, facilitated or planning a total of 405 community education (CE) events and 484 workforce development (WD) events between July 2017 and March 2019 – for an average of 58 CE and 69 WD events per quarter during this period (or an average of 127 CE or WD events per quarter).

In addition, to evaluate the workforce development events, data were collected directly from training participants using online questionnaires sent to the email addresses provided by the participants. Surveys were sent within a few days following the training and again two

[2] The specific tools used to collect data are available upon request.

months after the training to determine how participants were using what they had learned in the training in their work.

Between October 2017 and March 2019 (when we started collecting post-training follow-up data and the latest quarter for which we have data), 376 workforce development training events were conducted, hosted, or planned by a Behavioral Health Specialist. The training evaluation data in this report come from those individuals who attended one or more of those events. Electronic post-training evaluation forms were successfully sent to over 5,500 participants; more than 2,300 (42%) participants completed the post-training survey. Between October 2017 and December 2018, 4,687 follow-up surveys were successfully sent to participants, and 965 surveys (21%) were completed.

The estimated number of attendees at the community education events conducted, facilitated, or planned by the Specialists was over 13,000 (not an unduplicated count). Several of these events (e.g., information booths at health fairs), did not lend themselves to formal evaluation. At these events, Specialists distribute customized paper evaluation surveys tailored to the content and audience. These surveys are sent to the evaluation team for an event-specific summary of participant responses. Because these evaluations are customized to specific events, no cumulative analysis was conducted.

Stakeholder Survey. Community stakeholders across Oregon completed surveys that focused on all areas of the logic model: gaps in and barriers to services, the Specialists' core job functions, systems changes, and progress toward improving consumer outcomes. The sample for the survey consisted mostly of individuals named by the Specialists as people in their country or region having an interest in the Initiative and being decision makers or having influence with decision makers about issues such as budgeting, staffing, programming, training, or direct services. These included administrators, managers, direct service and primary care providers, and lay persons or advocates. The Specialists' lists were then supplemented with stakeholder names and email addresses provided by the BHI Director, Advisory Council members, and searches by the PSU team through agency listings to ensure similarity in coverage across different communities, as well as individuals who participated in evaluations of training conducted by the Specialists. In 2017, the Stakeholder Survey was distributed to 700 individuals. In 2018, the Stakeholder Survey was distributed to 1,213 individuals between February and March, representing an increase in the sample of 513, or about a 73% increase in identified stakeholders. In 2019, the Stakeholder Survey was distributed successfully to 1,784 stakeholders during February and March, representing an increase in the sample of 571, or a 47% increase. The response rates were 33, 32, and 26 percent in 2016-17, 2017-18, and 2018-19, respectively. The declining response rate may be due to a number of factors: the continually expanding list of individuals included as stakeholders, including more laypersons, some of whom may be more tangentially involved in and perhaps less knowledgeable about the Initiative; respondent fatigue from participating in previous years; and technical issues in the delivery of the questionnaire (i.e., restrictive firewall settings in some agencies, blocking receipt of the survey). The size of stakeholder lists varied by county and across the three years of the survey, with some counties experiencing an increase and others a decrease in terms of their share of respondents in the sample. Participating stakeholders represented all regions of the state and all types of program positions. About 52% of the stakeholders who answered the

survey item about the service area in which they worked, volunteered, or advocated were in rural counties, providing good representation of those communities. In 2017 and 2018 (Years 1 and 2 of the Stakeholder Survey), middle managers, program managers, and clinic directors comprised the largest share by position type. In 2019 (Year 3 of the Stakeholder Survey), direct service providers and primary care providers made up the largest share of respondents (Figure 4 below).

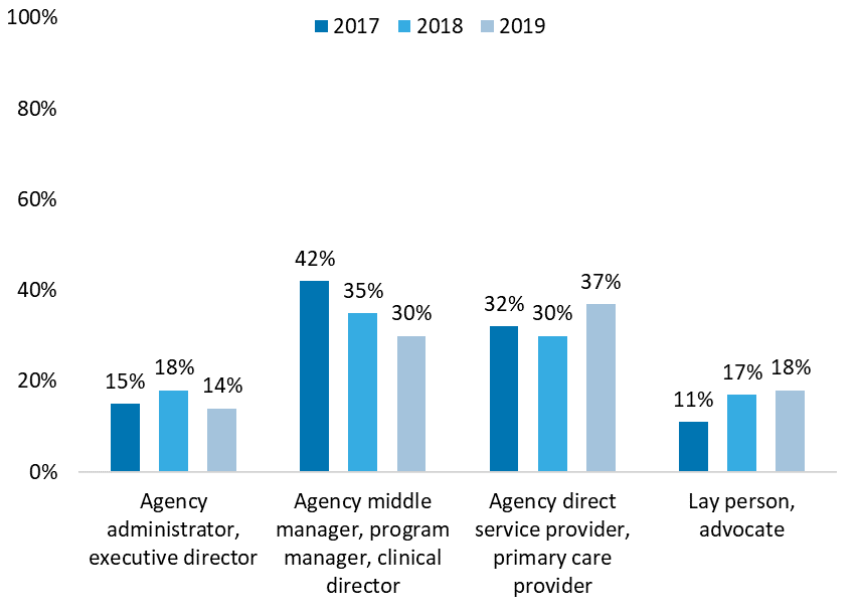


Figure 4. Distribution of stakeholders by position type

The results of the evaluation to date for each component of the logic model are presented in the next section. When available, data collected in FY 2016-2017 are compared with those collected during FY 2017-2019.

Evaluation Results

Barriers and Gaps in Services

Both stakeholders and Specialists were asked about each of 16 barriers to serving older adults and people with physical disabilities who have behavioral health needs that emerged from the 2014 needs assessment. These barriers comprised four categories: (1) physical infrastructure, (2) lack of services and programs, (3) lack of providers, and (4) policy and systems issues. Figures 5-8 show responses of stakeholders and Specialists over time. The stakeholder data were collected during the first quarter of each year through the online survey. The closest data point for Specialists consisted of the quarterly reports from the previous year, so those are the data used to maximize comparability in terms of time of measurement for the two groups.

Table 2

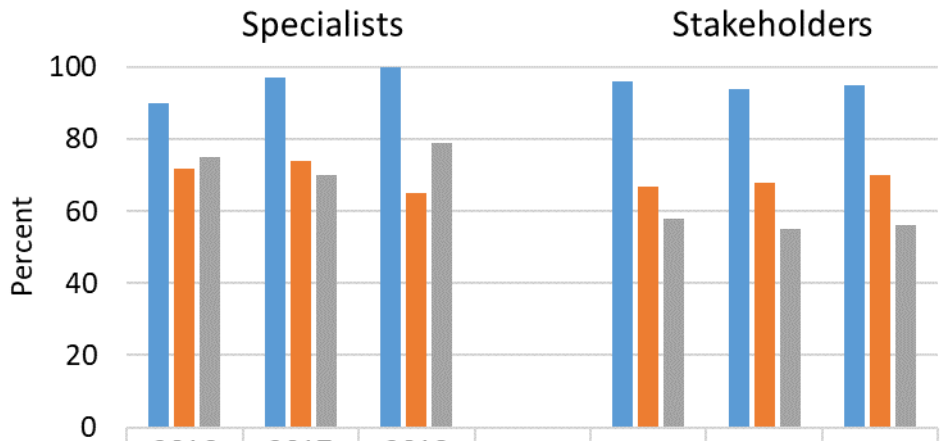
Top Five Barriers According to Specialists and Stakeholders

#	Specialists (Q4 2018)	Stakeholders (Q1 2019)
1	Lack of affordable housing (100%)	Lack of affordable housing (95%)
2	Lack of behavioral health services in long-term care settings (79%)	Lack of behavioral health services in long-term care settings (83%)
3	Distance to services (79%)	Restrictive eligibility criteria/person does not qualify (79%)
4	Restrictive eligibility criteria/person does not qualify (76%)	Lack of behavioral health programs specific to older adults and people with physical disabilities (77%)
5	Lack of transportation (65%)	Lack of in-home services (76%)

The two groups shared three of the top five challenges: lack of affordable housing, lack of behavioral health services in long-term care settings, and restrictive eligibility criteria.

Physical Infrastructure (Housing and Transportation)

Lack of affordable housing remained the top barrier identified by both stakeholders and Specialists, with over 90 percent of both groups identifying this as a barrier (see Figure 5 below). Transportation and distance to services continued to be barriers as well, with over 50 percent of both groups identifying these two barriers as present in their communities. When we analyzed the responses of stakeholders over time, there was some evidence that stakeholders perceived distance to services as having lessened somewhat as a challenge in 2019 compared to 2017. (Note that the figures below show the cross-sectional results and thus differ somewhat from the findings from the longitudinal analyses, which included only respondents who had responded to at least two of the three Stakeholder Surveys.)



	2016 Q4	2017 Q4	2018 Q4		2017	2018	2019
Housing	90	97	100		96	94	95
Transportation	72	74	65		67	68	70
Distance to services	75	70	79		58	55	56

Figure 5. Percent of stakeholders and Specialists reporting housing, transportation and distance barriers

We do not have enough low-cost housing for elders who can live independently, but need to be close to services. Transportation is minimal throughout the county.

-Stakeholder

Transportation remains a high need for many of our clients. There is also a huge need for in-home services that remains to be unrecognized.

-Stakeholder

We still have a huge need for affordable housing and transportation. There is also a lack of housing for older adults who have both physical and mental health issues.

-Specialist

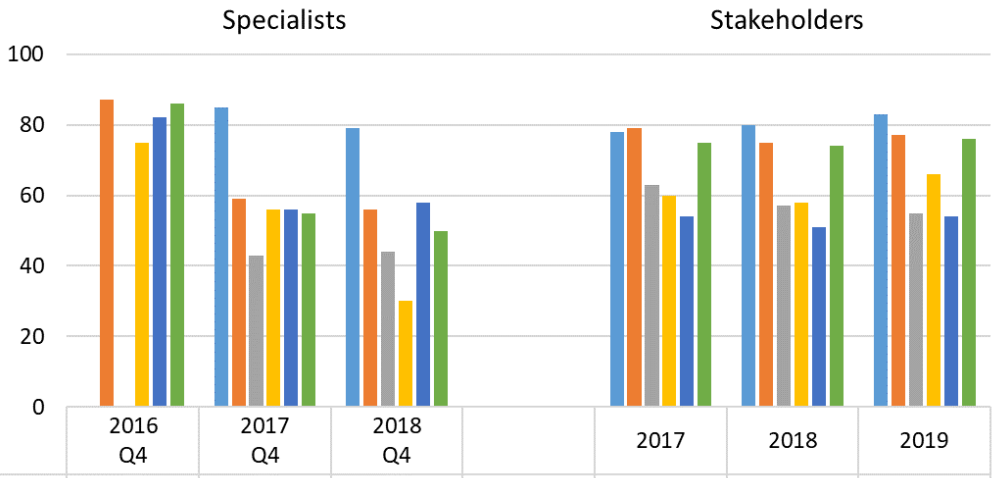
Lack of affordable housing, lack of transportation, and distance to services continue to be an issue in Douglas County.

-Specialist

Lack of Services and Programs

The next most challenging barrier according to both stakeholders (83%) and Specialists (79%), was the lack of behavioral health services in long-term care settings such as nursing homes and assisted living residential settings (see Figure 6). For stakeholders, the lack of behavioral health programs *specific* to older adults and people with disabilities was another significant barrier (reported by 77% of stakeholders). Specialists, however, perceived this barrier to have become significantly weaker over time, from 87 percent of Specialists identifying this barrier in Q4 2016 down to 56% in Q4 2018 (not shown on the above table).

An additional challenge related to lack of services and programs included a lack of in-home services, identified by three-quarters of stakeholders in all three years of the survey, and by 86% of Specialists in Q4 2016 down to 50% in Q4 2018. According to Specialists, therefore, this is another area of significant improvement. Lack of prevention and wellness services were reported by 63% of stakeholders in 2017, 57% in 2018 and 55% in 2019. Fewer than 50% of Specialists identified this as an issue in Q4 2017 (42%) and Q4 2018 (44%). Wait lists to obtain services were seen as a barrier by about 66% of stakeholders in both 2019 and 2017. Specialists' perceptions demonstrated significant improvement, however: in Q4 2016, 75% of Specialists reported wait lists as a significant barrier, but in Q4 2018, only 30% of Specialists did so. Lack of needed services other than those listed also lessened as a barrier, according to Specialists, with 82% listing these in Q4 2016 compared to 58% in Q4 2018.



	Specialists			Stakeholders		
	2016 Q4	2017 Q4	2018 Q4	2017	2018	2019
Lack BH in LTC		85	79	78	80	83
Lack services for population	87	59	56	79	75	77
Lack prevention and wellness		43	44	63	57	55
Wait list	75	56	30	60	58	66
Lack of other services	82	56	58	54	51	54
Lack of in-home services	86	55	50	75	74	76

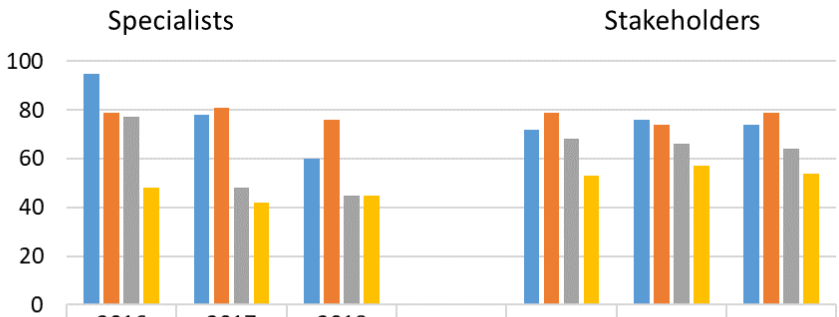
Figure 6. Percentage of stakeholders and Specialists reporting service and program barriers

Note: Data on behavioral health services and lack of prevention and wellness services were not collected from Specialists in 2016.

Policy and Systems Issues

Only one of the top five challenges identified by both stakeholders and Specialists fell in the category of policy and systems issues: restrictive eligibility criteria which prevent people with significant or complex needs from qualifying for services. About 76% of Specialists and 79% of stakeholders reported this barrier in their communities, with no significant change in either group. About three quarters of stakeholders perceived a lack of credentialed providers willing to accept Medicare reimbursement for behavioral health services as a barrier in both 2017 and 2019. As perceived by Specialists, however, this was an area of significant improvement: between Q4 2016 and Q4 2018, the share of Specialists identifying the lack of credentialed providers willing to accept Medicare reimbursement for behavioral health services as a barrier declined from 95 to 60 percent.

Other barriers related to policy and systems issues included a lack of integration of behavioral health and physical health services, reported by about two-thirds of stakeholders throughout the period. In contrast, 77% of Specialists identified this as a barrier in 2016, compared to fewer than 50% in Q4 2017 and Q4 2018 (although this improvement was not statistically significant). This change in Specialists' perception may be due to their continued efforts to build capacity for complex case consultation in their communities. In addition, there has been a push for the integration of behavioral health services in primary care among Coordinated Care Organizations. The change in perception among Specialists may be in response to these efforts. Finally, among Specialists, poor communication between relevant agencies and organizations was reported as a significant barrier by less than 50 percent of them, while the corresponding figures among stakeholders were slightly higher, ranging from 53 percent in 2017 to 54 percent in 2019. Figure 7 below displays the results pertaining to barriers related to policy and systems issues.



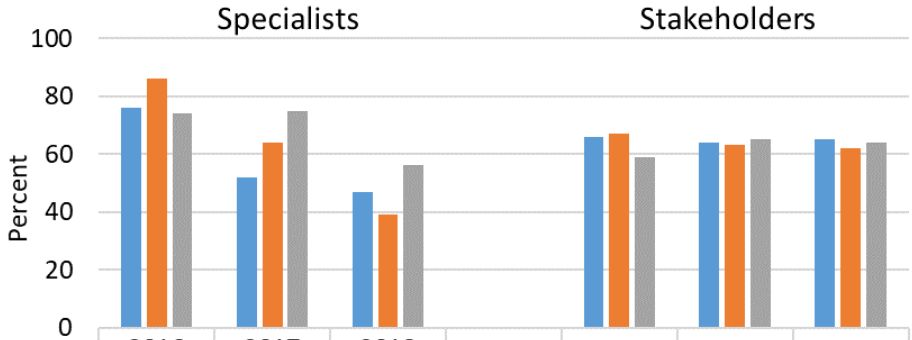
	Specialists				Stakeholders		
	2016 Q4	2017 Q4	2018 Q4		2017	2018	2019
Not accepting Medicare	95	78	60		72	76	74
Restrictive eligibility criteria	79	81	76		79	74	79
Lack of integration	77	48	45		68	66	64
Poor communication among agencies	48	42	45		53	57	54

Figure 7. Percentage of stakeholders and Specialists reporting policy and systems barriers

Lack of Providers

Issues within this category are also important to recognize, although none were in the top five barriers reported by stakeholders and Specialists (see Figure 8 below). All involve training or expertise of providers about behavioral health issues.

The share of Specialists who reported a lack of personnel with the required expertise to provide quality behavioral health services as a barrier in their communities declined from 76 percent in 2016 to 47 percent as of Q4 2018, a statistically significant improvement. However, among stakeholders, two-thirds continued to perceive this issue as a barrier throughout 2017 to 2019. Similarly, the share of Specialists who perceived a lack of primary care providers knowledgeable about behavioral health as a barrier decreased from 86 to 39 percent between Q4 2016 and Q4 2018 (although this decline was not linear and consistent over time, so it was not statistically significant). Among stakeholders, about two-thirds perceived this issue as a barrier in each of the three years of the survey. Finally, because Centers for Medicare & Medicaid Services (CMS) policies limit which types of providers can be reimbursed for services, many otherwise qualified providers cannot receive reimbursement. This limits access to services for those consumers who rely on Medicare for payment, as these consumers often do not have the means to pay out of pocket for these services. A little over half of Specialists (56%) perceived a lack of providers with the credentials required to get reimbursed for providing behavioral health services in their communities as a barrier. Although there was a decrease in the share of Specialists who reported this issue as a barrier since 2016, the change was not statistically significant. About two-thirds of stakeholders perceived a lack of providers with the required credentials for Medicare reimbursement to be an issue in their communities in 2019.



	2016 Q4	2017 Q4	2018 Q4		2017	2018	2019
Lack of required expertise	76	52	47		66	64	65
Lack of knowledgeable PCPs	86	64	39		67	63	62
Lack of providers with CMS required credentials	74	75	56		59	65	64

Figure 8. Percentage of stakeholders and Specialists reporting barriers related to providers

Strategies and Actions for Addressing Barriers

We now turn to the strategies and actions of the Specialists designed to address these barriers, including building community capacity through collaboration and coordination, training, and providing complex case consultation.

Collaboration and Coordination

Collaboration and coordination include any activity with community partners that is intended to or contributes to improvements to the local behavioral health system for older adults and adults with physical disabilities who have behavioral health needs. Collaboration typically occurs in meetings with community partners and may involve reviewing gaps in services, setting priorities, discussing solutions (e.g., evidence-based programs), allocating resources, and/or monitoring progress. Improved coordination of services may occur as a result of a meeting or discussion between community partners or a complex case consultation or may be the result of implementing or expanding an evidence-based program.

As of December 2018, at least half of the Specialists identified involvement in their regions from the following community partners: aging and disability services (97%), behavioral health services (88%), area Coordinated Care Organization (67%), residential care (64%), and hospital emergency departments (50%). With response categories ranging from (1) “not at all” to (4) “a great deal”, both aging and behavioral health services were perceived to be involved in coordination and collaboration somewhat (3) to a great deal (4). Primary care clinics and hospital/emergency departments were seen as a little (2) to somewhat (3) involved. Other community partners were seen as having little (2) to no (1) involvement.

There was consistent community partner involvement over time as perceived by Specialists.

Table 3

Perceived Community Partner Involvement in Coordination and Collaboration Activities: Specialists’ Quarter Reports, 2016-2018

Community Partner	**2016 Q4**	**2017 Q4**	**2018 Q4**	**Trend**
a. Aging services	97	97	97	n/s
b. Behavioral health services	86	91	88	n/s
c. Center for Independent Living	28	19	27	n/s
d. Veterans services	24	31	33	n/s
e. Primary care clinic	52	53	48	n/s
f. Hospital/emergency department	55	50	50	n/s
g. Area coordinating care organization	66	78	67	n/s
h. Local law enforcement	38	38	34	n/s
i. EMT or similar emergency responder	38	44	31	n/s

Table 3 (Continued)

Community Partner	2016 Q4	2017 Q4	2018 Q4	Trend
j. Tribal organization	7	21	13	n/s
k. Advocacy organization/consumer/family member	34	50	30	n/s
l. Residential care	55	56	64	n/s
m. Faith community	21	19	15	n/s
n. Elected government official	14	22	18	n/s
o. Home care/Home health care	55	42	48	n/s

Note: The percentages above include Specialists who indicated the community partner was involved either "somewhat" or "a great deal." Not all data points/quarterly data are shown for ease of presentation, but tests of linear trend utilized all available data; "n/s" indicates that the linear trend coefficient is not statistically significant.

In the Stakeholder Survey, respondents included all of these categories of community partners, with the largest proportions representing aging and disability services and behavioral health, as displayed in Figure 9 below. These two groups represented 22 and 20 percent of all responding stakeholders in 2019, respectively. The "other" category was composed of various community partners such as law enforcement, veterans services, tribal organizations, and faith communities, among others. The slight increase over time in the share of this group from 53% to 58% may be a sign that Specialists are reaching out to previously unconnected community partners.

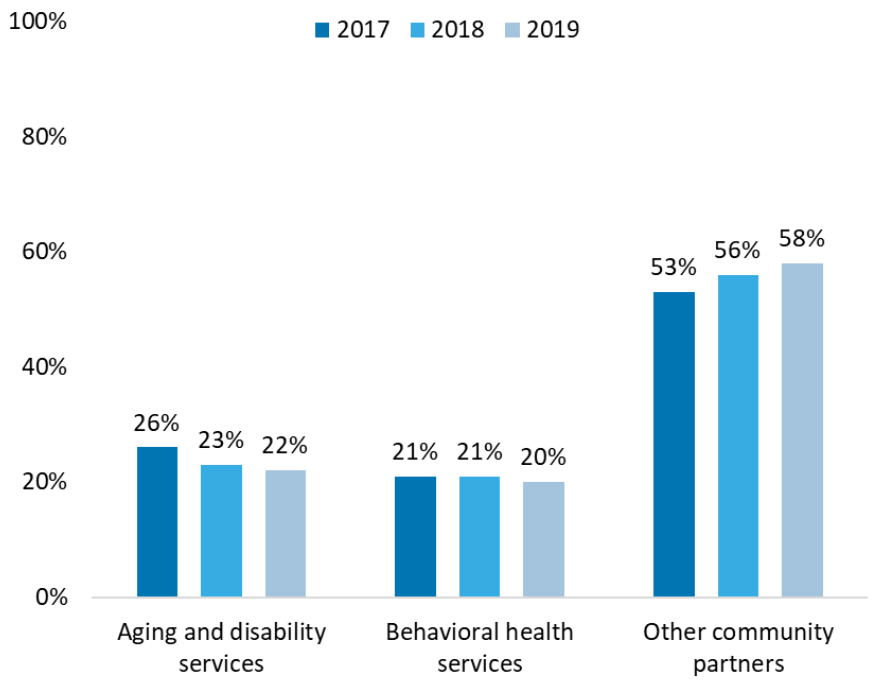


Figure 9. Percentage of stakeholders from each stakeholder group

Stakeholder Engagement. Engaging core stakeholders is imperative for building partnerships and bridging gaps between service sectors. A majority of stakeholders agreed or strongly agreed that the Initiative was a priority for their organization throughout the period (53% in 2017; 60% in 2018; 55% in 2019). Fifty-three percent of stakeholders also agreed or strongly agreed that "Community partners who attended coordination and collaboration discussions or meetings have agreed on what their priorities should be for addressing the gaps in behavioral health services for older adults and adults with physical disabilities," and this indicator improved between 2017 and 2019. About 70% of stakeholders agreed or strongly agreed that they had several other projects that were competing for their time and attention" but this indicator improved slightly (that is, there was less competition) (from 73% in 2018). Participants in joint discussions or meetings were seen as very committed to improving behavioral health services for older adults and adults with physical disabilities, with 86 percent of stakeholders agreeing or strongly agreeing with this statement.

Stakeholders also identified obstacles to engagement. There was strong evidence of worsening since 2018 and some evidence of worsening since 2017 with respect to the indicator that "the Initiative was a priority for their organization", which was a setback. In addition, the "right people" may be missing from the table in these collaboration and coordination discussions, with only 45% of stakeholders in 2019 reporting that the people who can make changes in agency programs or services were participating (a slight but not statistically significant increase from 42% in 2018).

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 in their communities declined from 43 percent in 2018 to 34 percent in 2019 (Figure 10 below). The share of stakeholders who reported having never attended these meetings increased from 18 percent in 2017 to 31 percent in 2019. There is some evidence to suggest that these observed changes in attendance in these meetings are statistically significant.

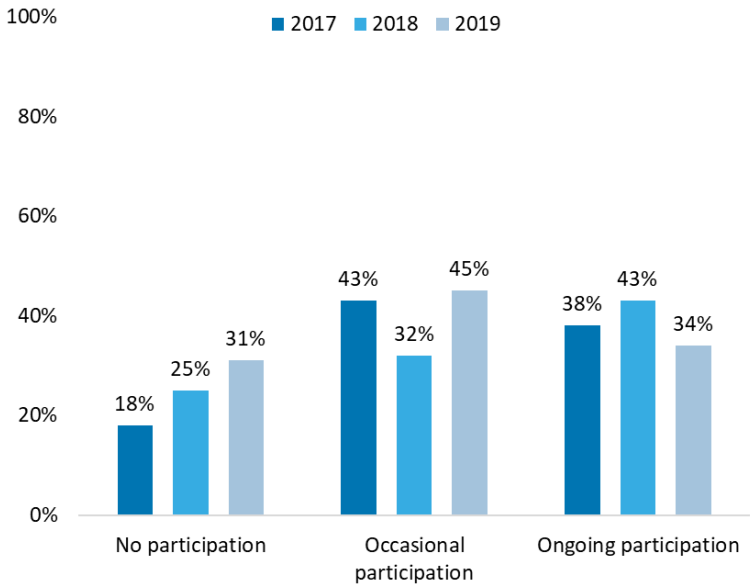


Figure 10. Participation by stakeholders in discussions with Specialists

In their quarterly reports, Specialists were asked to rate seven statements (1=strongly disagree to 5=strongly agree) about the extent to which core stakeholders were engaged with the Initiative through such activities as expressing support, having direct involvement, having regular contact with the stakeholders, and agreement on gaps and priorities in behavioral health services for older adults and people with disabilities (see Figure 11 below). The majority of Specialists agreed or strongly agreed with these statements. Core stakeholders' engagement in these activities as reported by Specialists did not change over time (it increased slightly between Q3 2016 and Q2 2017 (not significantly), but then it declined significantly back to the Q3 2016 level).

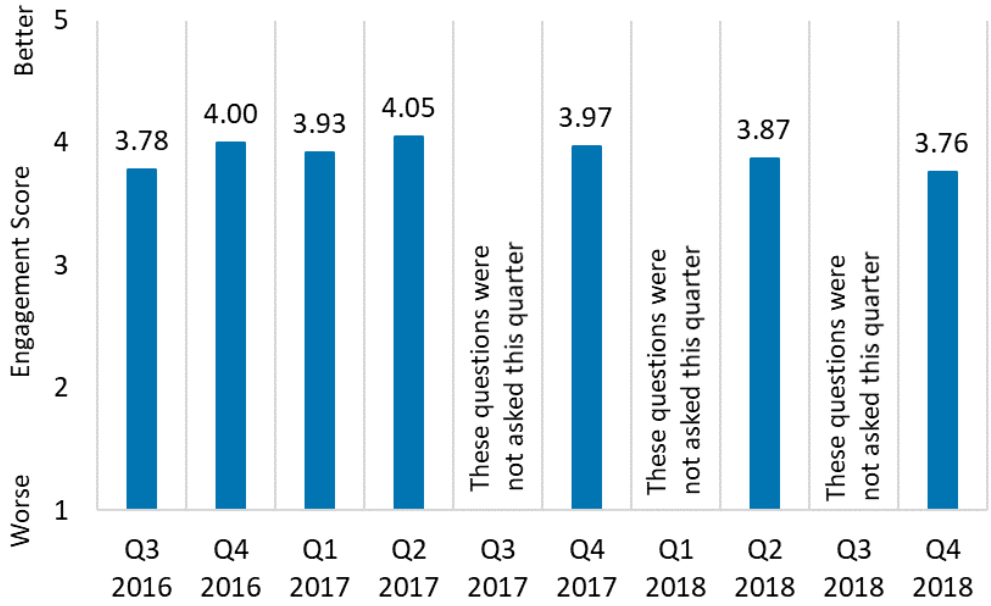


Figure 11. Specialists' ratings of stakeholder engagement

Community Building. Building and supporting community capacity is critically important to the success and sustainability of the Initiative. Specialists reported on 10 indicators of capacity in their communities. Examples of these indicators include: (1) forming a cohesive group to address gaps in services, (2) meeting often enough to make progress in reducing gaps in services, (3) putting formal agreements in place, and (4) ensuring "the right people" are participating in their meetings. Since July 2016, community partners' involvement in these activities has increased significantly (see Figure 12 below). Specifically, 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; formal agreements (such as memoranda of understanding or participation agreements) were more likely to be in place; agencies were not working in silos; and the interference of turnover in community partner organizations with the Initiative's momentum had declined.

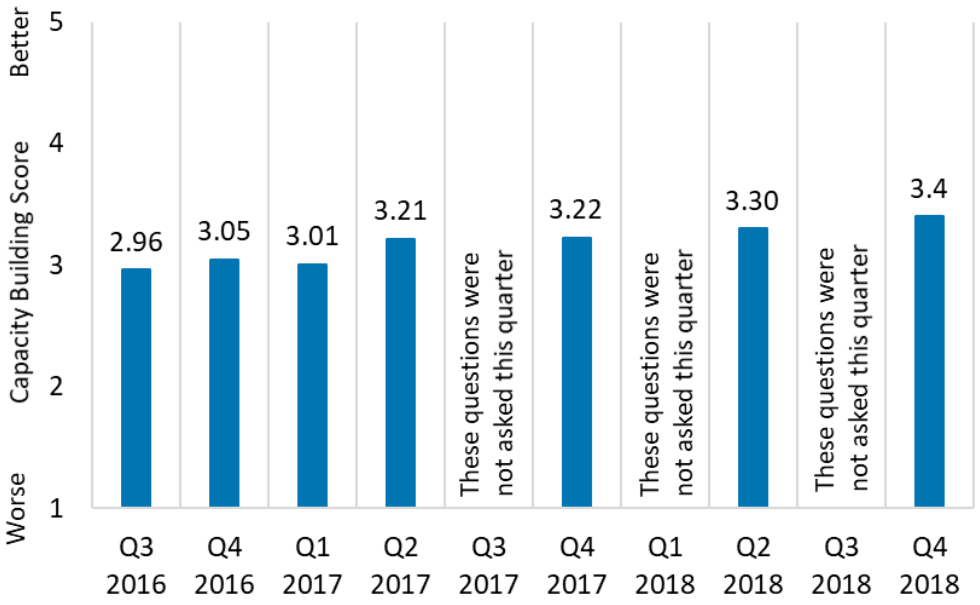


Figure 12. Specialists' ratings of community capacity

Complex Case Consultation

A complex case consultation (CCC) is defined as a discussion (in-person or via conference call) among the Specialist and one or more direct service provider, primary care providers, hospital staff, emergency responders, consumers or family members with the express purpose of resolving problems or concerns about the care or treatment plan for an older adult or adult with physical disabilities who have behavioral health needs. Specialists across Oregon used a reporting instrument to collect information about each complex case consultation in which they participated during between October 2017 and March 2019 (six quarters). This reporting instrument was developed in consultation with Specialists. During this period, Specialists reported on a total of 2,331 complex case consultations, roughly an average of 16 per quarter per Specialist. The number of cases per quarter varied considerably by Specialist, however, ranging from a few to over 50. (Note that because some cases have missing values on some variables, the sample size for each field or variable varies.)

The percentage of stakeholders who reported that they participated in any complex case consultation (CCCs) that included the Specialist remained fairly similar over time: 39% of Stakeholders in 2017, 44% in 2018, and 42% in 2019. When asked about the nature of complex case consultations that they attended, 45 percent of stakeholders reported that the majority of CCCs were unplanned, due to an urgent or crisis situation or the need to locate a resource for a client. This figure was similar in 2017 (47%) and 2018 (42%). The share of stakeholders who reported that the majority of CCCs were part of a regularly scheduled case review that involved staff only from their own agencies was 14 percent. Finally, the percentage of stakeholders who reported that the majority of the CCCs were part of a regularly scheduled case review meeting that included staff from different organizations or different departments within a large agency

(e.g., a multidisciplinary team meeting) remained the same, at 41 percent and did not change significantly over time.

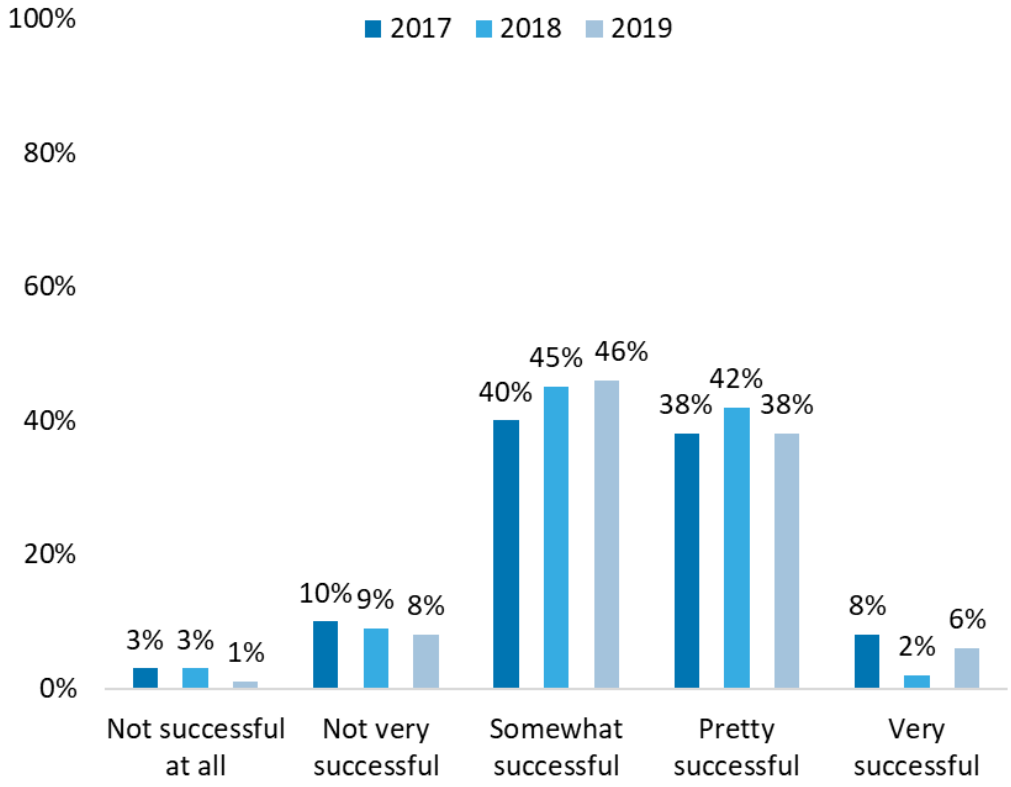


Figure 13. Stakeholder ratings of the success of complex case consultations

Overall, there was no statistically significant change over time in stakeholders' views of the success of CCCs in resolving the problems or concerns about the care or treatment plan for the older adults or adults with physical disabilities. About 44 percent saw the CCCs as having been very (6%) or pretty successful (38%) (almost all or most, respectively, problems were addressed) and another 46 percent saw them as somewhat successful (some problems were resolved but many remained unresolved); only 9 percent reported the CCCs as being not very successful (8%) or not successful at all (1%).

The reporting tool used by Specialists provided important new detail about the nature and scope of CCCs and the consumers who are served. These data were available beginning in October 2017 and through March 2019 (six quarters). The reporting instrument changed slightly over time, after incorporating feedback from the Specialists using the form and the OHA Project Director. Pooling the data from all six quarters, the consumers served in CCCs were slightly more likely to be female (52%), and the largest age group of consumers included people between ages 65 and 74 (34%), followed by those younger than age 60 (24%). The CCC consumers were older compared to Oregon's general population, based on available data from the American Community Survey 2012-2017 (see Figure 14).

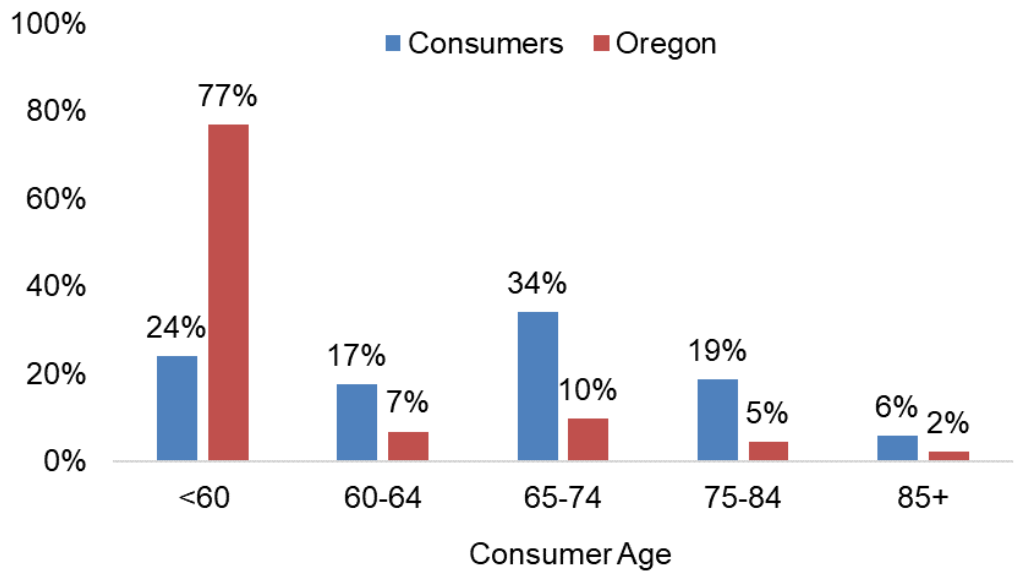


Figure 14. Age distribution among CCC consumers and Oregon residents

Eleven percent of consumers for whom information was available about their veteran status were veterans, although veteran status was unknown in one quarter (24%) of consultations. In 35 percent of cases, Specialists had previously consulted about the consumer. (This variable was added in Q2 2018 (n=1,239).) Just over half of consultations were planned (54%) and involved people from multiple organizations or multidisciplinary teams (51%) (combined because this variable changed over time). A small portion (13%) of cases involved a team from a single organization only.

The most common types of actions taken by the Specialists during the consultations were: assisting the person/organization who referred the case ("consultee") with information or referrals to services required by the consumer (63%); providing the consultee with clinical information about the consumer's presenting problems (33%); providing the consultee with additional staff training or coaching (29%); and providing the consumer and/or surrogate with short-term help in accessing services (28%). In 15 percent of cases, Specialists also took other actions, such as completing an assessment with a consumer or assisting the consumer with the service eligibility process.

For about half of the cases (45%), a change in residence was recommended. In 54 percent of those cases, however, a change in residence was not obtained either because the option was not available (42%) or the consumer refused (12%). A majority of recommended changes (70%) in residential setting were moves to higher level of care (see Figure 15). When residential needs were identified, Specialists noted special circumstances, such as the consumer

having refused the recommended residential setting or providers being unclear as to which setting would best suit consumer needs.

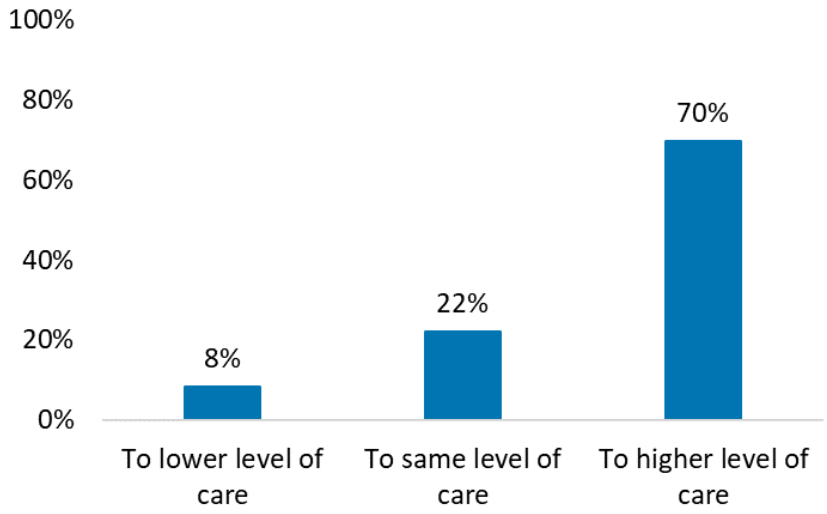


Figure 15. Recommended change in residential setting (if any recommended)

The Specialists reported that the community could provide at least some of the resources necessary to address the needs of the CCC consumer in 91 percent of cases. Resolution of complex cases often takes considerable time, particularly when resources are limited and barriers to services are significant. These cases also often demand considerable follow-up time from Specialists. Fourteen percent of cases were projected by Specialists to take more than three hours for follow-up activities.

As expected, most consumers presented with multiple issues. These issues were categorized as physical or medical; neuro-cognitive; psychiatric or mental health; social or individual characteristics; and systems issues (see Table 4). Overall, 62% of cases involved consumers with five or more issues; half of these cases (or 30% of all cases) had 10 or more issues. Specialists and others in the CCC did not always know whether the consumer had a relevant diagnosis. In other situations, a diagnosis was suspected but not yet determined. Consumer issues varied for each case consultation. Difficulties in navigating the system for the client, family members or other supports (51% of all cases) and complex and/or co-occurring medical conditions (46% of all cases) were the consumer issues most likely to be reported, followed by the lack of or poor family/natural supports (43%). There were several issues that were part of at least one third of cases: ADL and other functional limitations (34%), isolation or loneliness (35%), or understanding eligibility for services (36%). Specialists also identified "other" reasons for consultations that were not included in the reporting instrument. Examples include refusal to take opioid medication due to stigma and the need for durable medical equipment due to a physical disability. The distribution of presenting issues is displayed in Table 4 below. The quarters in which data were available for each problem/issue are also noted in this table.

Table 4

Share of Cases with Diagnosed and Suspected (or Diagnosis Pending) Issues, October 2017-March 2019

Broad Category	Problem/Issue	Data Availability						% Diagnosed	% Suspected
		Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019		
Physical Medical	Complex and/or co-occurring medical conditions	X	X	X	X	X		46	2
	Co-occurring medical conditions						X	43	2
	Geriatric Syndromes (e.g., frailty, falls, self-neglect)	X	X	X	X	X	X	27	3
	Unresolved medical need	X	X	X	X	X	X	15	2
	ADL and other functional limitations	X	X	X	X	X	X	34	5
	Delirium	X	X	X	X	X	X	1	1
	Polypharmacy	X	X	X	X	X	X	5	1
	High utilization of emergency department and/or 911	X	X	X	X	X	X	11	2
	Medical assistive device			X	X	X	X	5	1
Neurological Cognitive	Dementia	X	X	X	X	X	X	16	9
	Lack of capacity, competence for decision making	X	X	X	X	X	X	18	11
	Acquired or traumatic brain injury	X	X	X	X	X	X	7	1
	Intellectual disability			X	X	X	X	4	1
	Neurological disorder (e.g., seizures, Parkinson's)	X	X	X	X	X	X	3	<1
Psychiatric Mental Health	Mood Disorders (e.g., depression, anxiety)	X	X	X	X	X	X	26	16
	History of serious mental illness	X	X	X				16	3
	Serious mental illness			X	X	X	X	29	4
	Psychotic Disorders	X	X	X				10	1
	Personality Disorders	X	X	X	X	X	X	4	3
	Hoarding	X	X	X	X	X	X	3	1
	Animal hoarding	X	X	X	X	X	X	<1	<1
	Substance Use Disorders	X	X	X	X	X		15	4
	Substance Use Disorders (excl. Opioid Use Disorder)						X	12	2
	Opioid Use Disorder						X	3	1
	Medication misuse	X	X	X	X	X	X	3	2
	Suicidality	X	X	X			X	7	2
	Disruptive behaviors	X	X	X			X	12	3

Table 4 (Continued)

Broad Category	Problem/Issue	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	% Diagnosed	% Suspected
Social Individual	Isolation/loneliness	X	X	X	X	X	X	35	-
	Client refuses services	X	X	X	X	X	X	22	-
	Financial (e.g., cannot afford services, limited income)	X	X	X	X	X	X	27	-
	Housing/homelessness	X	X	X				28	-
	Housing			X	X	X	X	21	-
	Homelessness			X	X	X	X	22	-
	Lack of or poor family/natural supports	X	X	X	X	X	X	43	-
	Law enforcement/criminal justice involvement	X	X	X	X	X	X	12	-
	Food insecurity	X	X	X	X	X	X	12	-
	Abuse (physical, emotional sexual, financial)	X	X	X				7	-
	Self-Neglect	X	X	X				17	-
	Lack of insurance	X	X	X				2	-
System	System navigation (difficult for client/family/supports)	X	X	X	X	X	X	51	-
	Understanding eligibility	X	X	X	X	X	X	36	-
	Does not qualify for aging supports due to BH needs	X	X	X	X	X	X	13	-
	Does not qualify for BH supports due to ADL needs	X	X	X	X	X	X	10	-
	In home services needed and not available	X	X	X	X	X	X	9	-
	Health insurance limitations	X	X	X	X	X	X	6	-
	Workforce	X	X	X	X	X		2	-
	Inadequate workforce (insufficient, lack of training)						X	5	
	Can't afford/insurance won't cover services	X	X	X	X	X		4	-
	Can’t afford services						X	9	
	Lack of services	X	X	X	X	X	X	11	-
	Lack of or limited transportation	X	X	X	X	X	X	9	-
	Lack of communication between agencies	X	X	X	X	X	X	14	-
	Could not agree on a care plan	X	X	X	X	X	X	7	-
	Wait list is full or would take too long	X	X	X	X	X	X	2	-
	Hard to determine root cause(s)	X	X	X	X	X	X	7	-
	Legal issues (e.g., inappropriate evictions; guardianship issues)			X	X	X	X	9	-

Note: Date were not collected for suspected/diagnosis pending in issues under the social/individual and systems categories (as indicated by dashes).

Training: Workforce Development and Community Education

In their quarterly reports, Specialists reported conducting, facilitated or planning a total of 405 community education (CE) events and 484 workforce development (WD) events between July 2017 and March 2019 – for an average of 58 CE and 69 WD events per quarter during this period (or an average of 127 CE or WD events per quarter). These events covered a wide array of topics, such as system navigation, available resources, communicating needs, physical disability/function, and advance planning/end-of-life care. Participants ranged from advocates and consumers to individuals who work in behavioral health services, primary care, or local law enforcement. See Figure 16 for the topics covered most frequently in the trainings.

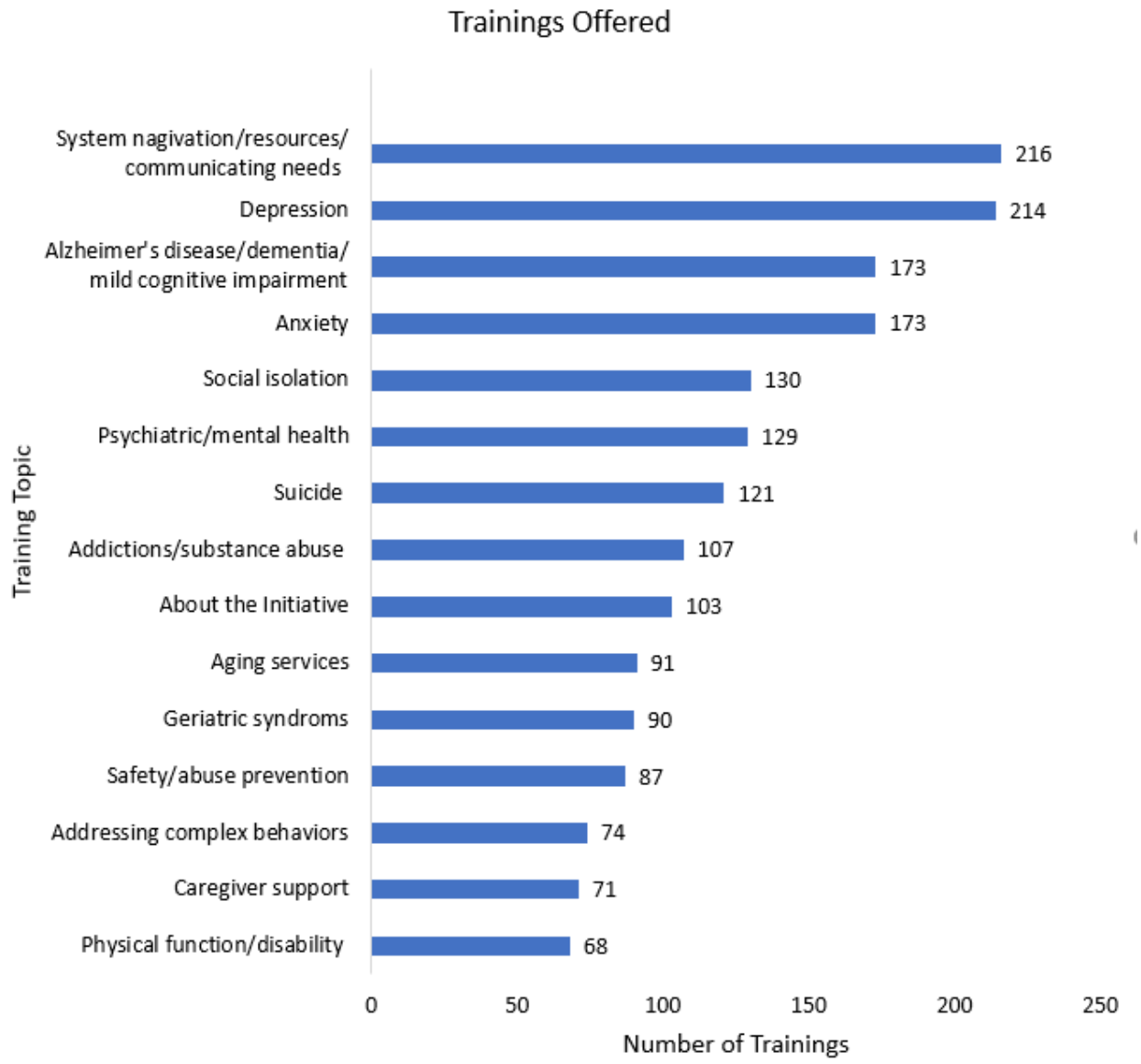


Figure 16. Trainings offered most frequently by Behavioral Health Specialists

Most of the stakeholders responding to the 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. In both 2018 and 2019, about 90% of stakeholders (both managers and staff) reported that their agencies were supportive of using the knowledge and skills they gained from trainings. In 2019, 72% of stakeholders agreed or strongly agreed that their agency provided opportunities for them to discuss or explore practice changes based on traning.

Stakeholders who reported that they did not attend any in-service or training events were asked why this was the case. The reasons cited most frequently were lack of awareness about training opportunities (57%) and lack of time (47%); these did not change from 2018. There was some evidence of an increase of financial constraints being a contributing barrier to attending trainings: Although in 2018, only 11 percent of stakeholders reported that trainings were too expensive, in 2019, 30 percent of stakeholders reported this to be a barrier. It should be noted that the Specialists generally provide trainings at no charge, but there may be travel or costs related to the loss of work that may present a financial barrier.

As described in the Data Sources section, 2,366 training participants completed the online evaluation of the training. They answered questions concerning their job characteristics, their knowledge about the topic before the training, how much they learned as a result of the training, their confidence in their ability to use the knowledge they gained, their perceptions of the training, trainer(s), and the training environment as well as demographic items. The training participants who responded to the evaluation represented a wide range of disciplines and positions within agencies. A majority of participants reported working for an aging and disability services organization (28%), followed by behavioral health services (24%). A smaller share reported working for health services (13%) or long-term services and supports organizations (6%). About one quarter of respondents (27%) reported working for other types of agencies, including but not limited to law enforcement, housing, faith organizations, advocacy groups and non-profits.

In October 2018, the online evaluation began including some additional demographic items, such as the participant's highest level of education, credentials, and hours provided of direct care service to clients, consumers, or patients. Of the participants who responded, 68 percent had a four-year or Bachelor's degree or higher. Across both quarters of data, MA/MS/MSW was the most common credential among participants (11%), followed by LCSW (7%). Seventy-seven percent of respondents reported providing at least one hour of direct care service, and 58 percent were providing direct care at least half of the time. Only eight percent reported providing care full time as part of their job.

We asked participants to rate their level of knowledge about the training subject before they attended the training. Twenty-nine percent of respondents reported having little or no knowledge of the training topic prior to the training, while seventy-one percent reported having at least a moderate amount of knowledge before the training.

According to the training participants, the trainings attended provided them with valuable information. Seventy-two percent of training participants reported having learned a

good or great deal, and another 20 percent reported they learned a moderate amount. Only nine percent reported having learned little or nothing at all.

An important workforce development objective is for training participants to be able to use their knowledge gains in their work. To gauge this, participants were asked how confident they were that they would be able to use the knowledge they had gained in their work. Since October 2017, a majority (83%) reported being pretty or extremely confident that they would be able to use the knowledge they gained in their work. Only a small portion (5%) reported being only slightly confident or not confident at all.

To explore whether these measures improved or worsened over time, we examined changes in mean scores over time for reported knowledge prior to training, perceived knowledge gains as a result of training, and confidence in ability to use the knowledge gained from training (see Figure 17 below). As the figure shows, the initial declines in reported knowledge prior to training were followed with a sustained increase beginning in Q3 2018. Initial declines in knowledge gained as a result of the training and in confidence in ability to use the knowledge gained were followed by increases, but then declines.

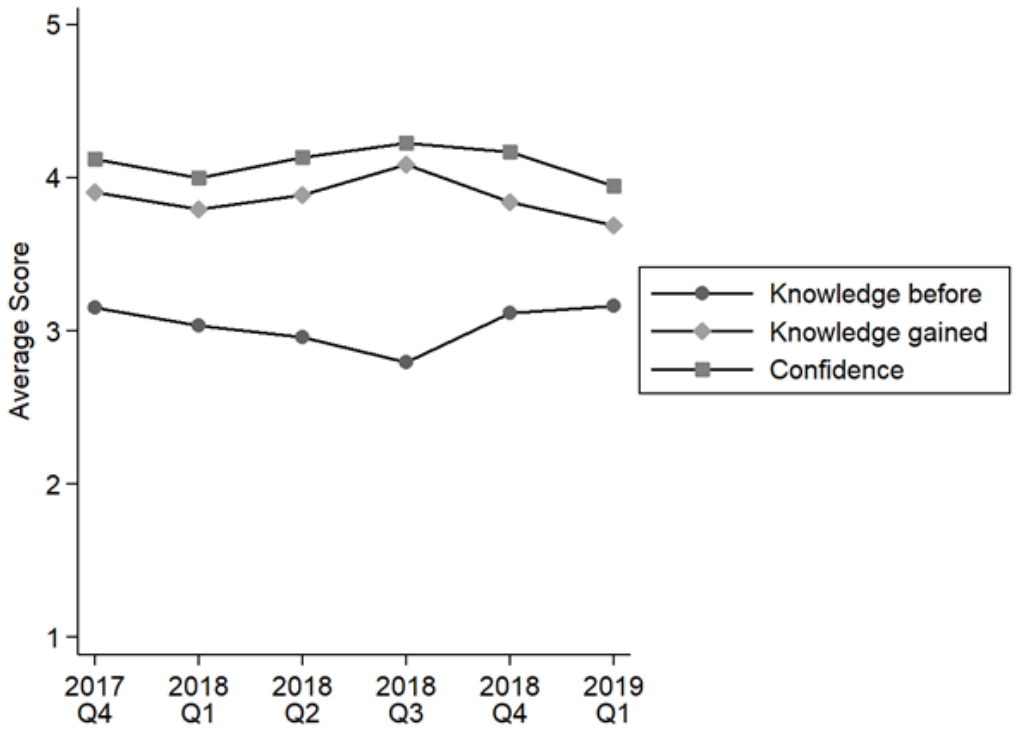


Figure 17. Participants' ratings of prior knowledge, knowledge gained, and confidence in ability to use the knowledge gained as a result of the training

By way of explanation, it is possible that training participants were being exposed to new topics and ideas during the period between October 2017 and September 2018, so they

were increasingly learning new things (hence the drop in knowledge before and increase in knowledge gained). Starting with July 2018, perhaps there was a period of stagnation in terms of topics covered or a saturation of topics. The decline in confidence in ability to use the knowledge gained from training may be due to participants becoming more aware of the structural constraints or barriers to their use of the knowledge they gain.

As part of our evaluation, we asked training participants several questions about the training/workshop, the trainer(s), and the environment in which the training took place. Overall, participants were positive regarding the contributions of the training to their work. Most participants (88%) somewhat or strongly agreed that the training met their expectations. The vast majority (91%) somewhat or strongly agreed that the training provided information that would be useful in their work.

It is important to have the support of employers for workforce events since they can help address barriers to training through co-sponsoring, providing release time, and contributing space. Most participants (91%) perceived that the topic of the training they had attended was in an area supported by their employer.

Considering that this Initiative focuses on older adults and people with disabilities who have behavioral health needs, it is important that the training topics are relevant to these two groups. A majority of training participants somewhat or strongly agreed that the training prepared them to work with or advocate for these two populations (86% and 82%, respectively).

Almost all participants perceived the trainer(s) to be prepared, knowledgeable and responsive to their questions. A majority of training participants somewhat or strongly agreed that trainers were well prepared and that the trainer(s) gave clear explanations of the training topic (93% each). Finally, 95 percent somewhat or strongly agreed that the trainer(s) welcomed questions and responded to them appropriately.

From October 2017 through December 2018, all training participants with valid email addresses were sent follow-up surveys two months after the training to understand how the information acquired in the training had been utilized in their work. Response rates were low, however (ranging from 17% to 26%), so these findings should be interpreted with caution. Still, the response rates for follow-up evaluations have been improving over time (in Q4 2017: 17 percent; Q1 2018: 19 percent; Q2 2018: 20 percent; Q3 2018: 23 percent; and Q4 2018: 26 percent). (The data from the Q1 2019 trainings' follow-up surveys were not available until mid-June and could not be included here.)

Among those who responded to the follow-up survey, the trainings had a significant impact (see Figure 18 below). With respect to organizational support, the vast majority (90%) reported having their supervisor's support for using the knowledge and skills gained from the training, 83% reported that they shared information from the training with their coworkers, and three quarters (72%) reported that their agency had the staff and resources needed to apply the information presented in the training.

The trainings also influenced services to older adults and people with disabilities. Two-thirds of the training participants reported that they were providing better services to older

adults (65%) and people with disabilities (63%) as a result of the training. Eighty-seven percent reported that they were able to use the information from the training in their job, 72 percent reported that their work improved as a result of training, and 81 percent reported that the training gave them confidence in their ability to meet the needs of this population. However, only one-third of respondents (30%) reported that their agency was using screening or assessment tools they had learned about at the training.

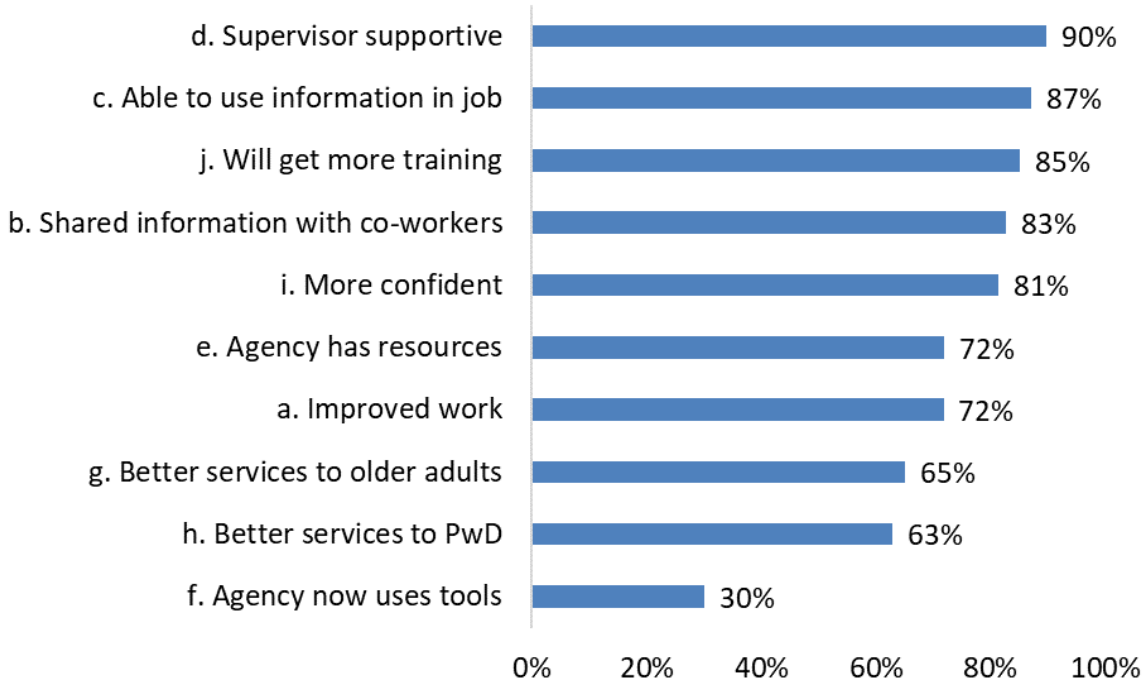


Figure 18. Percent of follow-up training evaluation respondents who agree or strongly agree with each statement (excluding "don't know" and "not applicable" responses), Q3 2017 through Q4 2018

Systems Change

As described throughout this report, as a result of this Initiative, the Specialists have established stakeholder groups that are engaged in active problem solving and building community capacity, provided training that is increasing knowledge and improving practice, and supporting complex case consultations. These activities are intended to contribute to system changes, so we turn now to examining the evidence for system changes that are resulting from these efforts.

A key element for bringing about systems change and positive consumer outcomes is the availability of a multidisciplinary team. A multidisciplinary team (MDT) is a group of professionals representing several disciplines who come together regularly to discuss consumers' specific needs. Specialists were asked six questions about the presence and characteristics of MDTs in their communities, including the availability of expertise, presence of core stakeholders on MDTs, and stakeholder organizations' willingness to provide services to

the client population. There was a slight but statistically significant increase in the overall MDT success as reported by Specialists over time (see Figure 19 below).

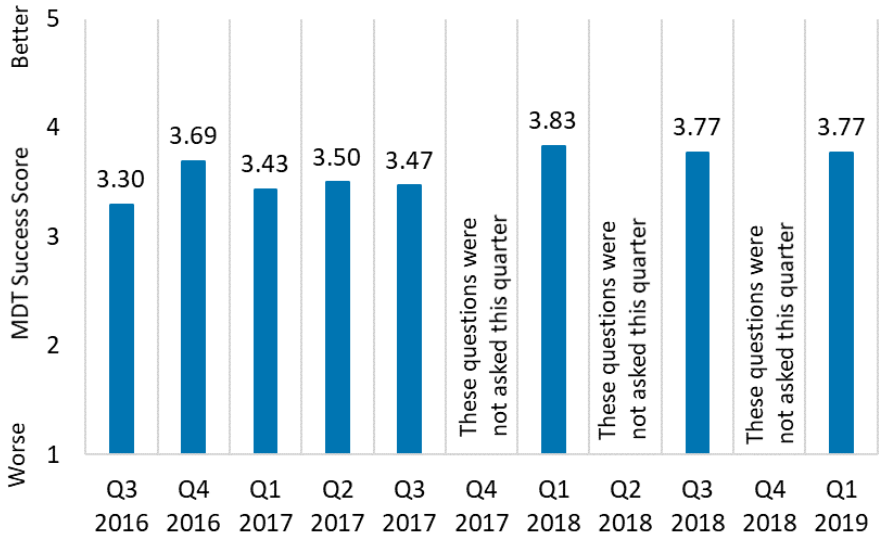


Figure 19. Specialists' ratings of success in multidisciplinary teams over time

Table 5 below reports the percentage of Specialists who reported that an outcome was achieved in their community to a fair or great extent as reported in the first quarter of 2017, 2018, and 2019.The final column of the table indicates whether there was a statistically significant, positive or negative linear (i.e., consistent) change over time since the first quarter data were available (some items were added in later quarters) to the first available quarter to Q1 2019. Note that for some items, the reported percentage is inconsistent with the finding because the changes were tested using longitudinal data, while the reports are cross-sectional in nature. In addition, it should be noted that for several indicators, there were as many as 60 percent "Don't know" responses. Indicators with "Don't Know" responses of more than 30 percent are followed by an asterisk.

With these caveats in mind, the findings reveal that over time, Specialists became significantly more likely to report that referrals for complex case consultation had increased (38% in Q1 2017 to 58% in Q1 2019), it had become easier to make referrals, providers were increasingly willing to accept Medicare reimbursement for older adults and people with disabilities who have behavioral health needs, consumers and their family members had greater access to needed services, inappropriate hospitalizations had declined, and relevant services agencies were more knowledgeable about each other and the role each plays in addressing the behavioral health needs of this population. There were already very high levels of commitment among community partners to improving behavioral health services for older adults and adults with physical disabilities (90% of Specialists agreed in Q1 2018, and 97% agreed in Q1 2019) and that relevant services agencies (mental health and addictions) were coordinating and/or collaborating to better meet the behavioral health needs of older adults and adults with physical disabilities (80% in Q1 2018 and 81% in Q1 2019).

Table 5
Specialists' Ratings of Indicators of Success Over Time

	2017 Q1	2018 Q1	2019 Q1	Sig.
a. Referrals for complex case consultation have increased.	38%	71%	58%	+
b. It has become easier to make referrals.	45%	72%	77%	++
c. Providers are increasingly willing to accept Medicare reimbursement for older adults and people with disabilities who have behavioral health needs.*	0%	4%	13%	+
d. Community partners have been more successful in resolving complex cases.	52%	32%	50%	n/s
e. Consumers and their family members have greater access to needed services.	24%	25%	50%	+
f. Organizations are able to obtain/grant waivers to existing eligibility criteria to expand access to services.*	12%	0%	21%	n/s
g. Emergency Department stays have declined.*	13%	6%	6%	n/s
h. Inappropriate hospitalizations have declined.*	17%	6%	12%	+
i. Fewer people are being evicted from care settings for behavioral issues.*	15%	10%	27%	n/s
j. Older adults and people with disabilities who have behavioral health needs and/or their family members are more likely to seek advice or help from direct service providers to better understand their signs and symptoms.*	23%	22%	53%	n/s
k. Relevant services agencies [aging, physical disability, and behavioral health (mental health and addictions)] are more knowledgeable about each other and the role each plays in addressing the behavioral health needs of this population.	62%	84%	81%	+
l. The majority of the people involved in the discussions or meetings are very committed to improving behavioral health services for older adults and adults with physical disabilities.	-	90%	97%	n/s
m. Relevant services agencies (mental health and addictions) are coordinating and/or collaborating to better meet the behavioral health needs of older adults and adults with physical disabilities.	-	80%	81%	n/s

Notes: Percentages refer to the share of cases responding "to a fair extent" or "to a great extent" in each quarter. A dash (-) indicates that the item was not asked that quarter. + $p < .01$, ++ $p < .05$.

Many stakeholders also reported systems-related successes. Below is a sample of their comments.

> *The most significant success has been to have more engagement with multiple systems of care in order for them to talk to each other.*

> *Having our older adult care coordinator stationed in our behavioral health department (and next door to our mental health walk-in center) has been very helpful.*

> *[A success is] that there is even a discussion occurring regarding this population. Bringing the issue front and center is vital in order for the issue to be addressed. The collaborations and partnerships that have developed out of this effort is [sic] also a success.*

> *The MDT meetings have been so very helpful in attempts to try creative approaches in solving specific case problems.*

Consumer Outcomes

Many groups within the population of older adults and people with physical disabilities are especially underserved yet have unique vulnerabilities that lead to increased needs for behavioral services. Stakeholders were provided a list of these groups and asked the extent to which behavioral health services were being provided to various specific subgroups of older adults and people with physical disabilities (Table 6 below). A sizable portion of stakeholders (from 18 to 39 percent) reported that they did not know the extent to which these groups were served. However, among stakeholders who did provide an assessment, none of the groups were reported to have been served to even a fair extent by more than one third of respondents. There was some evidence of decline between 2018 and 2019 in the share of stakeholders who reported that those living in memory care units and those at risk of behavioral health issues due to isolation were receiving behavioral health services to a fair or great extent. The item concerning memory care units is misleading; residents of memory care units are not the target of behavioral health services; rather, it is the staff who are the target for training. With respect to the finding concerning less agreement that behavioral health services were being provided for those who are isolated, greater awareness of the extent and effects of social isolation, due to more attention in the media and Specialists' efforts to raise awareness, likely contributed to this result.

Table 6
Stakeholders' Reports of Behavioral Health Services Provided to Underserved Populations, 2017-2019

	2017 %	2018 %	2019 %
a. Those living in nursing homes	16	12	13
b. Those living in assisted living communities	14	14	15
c. Those living in adult foster/care homes	23	18	17
d. Those living in memory care units	-	19	12
e. Those living independently	22	24	20
f. Those with early/mild behavioral health issues	19	19	14
g. Those at risk of behavioral health issues due to isolation	12	17	9
h. Ethnic minority populations	-	-	10
i. LGBTQ+ populations	-	-	12
j. Veterans	27	28	29
k. Those with substance use disorders	24	26	23
l. Those with serious mental illness	-	-	33
m. Dementia with behavioral symptoms	-	-	19

Notes: Percentages refer to the share of stakeholders who responded "to a fair extent" or "to a great extent" within valid (non-missing) responses each year. Dash (-) indicates that an item was not asked that year.

The long-term goal of the Behavioral Health Initiative is to improve the quality of life for older adults and people with disabilities who have behavioral health needs. Results from systems changes and their effect on large numbers of consumers may not be apparent in the short term, but ultimately they are how the Initiative will be evaluated. It is important to keep the focus on these consumer outcomes. These desired consumer outcomes are listed in Table 7 (see the next page).

To learn about stakeholders' perceptions of consumer outcomes, they were asked a series of questions about the extent to which progress had been made in the previous year to improve services in their community for older adults and adults with physical disabilities with behavioral health needs. There was a significant number of "don't know" responses (ranging as high as 50-60 percent), which most likely reflected the diverse nature of the stakeholders who were surveyed and their job positions (e.g., policymakers vs. direct care workers) as well as the lack of availability of outcome-specific data. Table 7 below displays stakeholders' responses. As reported earlier, Specialists were also asked to identify progress made toward system changes

and various consumer outcomes and had similarly high levels of "don't know" reponses for some items (as with Specialists' reports, those items with 30 percent or higher levels of "don't know" are noted with an asterisk). In addition, the wording of items across the two groups is not comparable. In the future, other ways of collecting data about these outcomes can be considered, including interviews with stakeholders and Specialists.

None of the indicators were assessed as having reached a fair or great extent between 2017 and 2019 by more than a third of stakeholders (see Table 7 below). There was also some evidence that some outcomes worsened over time, as reported by stakeholders. In particular, there was less agreement that older adults and people with physical disabilities who have behavioral health needs:

- *"were recognized as priority populations in their community."*
- "*were now more likely to have timely access to the full range of services they need (such as housing, medication management, transportation).*"
- "*were now more likely to have access to community-based behavioral health programs or services that have demonstrated their effectiveness.*"
- "*were more likely to receive help from direct service and/or primary care providers with the requisite knowledge and skills.*"

Finally, there was less agreement that "*Community partners were more successful in resolving complex cases.*"

Table 7
Stakeholder Assessment of Progress Toward Consumer Outcome Goals, 2017-2019

	2017 %	2018 %	2019 %
a. Older adults and people with physical disabilities who have behavioral health needs are recognized as priority populations in the community.	29%	28%	25%
b. These adults are more likely to have timely access to the full range of services they need (e.g., housing, medication management, transportation).	9%	11%	10%
c. These adults are more likely to have access to community-based behavioral health programs or services that have demonstrated their effectiveness.	19%	19%	11%
d. These adults are more likely to have information about ways to promote mental health well-being (e.g. social engagement, physical activities).	13%	17%	14%

Table 7 (Continued)

	2017 %	2018 %	2019 %
e. Lengths of stay for emergency departments, hospitals, jails, inpatient psychiatric units, the Oregon State Hospital have reduced for these adults.*	17%	17%	18%
f. "Evictions" of these adults from community-based long-term care facilities, nursing homes, public housing, etc. have been reduced.*	14%	10%	9%
g. These adults are more likely to have their signs and symptoms recognized as behavioral health needs rather than as being due to "aging."	29%	23%	22%
h. These adults are more likely to receive help from direct service and/or primary care providers with the requisite knowledge and skills.	22%	21%	17%
i. Older adults, adults with physical disabilities and/or their family members are more likely to seek advice or help from direct service or primary care providers to better understand their signs and symptoms.*	26%	32%	26%
j. Community partners have been more successful in resolving complex cases.	31%	31%	23%

Notes: Percentages refer to the share of stakeholders who responded "to a fair extent" or "to a great extent" within valid (non-missing) responses each year. An asterisk indicates that the percentage of "don't know" responses was 30% or greater.

Retention and Recruitment of Behavioral Health Specialists

Turnover of Behavioral Health Specialists, who form the backbone of the Behavioral Health Initiative, has the potential to affect the overall success of the Initiative. While a replacement Specialist is being recruited, local capacity building efforts may be stymied. Other factors related to turnover will affect the pace of local efforts as well, including the skills and experience of the new Specialist, the extent of the orientation that the new Specialist receives from the outgoing Specialist and/or the contractor, and the time it takes for the new Specialist to engage with local stakeholders and resume Initiative activities. Consequently, we recommend that the impact of turnover should be examined in the next biennium.

As of June 2019, seven of the original cohort of 24 Specialists remained in their positions, indicating that a majority have left and local communities and contractors have had to deal with turnover. It is difficult to determine what an expected rate of turnover would be for this position. Data to address this question are not available for Oregon, but every two years the U.S. Bureau of Labor Statistics publishes this information for the nation, which results from supplemental questions included in the Current Population Survey. The most recent data show

that median turnover for employees in the health care and social assistance category of industries has been fairly steady and was 3.9 years in January 2018.[3] For employees in healthcare support occupations, median tenure was 3.0 years in January 2018.[4] Public-sector workers tend to stay in their jobs longer than the average in the much larger private-sector workforce. The median tenure for public-sector workers in January 2018 was 6.8 years, compared with 3.8 years among workers in the private sector. Among public-sector workers in State government, median tenure was 5.9 years.[5]

The median tenure of Specialists excluding current Specialists is 2.75 years (2 years and 9 months); the median tenure including current Specialists is 2.83 years. Each of these statistics is less than either the national median tenure for employees in healthcare support occupations or especially that for employees in the health care and social assistance industry in the private sector.

There may be recruitment "best practices" that contractors could use when filling vacant positions. For example, if the applicant pool continues to be people with clinical experience in behavioral health, it would be helpful to explore how contractors can identify applicants who want to transition into a new role that does not involve having a caseload, may require a steep learning curve and may be the only position of its kind in the agency. Similarly, it would be useful to identify effective strategies for orienting a new Specialist.

Sources of job dissatisfaction that might impact retention should also be explored. These may include: salary and benefits, including financial and managerial support for professional development; workload, including travel; access to management for advice, support and direction; access to clerical support; and concern about continued state funding for the Specialists' positions.

Another important factor to consider is the extent to which Specialists "have the authority necessary to assure that system changes can be made to ensure service delivery systems will meet individual needs" that the Budget Workgroup originally intended them to have. Without this authority, it may not be possible to accomplish the desired systems changes. Similarly, some Specialists have considerable experience in bringing groups together; others do not, and could potentially benefit from professional development. Also, some managers are very supportive of the Initiative, while others are less so, and this can limit progress toward achieving the goals of the Initiative.

In 2020, the Initiative will mark its fifth year of operation. This would be a logical time to consider those personnel factors that may impact progress toward improving behavioral health systems of care for older adults and people with physical disabilities in local communities. Since Specialists are the mainstay of the Initiative, identifying ways to recruit and sustain a qualified workforce is critical to the Initiative's success statewide.

[3] Retrieved on 7/12/19 from https://www.bls.gov/news.release/tenure.t05.htm
[4] Retrieved on 7/12/19 from https://www.bls.gov/news.release/tenure.t06.htm
[5] Retrieved on 7/12/19 from https://www.bls.gov/news.release/tenure.t05.htm

Recommendations

The following recommendations have been developed by the Portland State University Institute on Aging evaluation team based on analyses of the evaluation data (i.e., Stakeholder surveys, Behavioral Health Specialists' quarterly reports, training evaluations, complex case consultation reports, and surveys of the 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.
    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 the progress of the Initiative. Since the Behavioral Health Specialists are the backbone of the Initiative:
    d. Assess the factors affecting Specialist turnover.
    e. 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, but work remains to be done to address the behavioral health needs of older adults and people with physical disabilities in Oregon. These findings demonstrate a need for system-level changes, the majority of which cannot be addressed by individual Specialists. Moreover, positive changes in the desired outcomes are likely to require considerably more time to realize than the few years of the Initiative's existence. Formal agreements for sharing information and resources and reducing silos between community partners still are needed. 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. 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.