Interim Report

2019-2020

# Evaluation of the Older Adult Behavioral Health Initiative

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Oregon Health Authority

## Report 1: Overview of Evaluation Results

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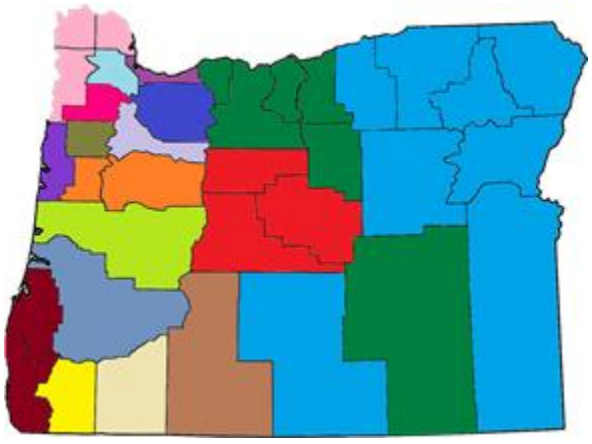
**Introduction and Background**

The Older Adult Behavioral Health Initiative (referred to as "the Initiative" in this report) is funded by the Oregon Health Authority (OHA) and comprises twenty-four Behavioral Health Specialists (referred to as "Specialists" in this report) located in communities throughout the state of Oregon. The Initiative is managed by the Project Director, Nirmala Dhar, who has overseen the Initiative since its formation in 2015. Non-profit agencies across the state were awarded contracts to hire the Specialists. The Specialists were hired to facilitate outreach and services to older adults and people with disabilities experiencing mental health and substance use dependence.

Every county in Oregon is covered by at least one Specialist (see Figure 1). Most counties are covered by one Specialist, although two or more Specialists may be serving in higher population areas (e.g., Central Oregon, Lane County, Multnomah County, Washington County). Based on a formula developed by the OHA, one Specialist is assigned for every 30,000 older adults in Oregon. Eastern Oregon counties have only two full-time Specialists and one part-time Specialist based on the population distribution across the state.

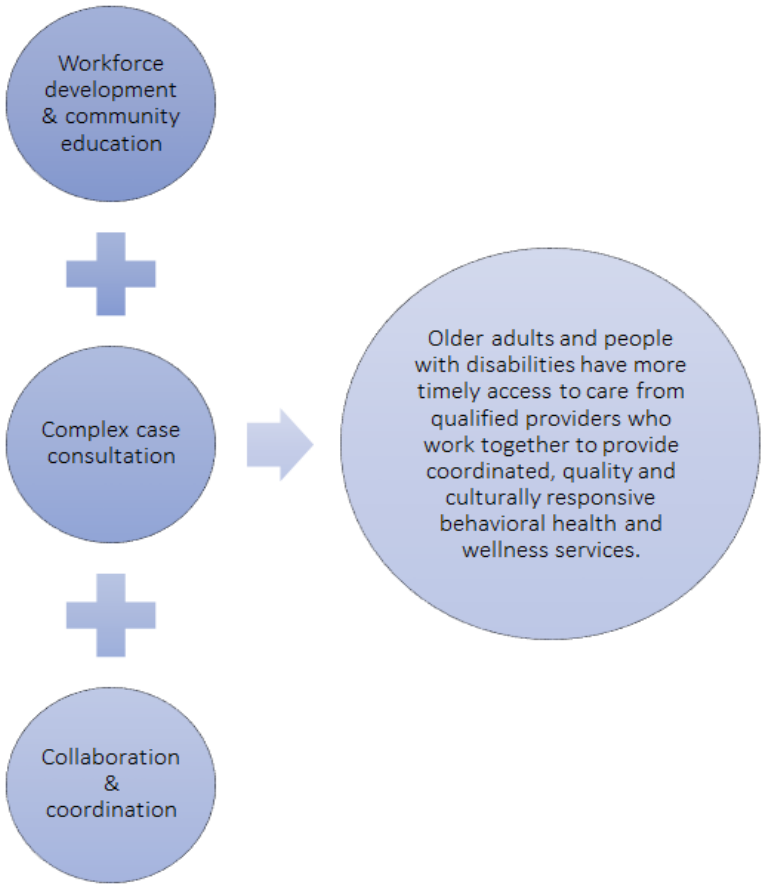
**Figure 1.** ***Specialist Distribution Across Oregon***



The Institute on Aging (IOA) at Portland State University (PSU) was contracted to conduct a needs assessment in 2014, which identified an overall lack of access to needed behavioral health services. Reducing these gaps has been the focus of the Specialists. To achieve this, they have 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) offer training to support workforce development and community health and wellness promotion (see Figure 2). The overall goal of the Behavioral Health Initiative is "To better meet the needs of older adults and people with disabilities by improving timely access to care from qualified providers who work together to provide coordinated, quality, and culturally responsive behavioral health and wellness services." In 2016, the IOA was contracted to evaluate the Initiative through a variety of data sources collected from the Specialists and Initiative stakeholders.

**Figure 2.** ***Specialist Core Job Functions & Goal Statement***



## Purpose and Methods

### Purpose

The purpose of the evaluation is: (1) to systematically collect and analyze data to document the activities and accomplishments of the Older Adult Behavioral Health Initiative and, (2) to identify ways in which the Initiative can continue to improve behavioral health services for older adults and people living with disabilities in Oregon.

### Data sources

Since 2016, the evaluation data were gathered from the Specialists through a variety of sources: qualitative and quantitative quarterly reports, complex case consultation reporting instruments detailing consultations Specialists organized or participated in, rosters to collect information about every workforce development training Specialists planned, hosted, or facilitated, and semi-structured interviews with each of the Specialists. Evaluation data were also collected from workforce development and community education event participants through a post-training evaluation and from 2-month follow-up evaluations.

Another long-standing data source on the Initiative are stakeholder surveys. These data, however, were not collected during this phase of the evaluation. Instead, the OHA asked the PSU Evaluation Team to develop a new evaluation instrument focused on a more narrowly defined set of Initiative stakeholders. Data collected from Initiative key informants took place through semi-structured interviews. These interviews were conducted with managers and executive directors of Area Agencies on Aging (AAA) and Aging and Disability Resource Center (ADRC) offices, Community Mental Health Programs (CMHP), and Aging and People with Disabilities (APD) offices.

#### *Quarterly Reports*

The Specialists submit reports quarterly. Three of the four quarterly reports mostly consist of open-ended qualitative questions about successes and challenges related to their core job functions. The reports are also used to collect information about multidisciplinary teams, evidence-based practices, community education training events, and plans for the upcoming quarter. One of the four quarterly reports mostly consists of quantitative scaling items to assess the Specialists' perception of progress in systems changes and outcomes, the state of behavioral health services for older adults and people living with disabilities in their communities, and coordination and collaboration among community partners.

### *Complex Case Consultations (CCC)*

Complex case consultation (CCC) is a core job function of Behavioral Health Specialists (or Specialists). Specialists work to promote a multi-disciplinary team and multi-morbidity approach to ensure older adults and people with disabilities receive the appropriate help at the right time and the right level of care. Keeping a detailed record of these CCCs is intended to inform the Initiative as well as key stakeholders of the types of consultations, reasons for consultations, and outcomes of consultation meetings in communities throughout Oregon.

Behavioral Health Specialists across Oregon used a data entry tool prepared by the Portland State University Evaluation Team to collect information about each CCC in which they participated between October 2017 and March 2020. From October 2017 through March 2020, Specialists reported participating in a total of 3,711 CCCs that took place in at least 30 counties.

### *Training: Workforce Development*

Workforce development training is aimed at enhancing the behavioral health-related knowledge and skills of aging services, health services, behavioral health services, and other professionals. Training participants who attend workforce development events planned, hosted, or presented by a Specialist sign a roster which collects information such as participants name, title, and email address. Participants then receive an electronic post-training evaluation from PSU within three days of receiving the roster from the Specialist. Participants provide information about their perceptions of the training, and summaries are then shared with the Specialist so they can determine how to improve future events. Between October 2017 and March 2020, 662 workforce development training events were planned, conducted, or sponsored by the Behavioral Health Specialists with an average of about 66 events per quarter. The post-training evaluation response rate remains relatively steady, ranging from 40% to 50%. Between October 2017 and March 2020, a total of 3,986 training participants (not unique cases) fully completed and 4,033 fully or partially completed the online evaluation of the training.

Two months after the training event, training participants also receive a 2-month follow-up survey which assesses how they incorporated knowledge learned from training into their professional practice. This survey has a lower response rate, ranging from 19% to 26%. As of October 2017, a total of 1,734 training participants (not unique cases) fully completed the follow-up training evaluation.

### *Training: Community Education*

Community education events are mostly geared toward educating older adults and caregivers about topics related to wellness, healthy aging, and behavioral health. Specialists are provided with an optional community education survey form to distribute at their training events. These forms are optional as paper evaluations may not be feasible to distribute or for training participants to complete at events, depending on the audience. Most of the items on the community education form are customizable to fit the specific education topic(s) covered.

Between October 2017 and March 2020, Specialists distributed the PSU evaluation form for 127 training events, and evaluations were completed by 1,595 (not unique cases) community members. Between July 2019 and March 2020, Specialists conducted 300 community education events and they distributed the PSU evaluation form for 29 (10%) of these events. Evaluations were completed by 426 community members (not unique counts).

### *Specialist Interviews*

In the fall of 2019, the PSU Evaluation Team conducted telephone interviews with each of the Behavioral Health Specialists. One goal of these interviews was to collect detailed information on their "special projects", which were loosely defined as the most significant projects the Specialist has worked on in their position. Specialists were asked about the purpose, community partner involvement, and their contributions to the project, as well as strategies used to overcome project challenges. Other questions included the Specialists' opinions about what would make the Initiative more successful and strategies and barriers to implementing projects in their communities. The Specialists' projects were analyzed and grouped into four categories: 1) improving access to behavioral health care, 2) increasing workforce knowledge and skills, 3) engaging community partners, and 4) working upstream on primary prevention. Descriptions of these projects were included in infographic factsheets and provided to the Specialists so they can share more information about the Initiative with stakeholders and community partners. Specialist data are also used to develop recommendations and provide examples of key findings.

### *Key Informant Interviews*

The Oregon Health Authority asked the PSU Evaluation Team to develop a new instrument to 1) assess key informants' perceptions of what is different now as a result of the Initiative; 2) determine how the Initiative can be improved; and 3) assess the involvement of the Initiative's partner organizations.

To answer these questions, the PSU Evaluation Team developed a brief survey and a qualitative interview instrument to gather open-ended data from directors and managers of key stakeholder agencies. These stakeholders (referred to as "key informants" in this report) work for aging services agencies or behavioral health agencies that interact with Specialists most often: APD offices, AAA-ADRCs, and CMHPs.

The final sample included 49 key informants out of a total recruited sample of 56. The PSU Evaluation Team aimed to interview an equal number of key informants for each stratum to collect equal amounts of information from each group, the sample had slightly more APD and CMHP agencies (*n* = 17 each) than AAA-ADRCs (*n* = 15), was more rural (*n* = 28) than urban (*n* = 21), and had more medium-to-low involvement (*n* = 28) than high involvement (*n* = 21).

## Key Findings

### Quarterly Reports

#### *Barriers and Gaps in Services*

In their quarterly reports, Specialists were asked about 16 barriers to serving older adults and people with disabilities who have behavioral health needs. These barriers emerged from the initial 2014 needs assessment and comprised four categories: (1) physical infrastructure, (2) lack of services and programs, (3) lack of providers, and (4) policy and systems issues. For each barrier, Specialists were asked about the degree to which each issue was a barrier in their community with the following response categories: (1) “Not at all”, (2) “not very much”, (3) “to some extent”, (4) “to a fair extent”, and (5) “to a great extent." The Evaluation Team treated Specialists’ scoring of 4 (“to a fair extent”) or a 5 (“to a great extent”) as identifying the item as a barrier. The following tables show the responses of Specialists over time. In the most recent quarter, in order of prevalence, the top five challenges reported by the Specialists were 1) lack of affordable housing (97%), restrictive eligibility criteria (83%), lack of BH services in LTC (69%), lack of integration (69%), and distance to services (69%) (see Table 1). Across all quarters from 2016 to 2019, a lack of affordable housing continues to be the greatest barrier to serving older adults and people living with disabilities who have behavioral health needs, with between 92% to 100% of Specialists reporting this as a barrier.

For all regression analyses, a fixed-effects modeling approach with longitudinal data were used to account for within-county trends. Because percentages in tables in this section were computed using cross-sectional data that does not account for county effects, it is possible that the regression trend may not seem to agree with percentage trends across time. Additionally, while tables display data points for quarters 2016 Q3, 2017 Q2, 2018 Q2, and 2019 Q3, regression analyses are conducted with all eight quarters in which these data were collected.

**Table 1.** ***Top Five Barriers to Services***

| # | 2016 Q3 | 2017 Q2 | 2018 Q2 | 2019 Q2 |
|---|---|---|---|---|
| 1 | Lack of affordable housing (92%) | Lack of affordable housing (94%) | Lack of affordable housing (100%) | Lack of affordable housing (97%) |
| 2 | Providers not accepting Medicare (92%) | Lack of transportation (77%) | Restrictive eligibility criteria (88%) | Restrictive eligibility criteria (83%) |
| 3 | Lack of transportation (88%) | Restrictive eligibility criteria (71%) | Lack of BH services in LTC (88%) | Lack of BH services in LTC (69%) |
| 4 | Lack of providers with CMS credentials (85%) | Distance to services (71%) | Distance to services (81%) | Lack of integration (69%) |
| 5 | Lack of BH services specific to the population (85%) | Providers not accepting Medicare (65%) | Lack of in-home services (81%) | Distance to services (69%) |

***Physical Infrastructure: Housing and Transportation***

Physical infrastructure barriers specifically asked about housing and transportation (see Table 2). The issue of a lack of affordable housing was identified as the biggest barrier faced by Specialist communities during all quarters. While lack of transportation was more often identified as a barrier than the distance to services through the end of 2017, this flipped starting in 2018. From 2018 Q1 through 2019 Q2, Specialist reporting of distance to services was more often reported as a barrier than the lack of transportation. Specialist rating of transportation ($B$ = 1.01, $p$ = .560) and distance to services ($B$ = 0.98, $p$ = .097) as a barrier did not change over time, however Specialists' rating of housing as a barrier indicated that this barrier has become significantly worse ($B$ = 1.02, $p$ = .002) from July 2016 to June 2019.

**Table 2.** ***Percentage of Specialists Reporting Infrastructure Barriers***

| Barrier | 2016 Q3 % | 2017 Q2 % | 2018 Q2 % | 2019 Q2 % | Trend |
|---|---|---|---|---|---|
| Lack of affordable housing | 92 | 94 | 100 | 97 | + |
| Distance to services | 73 | 71 | 81 | 69 | n/s |
| Lack of transportation | 88 | 77 | 69 | 62 | n/s |

Note. All quarters (8) are included in fixed-effects regression analysis, but only one quarter each year presented in the table. Because percentage calculations are computed with cross-sectional data and regression analyses are done with longitudinal data, there may seem to be some disagreement between percentage trends and regression trends.

### *Lack of Services and Programs*

The Specialists also identified barriers related to services and programs that were in need but remained unavailable. In the most recent quarter in which these data were collected (Q2 2019), the most challenging service and program barrier was the lack of behavioral health services in long-term care settings such as nursing facilities and assisted living residential communities (69%; see Table 3). Additional challenges reported by the Specialists in the most recent quarter, in order of prevalence were lack of behavioral health services specific to the population (52%), lack of in-home services (45%), waitlists for services are full or would take too long (41%), and lack of prevention or wellness services (34%). The least prevalent barrier to services and programs was unavailability of other (non-behavioral health) needed services, which 31% of the Specialists identified in the second quarter of 2019. From July 2016 through June 2019, Specialist rating of all barriers relating to services and programs, aside from lack of prevention or wellness services (which did not change), significantly decreased (see Table 3). This decrease in barriers in services and programs identified by the Specialists suggests that they have seen improvement in this category of issues initially identified in the 2014 needs assessment across the last three years.

**Table 3.** ***Percentage of Specialists Reporting Service and Program Barriers***

| Barrier | 2016 Q3 % | 2017 Q2 % | 2018 Q2 % | 2019 Q2 % | Trend |
|---|---|---|---|---|---|
| Lack of BH services in LTC | | | 88 | 69 | - |

| | | | | | |
|---|---|---|---|---|---|
| Lack of BH services specific to the population | 85 | 61 | 66 | 52 | - |
| Lack of in-home services | 77 | 61 | 81 | 45 | - |
| Waitlist is full or would take too long | 54 | 48 | 44 | 41 | - |
| Lack of prevention or wellness services | | | 34 | 34 | n/s |
| Other (not BH) needed services not available | 77 | 55 | 34 | 31 | - |

Note. All quarters (8) are included in fixed-effects regression analysis, but only one quarter each year presented in the table. Because percentage calculations are computed with cross-sectional data and regression analyses are done with longitudinal data, there may seem to be some disagreement between percentage trends and regression trends. Items asking about the barriers of lack of BH services in LTC and lack of prevention or wellness services were not asked until October 2017.

### *Policy and Systems Issues*

During the most recent quarter (2019 Q2), two of the top five barriers reported by Specialists were policy and systems issues (see Table 4). Eighty-three percent of Specialists reported that restrictive eligibility criteria and 69 percent of Specialists reported that a lack of integration among service agencies were barriers. A smaller percent of Specialists identified the barriers of providers not accepting Medicare (59%) and poor communication among agencies (31%). Across time, Specialists rating of the barriers of providers not accepting Medicare ($B$ = -0.09, $p$ < .001) and poor communication among agencies ($B$ = -0.03, $p$ = .006) significantly improved from 2016 Q3 to 2019 Q2.

**Table 4.** ***Percentage of Specialists Reporting Policy and Systems Barriers***

| Barrier | 2016 Q3 % | 2017 Q2 % | 2018 Q2 % | 2019 Q2 % | Trend |
|---|---|---|---|---|---|
| Restrictive eligibility criteria | 77 | 71 | 88 | 83 | n/s |
| Lack of integration | 69 | 48 | 56 | 69 | n/s |
| Providers not accepting Medicare | 92 | 65 | 44 | 59 | - |
| Poor communication among agencies | 54 | 26 | 28 | 31 | - |

Note. All quarters (8) are included in fixed-effects regression analysis, but only one quarter each year presented in the table. Because percentage calculations are computed with cross-sectional data and regression analyses are done with longitudinal data, there may seem to be some disagreement between percentage trends and regression trends.

### *Lack of Providers*

Issues within this category are also essential to recognize, although none were in the top five barriers reported by Specialists. Improvements in Specialists reporting of barriers relating to a lack of providers were observed from 2016 to 2019 (see Table 5). Specialist ratings of a lack of personnel with the required expertise to provide quality behavioral health services as a barrier in their communities declined from 77 percent in 2016 to 59 percent as of Q2 2019, a statistically significant improvement ($B$ = -0.05, $p < .001$). 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.

In the most recent quarter, over half of the Specialists (59%) perceived a lack of providers with the CMS credentials required to get reimbursed for providing behavioral health services in their communities as a barrier. From Q3 2016 to Q2 2019, Specialist rating of the lack of CMS credentialed providers as a barrier decreased from 85 percent to 59 percent, a significant improvement ($B$ = -0.04, $p$ = .01). While the reasons for the decrease could be attributed to a multitude of possible factors, changes to Medicare policy specific to behavioral health over the past few years may be one explanatory factor (McGinty, 2020). Finally, the Specialist ratings of a lack of primary care providers knowledgeable about behavioral health as a barrier decreased from 69 percent to 52 percent between Q3 2016 and Q2 2019, a significant improvement ($B$ = -0.03, $p$ = .023).

**Table 5.** ***Percentage of Specialists Reporting Lack of Providers Barriers***

| Barrier | 2016 Q3 % | 2017 Q2 % | 2018 Q2 % | 2019 Q2 % | Trend |
|---|---|---|---|---|---|
| Lack of qualified providers | 77 | 45 | 38 | 59 | - |
| Lack of providers with CMS credentials | 85 | 58 | 47 | 59 | - |
| Lack of PCPs knowledgeable about BH | 69 | 52 | 75 | 52 | - |

Note. All quarters (8) are included in fixed-effects regression analysis, but only one quarter each year presented in the table. Because percentage calculations are computed with cross-sectional data and regression analyses are done with longitudinal data, there may seem to be some disagreement between percentage trends and regression trends.

## Strategies and Actions for Addressing Barriers

The strategies and actions taken by the Specialists designed to address barriers to services for this population are also important to evaluate. These include building community capacity through collaboration and coordination, carrying out training, and consulting on complex cases.

### *Collaboration and Coordination*

Collaboration and coordination refer to any activities with community partners that bridges the service gaps to better meet the behavioral health needs of older adults and people with disabilities. 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. Specialists and their community partners may coordinate by meeting regularly to troubleshoot complex cases, planning and executing inter-agency training events, or by working together to promote, expand, or implement evidence-based programs. As of June 2019, all Specialists reported working collaboratively with their local aging and disability services agency and at least half of the identified involvement in their regions from the following community partners: aging services (100%), behavioral health services (79%), advocacy organizations/consumers/family (62%), residential care (59%), home care / home health care (55%), primary care clinics (52%), and area Coordinated Care Organizations (52%). (see Table 6). 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). Those reported to be less involved (a little (2) to somewhat (3) involved) included long-term care, primary care clinics, advocacy organizations, consumers and family members, home care/home health care, area Coordinated Care Organizations, hospital emergency departments, EMTs and similar emergency responders, veteran services, and law enforcement. Other community partners seen as having little (2) to no (1) involvement included: faith communities, elected government officials, tribal organizations, and centers for independent living.

From 2016 Q3 to 2019 Q2, community partner involvement as perceived by Specialists mostly stayed the same except for three types of organizations. A decrease in Specialist reported involvement was observed from Centers for Independent Living ($B$ = -0.04, $p$ < .001)

and hospitals / emergency departments (*B* = -0.03, *p* = .006), and an increase in Specialist reported involvement was observed from advocacy organizations, consumers, and family members was observed (*B* = 0.03, *p* = .016).

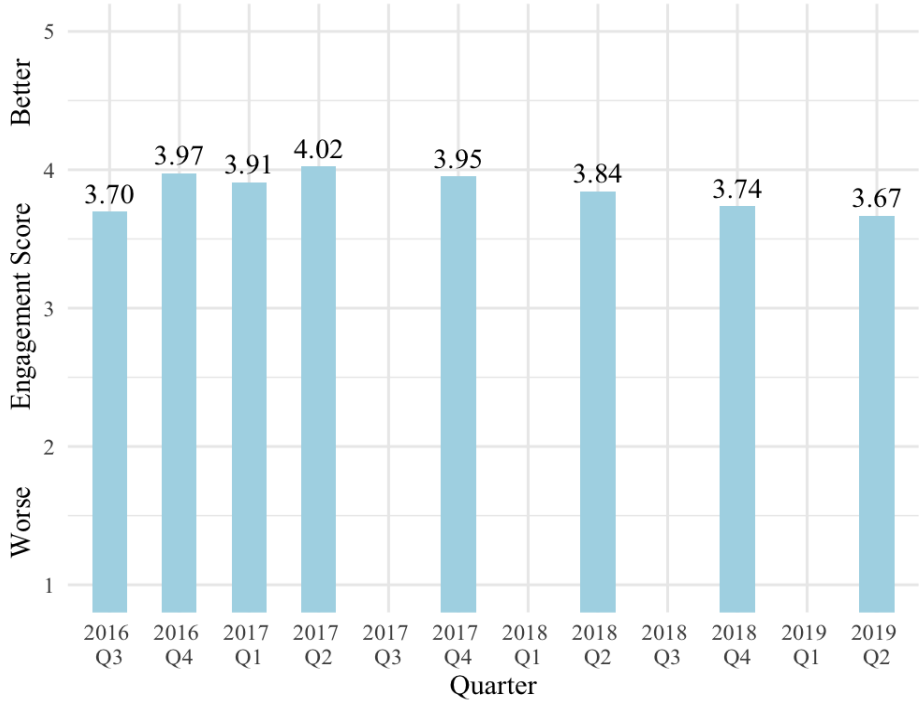
**Table 6.** ***Percentage of Specialists Perceiving Community Partner Involvement in Coordination and Collaboration Activities: Specialists' Quarterly Reports, July 2016 - June 2019***

| Community Partner | 2016 Q3 % | 2017 Q2 % | 2018 Q2 % | 2019 Q2 % | Trend |
|---|---|---|---|---|---|
| a. Aging services | 85 | 87 | 81 | 100 | n/s |
| b. Behavioral health services | 81 | 90 | 84 | 79 | n/s |
| c. Center for Independent Living | 31 | 26 | 25 | 10 | - |
| d. Veterans services | 38 | 32 | 41 | 21 | n/s |
| e. Primary care clinic | 35 | 61 | 47 | 52 | n/s |
| f. Hospital / emergency department | 38 | 65 | 50 | 41 | - |
| g. Area coordinating care organization | 62 | 81 | 72 | 52 | n/s |
| h. Local law enforcement | 31 | 35 | 28 | 28 | n/s |
| i. EMT or similar emergency responder | 35 | 42 | 28 | 28 | n/s |
| j. Tribal organization | 19 | 10 | 16 | 14 | n/s |
| k. Advocacy organization / consumer / family | 50 | 52 | 44 | 62 | + |
| l. Residential care | 46 | 71 | 69 | 59 | n/s |
| m. Faith community | 23 | 26 | 16 | 28 | n/s |
| n. Elected government official | 12 | 26 | 25 | 10 | n/s |
| o. Home care / Home health care | 23 | 42 | 38 | 55 | n/s |

Note. All quarters (8) are included in fixed-effects regression analysis, but only one quarter each year presented in the table. Because percentage calculations are computed with cross-sectional data and regression analyses are done with longitudinal data, there may seem to be some disagreement between percentage trends and regression trends.

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 3 below). Additionally, two items that asked about barriers to engagement with stakeholders (i.e., "In spite of my efforts, core stakeholders are not involved." and "Many core stakeholders are too busy to participate in the Initiative.") were reverse coded so that for all stakeholder engagement items, higher scores mean greater engagement from stakeholders. The majority of Specialists agreed or strongly agreed with these statements. Core stakeholders' engagement in these activities as reported by Specialists did not significantly change over time from Q3 2016 through Q2 2019 ($B$ = -0.02, $p$ = .058). However, after a significant increase in involvement scores was observed from 2016 Q3 to 2017 Q2 ($B$ = 0.07, $p$ = .034), followed by a significant decrease in involvement from the peak in 2017 Q2 to the most recent measurement period in 2019 Q2 ($B$ = -0.04, $p$ < .001), with the most recent engagement score reverting to 2016 Q3 levels. This may suggest that after an initial spike in motivation by stakeholders to engage with Specialists that peaked about two years after the formation of the Initiative (from July 2016 to June 2017), existing priorities may have gradually pulled stakeholders away from engaging with the Initiative over the next two years (through June 2019) and back to original levels, which still reflect an engagement score above the neutral point (i.e., between "neither agree nor disagree" (3) and "agree" (4) that stakeholder is engaged). However, other reasons could account for this shift back toward original levels such as Specialist turnover and the need for new Specialists to reacquaint stakeholders to the Initiative.

**Figure 3.** ***Specialists' ratings of stakeholder engagement***



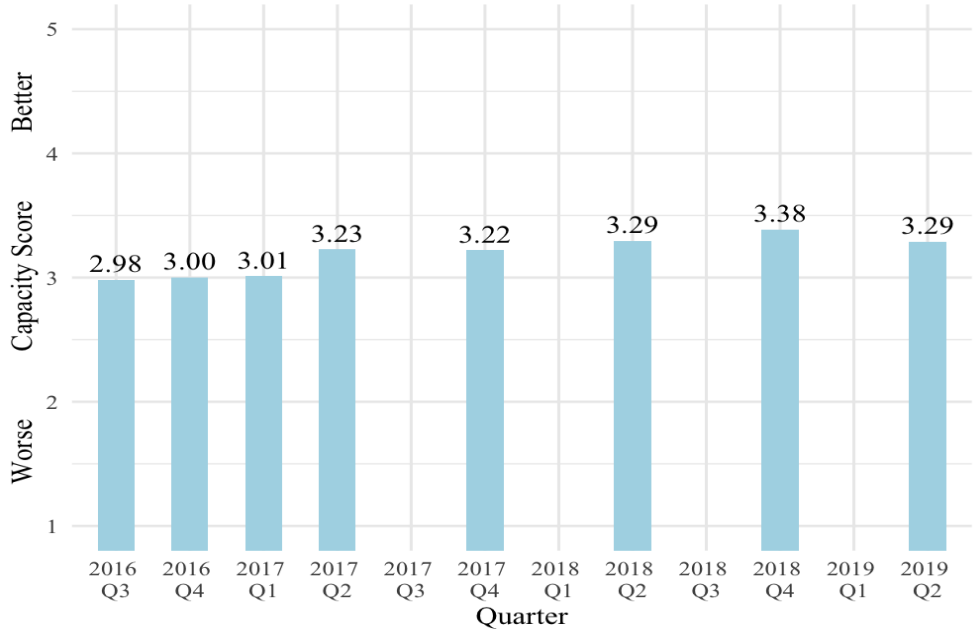

Note. Quantitative survey items were not asked during the first and third quarters of each year starting in Q3 of 2017.

### *Community Capacity 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. A composite score of community capacity was created from the 10 indicators by averaging scores on a scale from 1 "strongly disagree" to 5 "strongly agree" with higher scores reflecting greater community capacity. This includes several reverse coded items that ask about barriers to increasing community capacity (e.g. "i. Turnover in community partner organizations interferes with momentum."). Since July 2016, Specialist reporting of community capacity in these activities has significantly increased ($B$ = 0.04, $p$ = .002) (see Figure 4 below). When looking at the ten specific items, all but 3 aspects of community capacity significantly improved from 2016 Q3 to 2019 Q2. Specifically, only Specialists reports of community partners engaging in quality improvement ($B$ = 0.03, $p$ = .11), turnover in community partner organizations interfering with momentum (reverse coded) ($B$ = 0.02, $p$ = .11), and of the right people who can

make changes in agency programs or services are participating in our discussions or meetings (*B* = -0.01, *p* = .599) did not significantly improve across time (see Table 7).

**Figure 4.** ***Specialists' ratings of community capacity***




Note. These questions were not asked in 2017 Q3, 2018 Q1, 2018 Q3, and 2019 Q1. Quantitative survey items were not asked during the first and third quarters of each year starting in Q3 of 2017.

**Table 7.** ***Specialists' ratings of community capacity from 2016 Q3 to 2019 Q2***

| Items | Trend |
|---|---|
| a. CPs have formed a cohesive group | + |
| b. CPs meet often enough to make progress | + |
| c. Old resentments get in the way (Reverse) | + |
| d. Consumers represented at CP meetings | + |
| e. CPs engaged in quality improvement | n/s |
| f. CP coordination has improved | + |
| g. Agencies work in silos (Reverse) | + |

| | |
|---|---|
| h. Formal agreements are in place | + |
| i. Turnover interferes with momentum (Reverse) | n/s |
| j. The right people are participating | n/s |

***Training: Workforce Development***

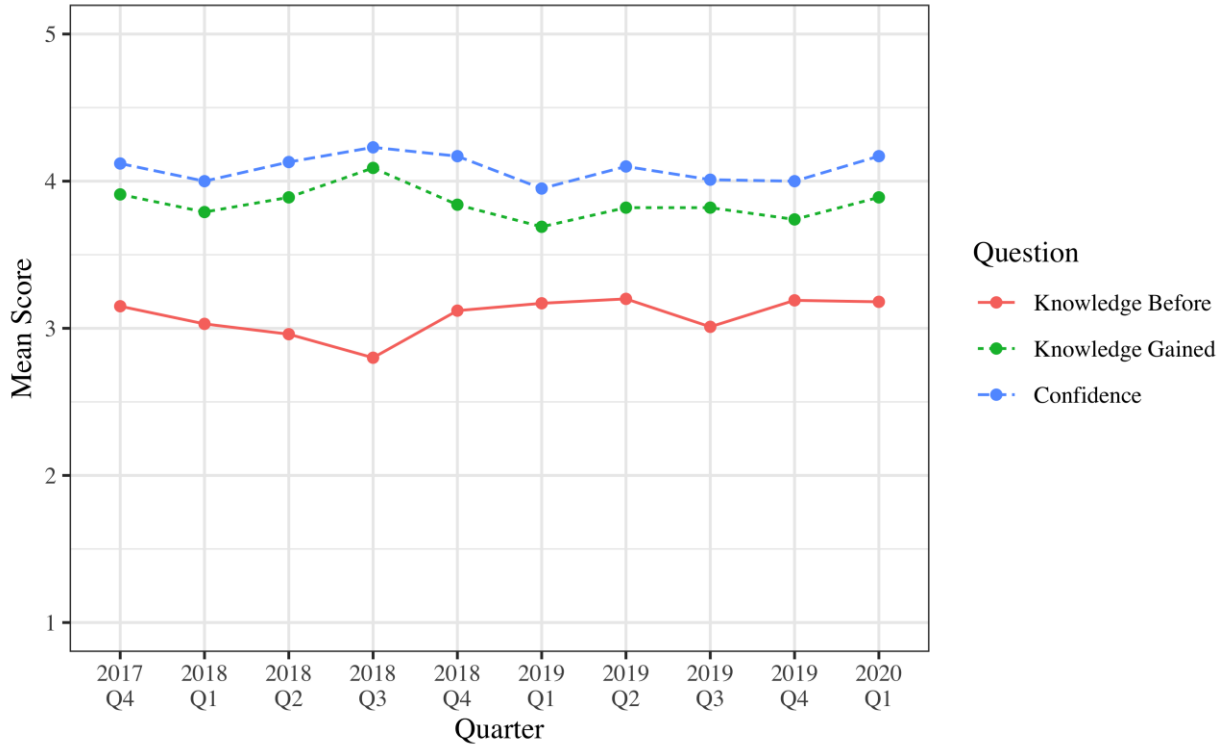
Between October 2017 and March 2020, 662 workforce development training events were planned, conducted, or sponsored by Specialists with an average of 66.2 training events per quarter. A total of 3,986 training participants fully completed and 4,033 fully or partially completed the online evaluation of the training.

Response rates for specific events varied within and across quarters, ranging from 40.8% to 51.4% between October 2017 and March 2020. However, across all quarters from October 2017 through March 2020, average response rates did not change over time based on a non-significant analysis of variance ($p$ = .525). During the most recent reporting period (July 2019 through March 2020), response rates for specific events ranged from zero to 100 percent. Six event(s) received no response. Eighteen events had response rates between one and 20 percent, and fifteen events had response rates higher than 60 percent. The variation in response rates over time reflects the diversity in participant characteristics that may be associated with the probability of responding to online training evaluations (such as service area, organization, occupation).

Respondents were asked about their position. During the most recent reporting period (July 2019 through March 2020), 27 percent were direct service or primary care providers; 13 percent were middle managers, program managers, or clinical directors at their organization or agency; 13 percent were lay persons or advocates; and four percent were agency administrators or executive directors. The largest group of respondents (42 percent) selected the “Other” category, which included job titles such as case managers, police officers, behavior consultants, and eligibility specialists. The distribution of these categories has changed over time across all quarters (from October 2017 through March 2020), based on significant p-value for Pearson’s chi-square test ($p$ < .001). The diversity and variation in respondents’ occupations highlights the extent to which the Specialists are striving to create a knowledgeable workforce in their communities including a variety of professionals such as EMTs who may not be directly focused on this population in their typical work and training, but are now prepared to support older adults and people with disabilities who have behavioral health needs.

An important workforce development objective is for training participants to be able to use knowledge gains in their work. To measure these gains, training participants were asked their level of knowledge before and after training as well as their confidence post-training. 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 were examined (Figure 5). During the current measurement period from July 2019 through March 2020, participants reported having between "a moderate amount" to "a good deal" of knowledge prior to training (M = 3.12), gaining "a moderate amount" to "a good deal" of knowledge from training (M = 3.81), and being "pretty confident" to "extremely confident" in their ability to use knowledge gained from the training in their work with consumers (M = 4.05). The most recent quarterly data are consistent with the findings over time. This suggests that knowledge and confidence both appear to increase after participation in these trainings.

**Figure 5.** ***Means of pre-training knowledge, knowledge gains attributed to training, and confidence in ability to utilize knowledge learned items across quarters***




***Training: Community Education***

Community education participants were asked to answer the following questions in relation to the content of their training on a scale from 1 (strongly disagree) to 7 (strongly agree) (see Table 8). Table 9 shows the mean scores for each item in the community education

evaluation for the first quarter of each year as well as whether there was a significant linear trend across all quarters (from 2017 Q4 to 2020 Q1). Table 10 below shows the mean scores for each item in the community education evaluation for participants who filled out the evaluation during the current reporting period from July 2019 through March 2020.

**Table 8.** ***Community Event Evaluation Questions***

| | |
|---|---|
| Question 1 | I know more about this issue. |
| Question 2 | I know more now about how to improve wellbeing. |
| Question 3 | I know the warning signs. |
| Question 4 | I am confident that I know how to get more information on this topic. |
| Question 5 | I will recommend this presentation to other people. |
| Question 6 | This presentation was held in a location that was convenient for me. |
| Question 7 | This presentation was at a time of day that was convenient for me. |

One hundred twenty-seven community education trainings were conducted by the Specialists across all quarters from 2017 Q4 to 2020 Q1, and 29 of these events were conducted during the current reporting period (i.e., 2019 Q3 to 2020 Q1). The total number of participants all time who completed or partially completed the community education survey was *n* = 1595. The total number of participants during the most recent reporting period who completed or partially completed the community education survey was *n* = 426.

**Table 9.** ***Community Education Evaluations Across Time with Linear Regression Significance***

| | **2018 Q1** ***M*** **(*SD*)** | **2019 Q1** ***M*** **(*SD*)** | **2020 Q1** ***M*** **(*SD*)** | **Total** ***M*** **(*SD*)** | **Linear Trend** |
|---|---|---|---|---|---|
| I know more about this issue | 5.95 (1.43) | 6.05 (1.33) | 6.04 (1.28) | 6.04 (1.27) | n/s |
| I know more about how to improve wellbeing | 5.89 (1.46) | 5.95 (1.39) | 6.03 (1.22) | 5.92 (1.30) | n/s |
| I know the warning signs | 5.72 (1.55) | 6.00 (1.24) | 6.07 (1.18) | 5.91 (1.25) | n/s |
| I know how to get more info | 5.82 (1.57) | 5.97 (1.39) | 5.90 (1.32) | 5.96 (1.32) | n/s |

| | | | | | |
|---|---|---|---|---|---|
| I will recommend this presentation | 6.09 (1.54) | 6.36 (1.15) | 6.33 (1.14) | 6.26 (1.22) | - |
| The location was convenient | 6.51 (1.12) | 6.58 (1.00) | 6.46 (1.16) | 6.49 (1.08) | - |
| The time was convenient | 6.49 (1.16) | 6.51 (1.03) | 6.39 (1.17) | 6.50 (1.07) | n/s |

Note. A linear trend value of "-" refers to $p < .05$ in the negative direction and a linear trend value of "+" refers to $p < .05$ in the positive direction. While only select quarters are presented in the table, all quarters from 2017 Q4 to 2020 Q1 were included in the linear trend calculation.

**Table 10.** ***Community Education Evaluations from July 2019 to March 2020***

| | **July 2019 - March 2020** ***M*** **(*SD*)** |
|---|---|
| I know more about this issue | 5.82 (1.29) |
| I know more about wellbeing skills | 5.77 (1.27) |
| I know the warning signs | 5.79 (1.19) |
| I know how to get more info | 5.78 (1.27) |
| I will recommend this presentation | 5.97 (1.35) |
| The location was convenient | 6.27 (1.17) |
| The time was convenient | 6.42 (1.15) |

**Complex Case Consultations (CCC)**

Complex case consultation (CCC) is a core job function of the Specialists. A CCC is defined as a discussion (in-person or via conference call) among the Specialist and one or more direct service providers, 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 living with physical disabilities who have behavioral health needs. Detailed tracking of these CCCs is intended to inform the Initiative as well as key stakeholders of the types of consultations, reasons for consultations, and outcomes of consultation meetings in communities throughout Oregon. This information is critical to informing policymakers about services and resources that are needed by this population.

The Specialists used a data entry tool prepared by the PSU Team to collect information about each CCC in which they participated between October 2017 and March 2020. From October 2017 through March 2020, Specialists reported participating in a total of 3,711 CCCs that took place in at least 30 Oregon counties.

**Complex Case Consultations: Planning Status and Structure**

Focusing only on cases with valid responses, over half of all consultations were planned across all quarters (53%) and when focusing only on the current measurement period (55%). Across all quarters, 52 percent of cases involved staff from multiple departments, organizations, or disciplines in the form of multidisciplinary teams (20%) or people from multiple organizations/departments (28%) (Table 11). Similarly, when focusing on cases from the most recent measurement period, 47 percent of cases involved staff from multiple departments, organizations, or disciplines, in the form of multidisciplinary teams (32%) or people from multiple organizations/departments (15%).

**Table 11.** ***Structure of the complex case consultation***

| | Valid % (2018 Q1) | Valid % (2019 Q1) | Valid % (2020 Q1) | Count (All Qs) | Percent (All Qs) | Valid % (All Qs) |
|---|---|---|---|---|---|---|
| Single Org. (Individual) | 34% | 46% | 50% | 1,446 | 39% | 39% |
| Single Org. (Team) | 14% | 13% | 8% | 477 | 13% | 13% |
| Multiple Org./Multiple Departments | 52% | 21% | 14% | 1,021 | 28% | 28% |
| Multidisciplinary Team | 0% | 20% | 27% | 740 | 20% | 20% |
| Missing/non-standard | - | - | - | 27 | 1% | - |

The majority of 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 12).

Across all reported years, *co-occurring medical conditions* and *ADLs and other functional limitations* were most likely to be diagnosed (48% and 34% of all CCCs, respectively) within the **physical/medical category**, followed by *geriatric syndromes (e.g., frailty, falls, self-neglect)*; 29%). These problems/issues were followed in prevalence by *unresolved medical need* (18%), *high utilization of emergency departments and/or 911* (11%), and *medical assistive devices* (8%). *Polypharmacy* (4%) and *delirium* (1%) were the least cited reasons in this category.

Under the **neurological/cognitive category**, across all years, *lack of capacity, competence for decision making* (17% diagnosed and 10% suspected) and *dementia* (17% diagnosed and 9% suspected) were the most frequently selected problems/issues. *Acquired or traumatic brain injury (e.g., stroke)*, *neurological disorder (e.g., seizures, Parkinson's)*, and *intellectual disability* were less frequently selected (8%, 4%, and 3% diagnosed, respectively).

For the **psychiatric/mental health category**, across all years, *serious mental illness* (27% diagnosed and 4% suspected) and *mood disorders (e.g., depression, anxiety*; 26% diagnosed and 15% suspected) were most likely to be selected, followed by *substance use disorders (excl. opioid use disorder)* (15% diagnosed and 4% suspected), and *disruptive behaviors* (14% diagnosed and 3% suspected). In contrast, diagnoses of *suicidality* (6%), *personality disorders* (4%), *medication misuse* (3%), *hoarding* (3%), and *opioid use disorder* (3%) were less likely to be selected within this category. Less than one percent of cases involved a consumer with a diagnosis of *animal hoarding*.

Across all years, *lack of or poor family/natural supports* were the most frequently cited problem/issue (48% of all CCCs) in the **social/individual category**, followed by *isolation/loneliness* (34%), *financial (e.g., cannot afford services, limited income)* (26%), *housing* (24%), *consumer refuses services* (22%), and *food insecurity* (11%). *Law enforcement/criminal justice involvement* and *homelessness* were the least commonly selected problems/issues in this category (10% and 10%, respectively).

Across all years, **system-related issues** most frequently involved problems with *system navigation (difficult for consumer/family/supports)* (47% of all CCCs) and *understanding eligibility* (32%). These problems/issues were followed in prevalence by *lack of communication between agencies* (12%), *does not qualify for aging supports due to BH needs* (11%), *lack of services* (10%), and *does not qualify for BH supports due to ADL needs* (9%). A smaller share of cases involved consumers who experience *hard to determine root cause(s)* (8%), *can't afford services* (8%), *in home services needed, but not available* (8%), *lack of or limited transportation*

(7%), *legal issue (e.g., inappropriate evictions; guardianship issues)* (7%), *health insurance limitations* (6%), *could not agree on a care plan* (5%), *inadequate workforce (insufficient, lack of training)* (4%), or *waitlist is full or would take too long* (2%).

Regardless of broad categories into which problems/issues were grouped, across all quarters, the most prevalent diagnosed issues are *lack of or poor family/natural supports* (48%) and *co-occurring medical conditions* (48%). The most prevalent suspected/diagnosis pending issues regardless of broad category are *mood disorders (e.g., depression, anxiety)* (15%) and *lack of capacity, competence for decision making* (10%). Similar to previous quarters, these problems remain the most prevalent issues presenting in CCCs.

**Table 12.** ***Reasons for a consultation (Diagnosed)***

| Broad Category | Problem/Issue | 2018 Q1 % | 2019 Q1 % | 2020 Q1 % | All Qs % |
|---|---|---|---|---|---|
| **Physical Medical** | Co-occurring medical conditions | 43 | 43 | 62 | **48** |
| | ADL and other functional limitations | 32 | 37 | 43 | **34** |
| | Geriatric syndromes (e.g., frailty, falls, self-neglect) | 23 | 33 | 36 | **29** |
| | Unresolved medical need | 11 | 17 | 35 | **18** |
| | High utilization of emergency department and/or 911 | 8 | 13 | 17 | **11** |
| | Medical assistive device | - | 7 | 8 | **8** |
| | Polypharmacy | 3 | 6 | 5 | **4** |
| | Delirium | 1 | 2 | 2 | **1** |
| **Neurological Cognitive** | Lack of capacity, competence for decision making | 19 | 17 | 18 | **17** |
| | Dementia | 14 | 18 | 18 | **17** |
| | Acquired or traumatic brain injury (e.g., stroke) | 6 | 7 | 8 | **8** |
| | Neurological disorder (e.g., seizures, Parkinson's) | 5 | 5 | 10 | **4** |
| | Intellectual disability | - | 3 | 4 | **3** |
| | Serious mental illness | 17 | 33 | 30 | **27** |
| | Mood disorders (e.g., depression, anxiety) | 21 | 26 | 34 | **26** |

| | | | | | |
|---|---|---|---|---|---|
| **Psychiatric Mental Health** | Substance Use Disorders (excl. Opioid Use Disorder) | 19 | 12 | 19 | **15** |
| | Disruptive behaviors | 13 | 14 | 20 | **14** |
| | Suicidality | 7 | 6 | 5 | **6** |
| | Personality disorders | 2 | 3 | 2 | **4** |
| | Medication misuse | 3 | 5 | 7 | **3** |
| | Hoarding | 2 | 3 | 5 | **3** |
| | Opioid Use Disorder | - | 3 | 5 | **3** |
| | Animal hoarding | 0 | 0 | 1 | **< 1** |
| **Social Individual** | Lack of or poor family/natural supports | 47 | 57 | 53 | **48** |
| | Isolation/loneliness | 35 | 37 | 30 | **34** |
| | Financial (e.g., cannot afford services, limited income) | 25 | 29 | 28 | **26** |
| | Housing | 30 | 24 | 22 | **24** |
| | Consumer refuses services | 20 | 23 | 27 | **22** |
| | Food insecurity | 9 | 16 | 17 | **11** |
| | Law enforcement/criminal justice involvement | 14 | 12 | 9 | **10** |
| | Homelessness | - | 13 | 16 | **10** |
| **System** | System navigation (difficult for consumer/family/supports) | 50 | 53 | 53 | **47** |
| | Understanding eligibility | 40 | 36 | 35 | **32** |
| | Lack of communication between agencies | 16 | 14 | 9 | **12** |
| | Does not qualify for aging supports due to BH needs | 14 | 13 | 12 | **11** |
| | Lack of services | 14 | 9 | 10 | **10** |
| | Does not qualify for BH supports due to ADL needs | 10 | 11 | 13 | **9** |
| | Hard to determine root cause(s) | 7 | 7 | 12 | **8** |
| | Can't afford services | 4 | 9 | 22 | **8** |
| | In home services needed, but not available | 12 | 11 | 10 | **8** |
| | Lack of or limited transportation | 9 | 12 | 6 | **7** |

| | | | | | |
|---|---|---|---|---|---|
| | Legal issue (e.g., inappropriate evictions; guardianship issues) | - | 9 | 4 | **7** |
| | Health insurance limitations | 4 | 5 | 5 | **6** |
| | Could not agree on a care plan | 9 | 6 | 3 | **5** |
| | Inadequate workforce (insufficient, lack of training) | 2 | 5 | 6 | **4** |
| | Wait list is full or would take too long | 2 | 2 | 1 | **2** |

Note. Percentages in the "All Qs" column include the average across all quarters from 2017 Q4 to 2020 Q1. Cells with a "-" instead of a percentage indicate that the problem/issue was not asked about in this quarter.

### Complex Case Consultation: Specialist's actions and recommendations

Actions taken by Specialists during consultations included assisting consultee with information/referrals to services required by the consumer (57% across all quarters; 51% during the current reporting period), providing consultee with clinical information about the consumer's presenting problems (37% across all quarters; 41% during the current reporting period), providing consultee with additional staff training/coaching (27% across all quarters; 25% during the current reporting period), providing the consumer and/or surrogate with short-term help in accessing services (30% across all quarters; 33% during the current reporting period), and other various activities (14% across all quarters; 13% during the current reporting period) (Table 13). Most of the comments written in the "other Specialist actions" column further describe an item selected in the predetermined list.

**Table 13.** ***Specialist's actions during the consultation***

| | Count (2019 Q3 - 2020 Q1) | Percent (2019 Q3 - 2020 Q1) | Count (All Qs) | Percent (All Qs) |
|---|---|---|---|---|
| Assisted consultee with info/referrals to services required by the consumer | 550 | 51% | 1,526 | 57% |
| Provided consultee with clinical info about consumer's presenting problem(s) | 441 | 41% | 982 | 37% |
| Provided consultee with additional staff training/coaching | 267 | 25% | 720 | 27% |
| Provided consumer and/or surrogate with short-term help in accessing services | 354 | 33% | 797 | 30% |
| Other | 142 | 13% | 384 | 14% |

*Note.* Because multiple actions can be selected for each consumer, the percentages need not add up to 100.

General recommendations for the consumer emerging from the case discussions included change in residence (30% across all quarters; 35% during the current reporting period), change in services and/or care plan (47% across all quarters; 51% during the current reporting period), review of current medications and possible adjustment (21% across all quarters; 28% during the current reporting period), admission to emergency department or hospital (6% across all quarters; 6% during the current reporting period), and other recommendations (28% across all quarters; 28% during the current reporting period) (Table 14). A majority of the comments written in the "other recommendations" column include actions taken, or follow-up tasks, and few comments describe specific recommendations for the consumer. Comments that describe specific recommendations mostly describe referrals and connections that should be made to connect the consumer with necessary services.

Also included in the form is a comment box for Specialists to describe follow-up tasks they will perform for this consultation. This box was included to assist the Specialists in keeping track of follow-up tasks for each of their case consultations. Most comments describe participating in a follow-up meeting with another team member or continuing to monitor the consumer and provide support to a family member.

**Table 14.** ***General recommendations for the consumer emerging from the case discussion***

| | Count (2019 Q3 - 2020 Q1) | Percent (2019 Q3 - 2020 Q1) | Count (All Qs) | Percent (All Qs) |
|---|---|---|---|---|
| Change in residence | 376 | 35% | 800 | 30% |
| Change in services and/or care plan | 545 | 51% | 1,238 | 47% |
| Review of current medications and possible adjustment | 297 | 28% | 571 | 21% |
| Admission to ED or hospital | 66 | 6% | 158 | 6% |
| Other | 298 | 28% | 751 | 28% |

*Note.* Because multiple recommendations can be selected for each consumer, the percentages need not add up to 100.

The degree to which community resources were available to consumers changed over time based on a significant chi-square test ($\chi^2$ (18) = 64.45, $p < .001$). For cases with information on community resources, in 56 percent of cases across all quarters and 57 percent of cases during the current measurement period, the community had all the resources available to address the needs of the consumer. Only in eight percent of cases across all quarters and seven percent of cases during the current measurement period did the community partners have none of the resources available to address the needs of the consumer.

**Specialist Interviews**

Each of the Behavioral Health Specialists were interviewed about their most significant projects and their perspectives about the Initiative. The Specialists provided information on up to three projects that they considered to be the most significant to them. These were condensed and grouped into four main categories based on the focus of the projects: 1) Improving access to behavioral health care; 2) Increasing workforce knowledge and skills; 3) engaging community partners; and 4) Working upstream on primary prevention. See Appendix 1 for project descriptions and Appendix 2 for a full list of projects.

Specialists were also asked about barriers to implementing these significant projects and strategies utilized for overcoming these barriers. Additional questions included how the Initiative could be more successful and the extent to which they consult and collaborate with other Specialists. Several themes emerged from these interviews. Specialists provided suggestions to improve the Initiative and the wider behavioral health system in Oregon and these are described in the recommendations section of this report.

**Barriers to Implementing Projects.** The Behavioral Health Specialists were asked about the greatest barriers they faced implementing their most significant projects in their communities. Specialists provided a range of barriers that hindered their ability to implement these projects including inter-agency issues, logistical issues, and lack of memorandums of understanding (MOU). Examples of inter-agency issues include old resentments between agencies and lack of understanding of what other agencies provide.

> "There were lots of unresolved issues between agencies with accumulated anger. Some agency representatives had never met each other. None of them appeared to understand the services that each other provided." (Specialist, Rural)

Specialists described several examples of why an MOU would have made their project more successful, including agreement upon how to handle cross-referrals.

> "Achieving an MOU among the three APS units (Mental Health, Aging, Intellectual and Developmental Disabilities) in my county. There is a huge "silo" warfare going on among them about who is going to serve the client. Cases get dropped or lost. I tried to get them to agree on criteria and how to handle cross-referrals. I could not get buy-in because of internal administration issues in two of the units. I also think none of the units wanted to change the status quo and have to do their work differently." (Specialist, Urban)

Examples of logistical issues include long waitlists and finding trainers who are qualified to train on a particular topic, especially in rural communities where there are often staff shortages. Other barriers described by Specialists included high turnover and lack of Medicare providers.

> "Still there is general frustration about the lack of infrastructure to provide mental health services to people who need them – access to providers who accept Medicare, lack of mental health/geriatric providers. It makes partnerships difficult; hospital social workers, case managers get frustrated when their patients/clients can't get services." (Specialist, Rural)

**Strategies to Overcoming Barriers.** Specialists were asked to describe strategies used to overcome the greatest barriers they faced in implementing projects in their communities. The most frequently cited strategies included communication, marketing, and using personal attributes such as persistence or patience. Examples of communication strategies include turning to other Specialists and the Project Director for help and joining different boards and meeting key stakeholders to assist with their projects.

> "I try to volunteer where I can on different boards, attend meetings I wouldn't usually attend." (Specialist, Rural & Urban)

Examples of marketing strategies include setting up meetings and presentations with key agencies to share data and solicit their buy-in on projects and providing formal training events.

> "Lots of collaboration and working with the providers. Revamped the referral form to be more specific. Getting our staff on the same page about what the purpose of the program was and what it was not. To get support from the community - I did presentations at various agencies and really pushed to program as part of their suite of programs." (Specialist, Urban)

Examples of personal attributes that assisted the Specialists were persistence, patience, and being friendly when communicating with key stakeholders. Specialists are able to draw from their professional experience to determine how to best work with their stakeholders.

> "I am pretty self-directed by nature. I use the knowledge that I have gained from my 32 years of work." (Specialist, Urban & Rural)

Specialists also described efforts to restructure their projects, finding advocates and their own professional development as helpful strategies for overcoming barriers. They were asked if the strategies they used to overcome barriers were successful. Most noted that their strategies yielded mixed success though they did not necessarily address all barriers.

**Collaborating with Other Specialists.** Specialists described troubleshooting issues or soliciting ideas from their colleagues. They were asked about the extent to which they collaborate and communicate with other Specialists. They provided a variety of responses to this question. Some Specialists described the frequency of collaboration (whether the collaboration was ad hoc or regularly scheduled), and the format or method of collaboration. Most Specialists said they have a lot of collaboration with their peers, followed by some collaboration, and rare collaboration. Specialists who stated that they collaborate with other Specialists often mentioned that they collaborate with Specialists who are more proximal to them, and they get ideas from each other about training events and projects to set up in their own communities. They often lean on each other's unique skill sets to further enhance their own work.

> "I collaborate very regularly, with many Specialists, particularly with those who are more proximal to me. I have collaborated with most Specialists at some point in time since the Initiative began… I have always leveraged the knowledge of my counterparts to support the work. I regularly put professionals in touch with Specialists in different parts of the state, whether it be for consultation or system navigation." (Specialist, Urban & Rural)

Those who sometimes collaborate with their fellow Specialists mentioned that they utilize them on an as-needed basis, depending on the project and distance is a barrier to frequent collaboration.

> "We collaborate on an as needed basis, depending on the project and need. We're not in each other's back yards. For us it's the geographic distance. We do utilize the group email and the phone, and the peer meetings." (Specialist, Urban & Rural)

Specialists described the format in which they collaborate with other Specialists. The most frequently cited methods were email, phone and peer networking meetings. They also collaborate on consultations, projects, and training events.

## Recommendations from the Specialists

The Specialists offered a number of potential recommendations for ways to improve the Initiative at both a systems level as well as at a local level. These recommendations are provided here.

**Systems Level Recommendations**

**Public Payment Systems**

- Recruit providers who will provide Medicare services. Specialists can help address the shortage of behavioral health providers by working to recruit more professionals to enroll in Medicare as well as by expanding their outreach beyond agencies that only serve Medicaid clients.
- Address issues related to billing and access to Medicare through promoting technical assistance and education to providers.
- Reduce existing barriers to Medicaid coverage of mental health services in Oregon, particularly for consumers who reside in licensed care settings

**Funding for the Initiative**

- Provide funding for workforce development events to decrease knowledge gaps.
- Direct additional financial support to Specialists to maintain existing projects and implement new programming in their local communities.
- Increase funding to hire more full-time Specialists, especially in Eastern Oregon.

**Establish formal agreements between agencies**

- Establish MOUs between aging and behavioral health systems to promote information sharing and to prevent clients from falling through the cracks.
- Implement state-level MOUs between Department of Human Services and Oregon Health Authority's Behavioral Health division.
- Use braided funding to better address consumer issues through reduced administrative burden related to billing.

**Address gaps in services**

- Provide sustained funding for AAA-ADRC mental health programs to provide a safety net for people who live alone and lack natural supports.
- Address the lack of medical support for mental health as there is a need to provide consumers with medical care.
- Support more affordable housing options for this population. Increase access to Enhanced Care services provided by licensed care settings.

**Prioritizing older adults**

- Ensure that community mental health programs prioritize the older adult population.
- Raise awareness with policymakers on data related to older Oregonians living with behavioral health needs.

**Initiative-level recommendations**

**Elevate the organizational level of the Specialist position and provide more support from leadership**

- Afford greater authority and decision-making abilities to the Specialists so the Initiative has greater impact.
- Require APD to seek consultation from the Specialists as Specialists have difficulty getting buy-in without being in managerial positions.
- Support the Initiative in having greater influence so they can get their 'foot in the door' with primary care physicians and APD foster home providers.
- Allow Specialists to advocate for addressing gaps in services with senior leaders and department directors.

**Clarify the Initiative's goals and measures of success for Specialists**

- Establish clear boundaries for the Specialist role, where the Initiative is headed, and what data Specialists should be collecting.
- Ensure consistency amongst Specialists across the state so a base level of service and activities could be measured across all counties. This would help maintain lasting change and measure progress.

**Increase the role flexibility of the Specialists**

- Allow Specialists to provide direct services. This would be especially beneficial in rural communities where there are provider shortages.

**Advertise the Initiative**

- Conduct targeted statewide marketing about the Initiative and what Specialists provide.

**Key Informant Interviews**

In 2020, the OHA asked the PSU Evaluation Team to develop a new quantitative survey and qualitative interview instrument to gather open-ended data from directors and managers of key stakeholder agencies that work with the Initiative. These stakeholders (referred to as "key informants" here) work in aging and behavioral health agencies that interact with Specialists most often: Aging and People with Disabilities (APD) offices, Area Agencies on Aging - Aging and Disability Resource Centers (AAA-ADRC), and Community Mental Health Programs (CMHP).

One of the primary goals of these interviews and surveys is to assess the perceptions of what has changed since the start of the Initiative. Another goal is to determine how the Initiative can be improved so that it can better support the work of agencies that work to advance behavioral health within their local communities. Lastly, this research seeks to gauge the involvement of the Initiative's main partner organizations including aging services and behavioral health agencies in Oregon. For the work of the Initiative to be successful, the Specialists must collaborate and coordinate with local behavioral health and aging services agencies. As such, these stakeholder's perceptions of the Initiative, including its perceived effectiveness and the degree to which coordination is occurring is an important source of information. To understand how the Initiative is perceived by and has influenced the work of core community stakeholders, in-depth interviews were conducted with management level staff at AAA-ADRCs, APD offices, and CMHP offices throughout Oregon.

Several themes and important findings emerged from the data collected by the PSU Evaluation Team through surveys and interviews of key informants. These key informants are individuals in middle-level management or leadership positions with service agencies that work with older adults or provide behavioral health. The findings were reported out by key informants' agency type (AAA-ADRC, APD, and CMHP), geography (urban or rural), and level of self-reported involvement with the Initiative.

Descriptive statistics were computed for each quantitative survey item as well as for a total involvement score. The total involvement score included all items that either referenced the Initiative or a key component of the Initiative and had sufficient face validity for assessment. Item 2 (*Our staff is knowledgeable about the behavioral health needs of older adults and people with disabilities*) and Item 6 ( *Our staff are using screening and assessment tools recommended by the Behavioral Health Specialist(s) with our organization's consumers*) were excluded from the total score because the PSU Evaluation Team could not be sure, based on the language of the items, that key informants were referring to knowledge or the use of tools, respectively, that were specifically tied to Specialists and the Initiative. Key informants were designated as having "low to medium" involvement if their total score was less than or equal to 7/10) and were designated as having "high" involvement if their total score was greater than 7/10. The survey-based key informant involvement indicator was used to compare qualitative themes by the level of involvement with the Initiative.

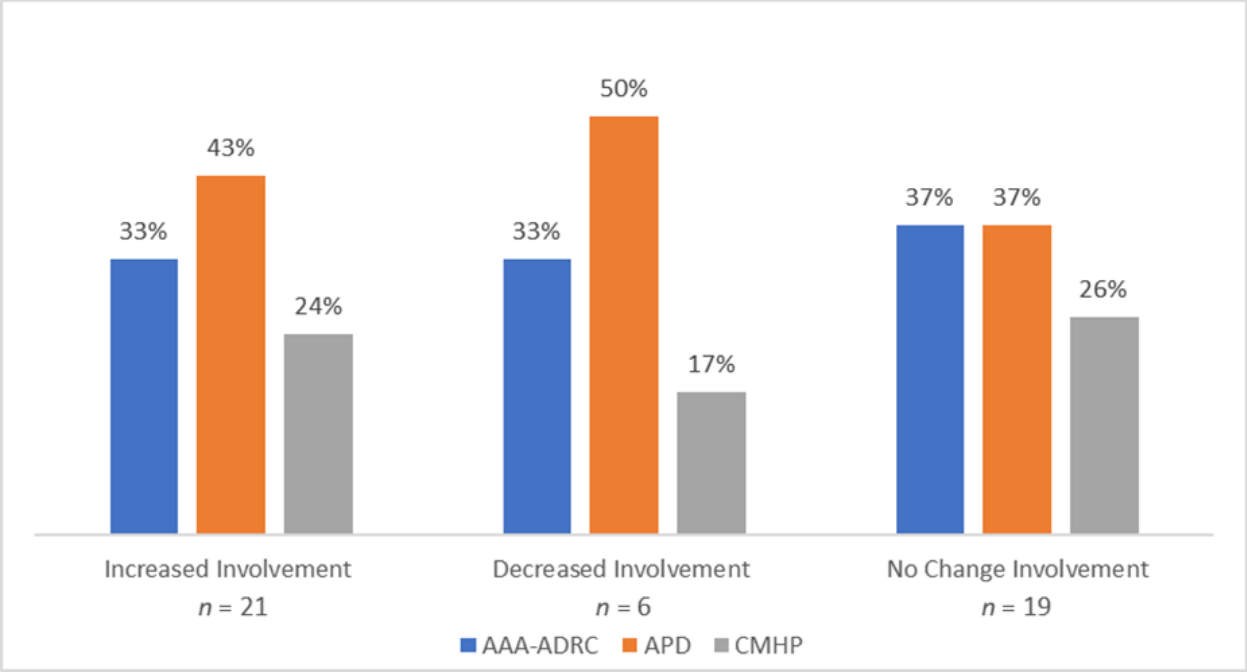
Thematic analysis was used to identify and describe themes relating to key informants' involvement with the Initiative, their perceptions of Initiative outcomes, and suggestions for

ways the Initiative and the larger behavioral health and aging service systems could improve the behavioral health of consumers.

Qualitative coding was conducted by a team of five researchers and followed a five-phase process of 1) open coding, 2) initial codebook development, 3) collaborative coding, 4) parallel coding, and 5) independent coding. The PSU Evaluation Team identified the most prevalent themes for each interview question and thematically analyzed the text for meaningful and representative examples of each theme. Group comparisons were also conducted to identify whether theme endorsement differed by key informant location in rural or urban communities, work in APD, AAA or behavioral health agencies, or level of involvement with the Initiative. Since the open-ended interview questions allowed key informants to respond to questions about their experiences with and perceptions of the Initiative based on their interpretation of the question, prevalence rates of themes should be interpreted differently than one would interpret quantitative analysis of survey items with closed sets of possible responses. If a specific theme did not emerge in an interview, this does not mean that the key informant would not have endorsed that theme had it been explicitly asked of them. A high prevalence rate of a qualitative theme can be interpreted as an idea or concept that is very relevant to key informants. A low prevalence rate can be interpreted as an idea or concept that is perhaps not as relevant to key informants as a highly prevalent theme, but does not necessarily reflect a lack of agreement with the theme. Different data may have emerged if the item were asked explicitly. The prevalence rates of themes are reported below as well as examples from interview text that give greater context and meaning to those themes.

To better understand involvement, the PSU Evaluation Team asked key informants if their agency's involvement with the Initiative had changed over time. Twenty-one key informants (42%) reported their agency's involvement with the Initiative had increased with time. Another six key informants (12%) indicated their agency's involvement with the Initiative had declined over time. A little over one-third (*n* = 19, 38%) of key informants reported no change in their agency's involvement.

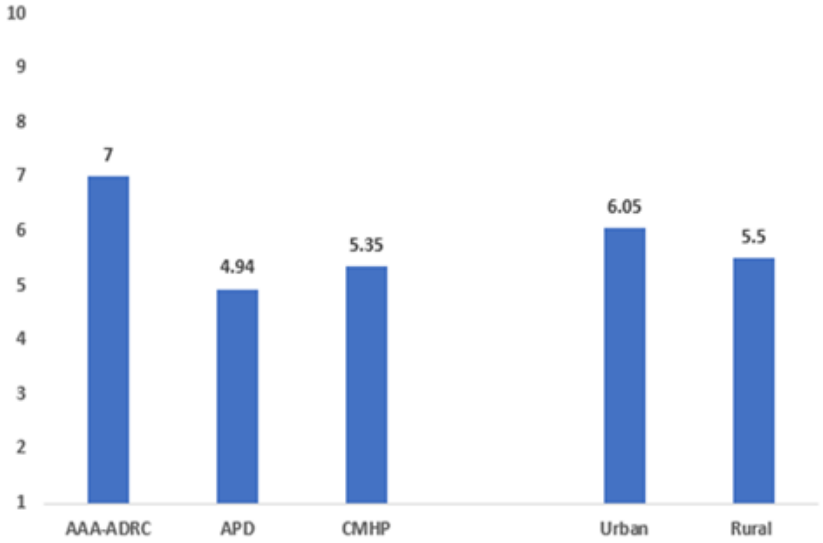
**Figure 6.** ***Self-reported change in Involvement across time by agency type***




The findings from these interviews point to several perceived changes that have taken place due to the Initiative. These include improved BH services for older adults and people living with disabilities, improved collaboration and coordination between local agencies, and workforce development efforts that have resulted in a more knowledgeable workforce.

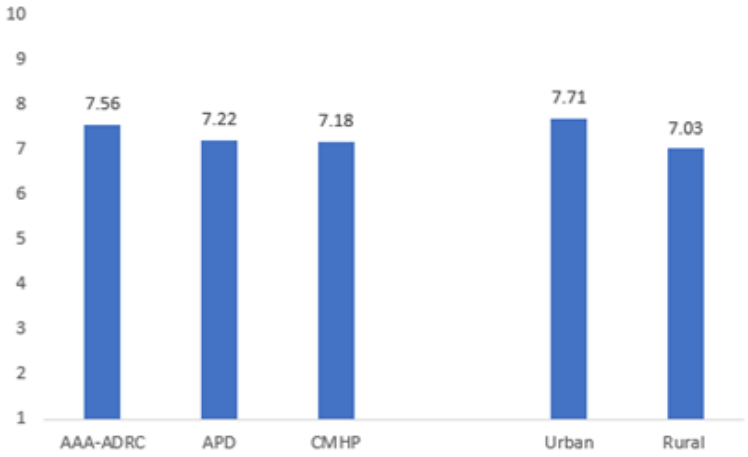
To assess key informant knowledge of the Initiative, the PSU Evaluation Team asked both quantitative and qualitative questions about their knowledge and communication about the Initiative. First, key informants were asked to respond to this statement on a scale of 1-10: Our staff is knowledgeable about the Initiative and its purpose. AAA-ADRC key informants responded with a mean score of 7.00 (*SD* = 2.45), while CMHPs had a score of 5.35 (*SD* = 2.74) and APD offices had a score of 4.94 (*SD* = 2.48). When compared by location, urban-based key informants had a score of 6.05 and rural-based key informants had a mean score of 5.50 (*SD* = 2.87) (see Figure 7). All scores fell into the medium to low range in terms of involvement. This suggests there is some room for improvement in terms of working with community partners to ensure they are knowledgeable about the Initiative and that the purpose of the initiative is clear. Specialists might focus more attention on outreach efforts with APD offices, which reported being the least knowledgeable about the Initiative.

**Figure 7:** ***Staff Knowledge about the Initiative and purpose.***




Knowledge of the behavioral health needs of older adults and people living with disabilities within one's community is an important base from which to be able to address those needs. The key informants were asked to rate the following statement on a scale from one to ten: our staff is knowledgeable about behavioral health needs of older adults and people with disabilities. AAA-ADRCs had a mean score of 7.56 (*SD* = 1.75), APD a score of 7.22 (*SD* = 1.22), and CMHP had a score of 7.18 (*SD* = 1.88). These mean scores were all in the range of high-level involvement. When compared by geographic setting, rural agencies had a mean score of 7.03 (*SD* = 1.75), while urban agencies had a mean score of 7.71 (*SD* = 1.31) (see Figure 8). Again, both of these scores fall into the high range. This is a positive finding and suggests that knowledge about the behavioral health needs of older adults and people living with disabilities is high across all agencies that work with the Initiative.

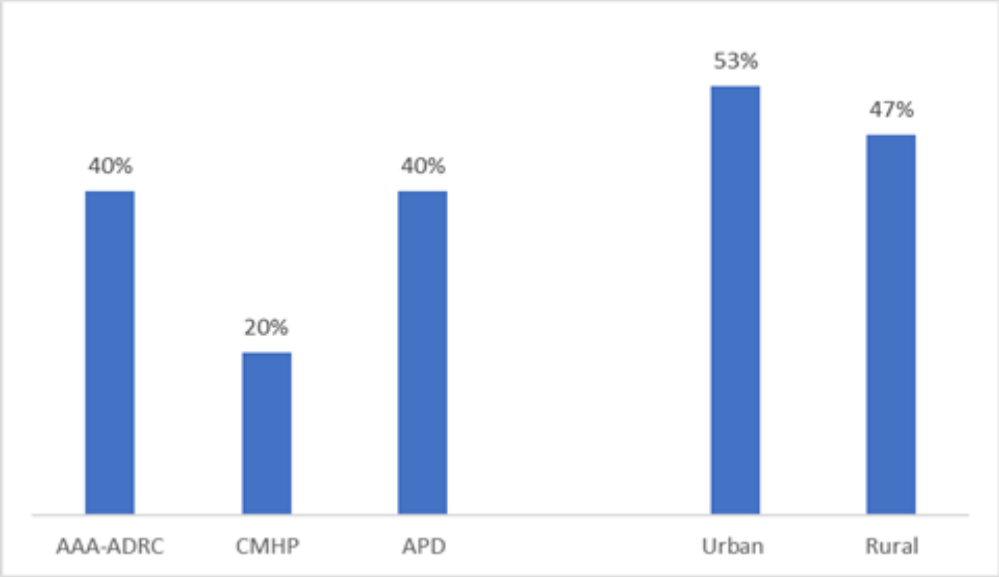
**Figure 8.** ***Staff Knowledge of Older Adult Behavioral Health Needs***




**Improved *Behavioral Health Services***

About one-third (31%), or 15 respondents reported that as a result of the Initiative, more behavioral health services are now available to older adults and people living with disabilities or that they are now receiving them at a higher rate. This included support services for consumers on Medicaid and community-based programs that address behavioral health needs (e.g., loneliness and isolation). Of those who reported an increase in BH services for consumers, seven respondents (47%) were based in rural areas, and eight were urban-based (53%). Six key informants (40%) were from AAA-ADRCs, six were from CMHPs (40%), and three were from an APD (20%) (see Figure 9). As one key informant explained,

**Figure 9.** ***Changes in Behavioral Health Services Since Initiative Began (Percentages)***

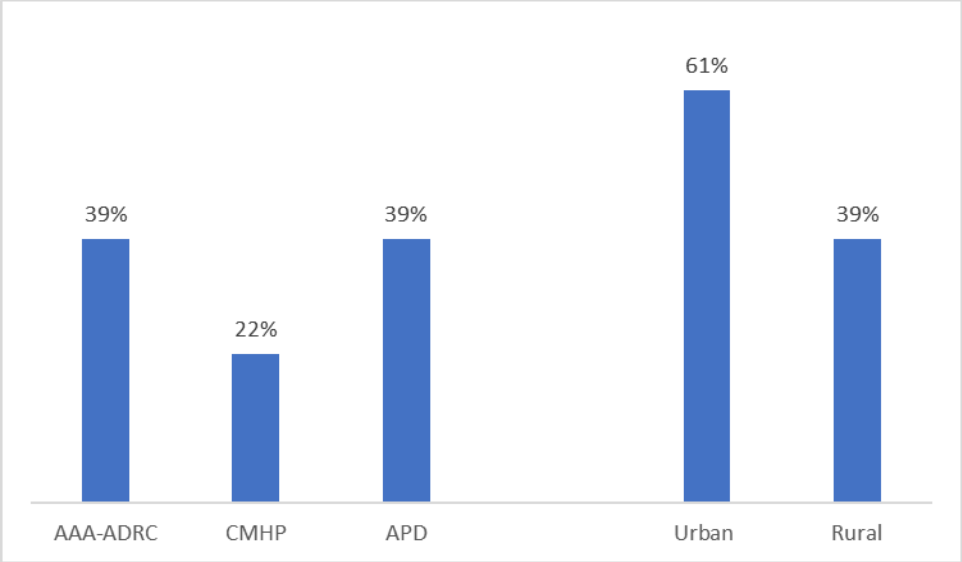



> "…because of the Specialist's education out in the community to agencies who serve people with BH issues, especially around issues of dementia (e.g., the progression of dementia) and strategies for responding to disruptive behaviors, community awareness about dementia and professional training about dementia is better in my community. I also think older adults with behavioral health needs are receiving better service because the Specialist's input on CCCs has been helpful on those complex cases where it is very difficult to provide services because of multiple issues." (AAA-ADRC, Urban)

**Collaboration and Coordination**

Eighteen respondents (37%) reported that collaboration between agencies has improved as a result of the Initiative. This includes greater agency diversity in community groups, stakeholder groups, and collaboratives. Of those, eleven respondents (61%) were located in rural areas, while seven were urban-based (39%). When compared by agency type, seven respondents were from AAA-ADRCs (39%), four were from APDs (22%), and seven were from CMHPs (39%). When compared by high and low involvement with the Initiative, 12 key informants (67%) were from high involvement agencies compared to six (33%) who were from low-medium involved agencies.

**Figure 10.** ***Increased Coordination and Collaboration (Percentages)***

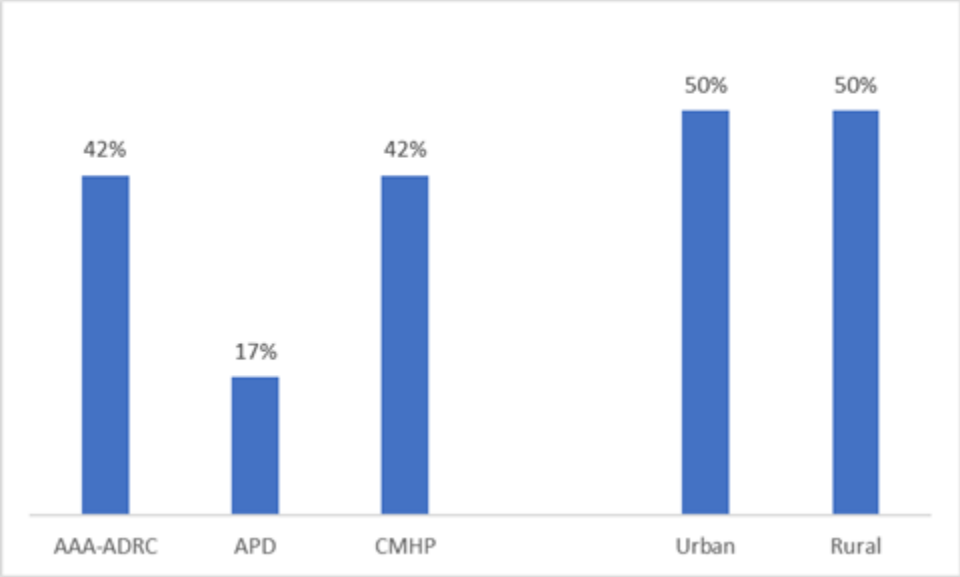



"I think there is a lot of work that still needs to be done. But I now have a starting place for how to serve people. Before there was a lot of red tape. Now there are points of contact to move, actually move forward." (AAA-ADRC, Rural)

**Workforce Development**

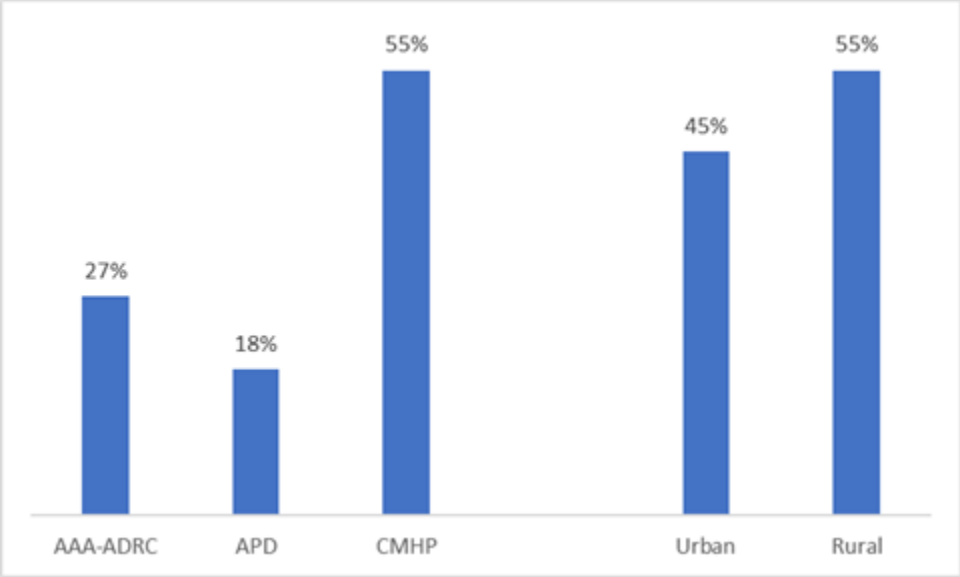
Twenty-four key informants (49%) reported that there is a more knowledgeable workforce due to workforce development training provided through the Initiative. This included reports of staff attending more training by the Initiative.

**Figure 11:** ***Workforce is More Knowledgeable due to the Initiative (Percentages)***




"I think there are some resources like the hoarding group (Buried in Treasures) that have been made more available. Providers have been able to attend more training and increase their skill level…" (CMHP, Urban)

**Figure 12.** ***Increase Coordination and Collaboration (Percentages)***

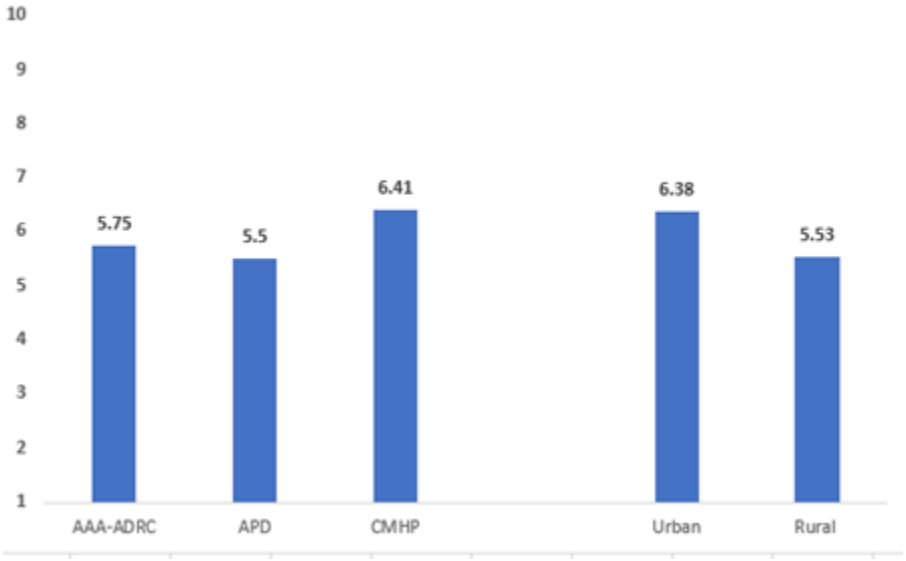



What role key informants' agencies may have played in facilitating those changes emerged from the interviews including through **providing resources** (both directly and in-kind) to the Initiative, **collaborating with other agencie**s, as well as directly **collaborating with the Specialists**.

**Perception of Change**

In order to assess the effectiveness of the Initiative at improving services for older adults and people living with disabilities who have behavioral health needs, participants were asked to provide a score on a scale of 1-10 to indicate their perception of the Initiative's overall effectiveness. AAA-ADRC key informants responded with a mean score of 5.75 (*SD* = 2.44), while APD offices had a score of 5.50 (*SD* = 2.55) and CMHP offices a score of 6.41 (*SD* = 2.00). When compared by location, urban-based key informants had a score of 6.38 (*SD* = 2.01) and rural-based key informants had a mean score of 5.53 (*SD* = 2.50) (see Figure 12). All scores fell into the medium-low range in terms of involvement. This suggests there is still room for the Initiative to improve services for this population.

**Figure 13.** ***Overall Effectiveness of the Initiative***



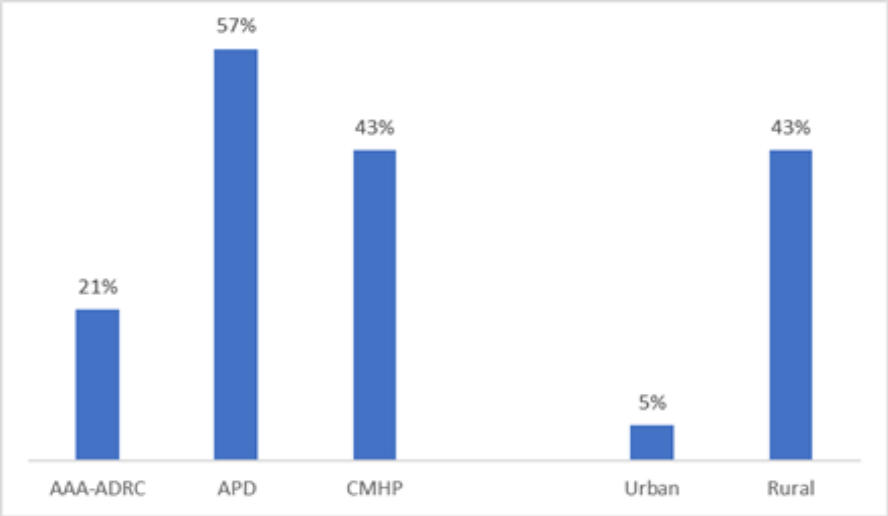

**Providing resources**

Key informants were asked about the resources their agency had contributed in support of the Initiative. Some types of resources are required based on the contract that an agency has with the Initiative such as in-kind office space.

Fourteen respondents (29%) reported contributing resources that supported the changes they described. Examples of resources allocated include providing space for training events, space for specialists to work, and other forms of resource allocation. Of these, fewer respondents located in rural areas (6 or 43%) compared with urban-based respondents (8 or 57%) said they contributed resources as a way to support the Initiative. When compared by agency type, of those who reported contributing resources that supported changes, three

respondents (21%) were from AAA-ADRC, five (57%) were from an APD, and six (43%) were from CMHPs (see Figure 13). When compared by involvement with the Initiative, 11 key informants (79%) were from high involvement agencies compared to three (21%) who were from low-medium involved agencies.

**Figure 14.** ***Agencies Contributed Resources***




**Collaborating with other agencies**

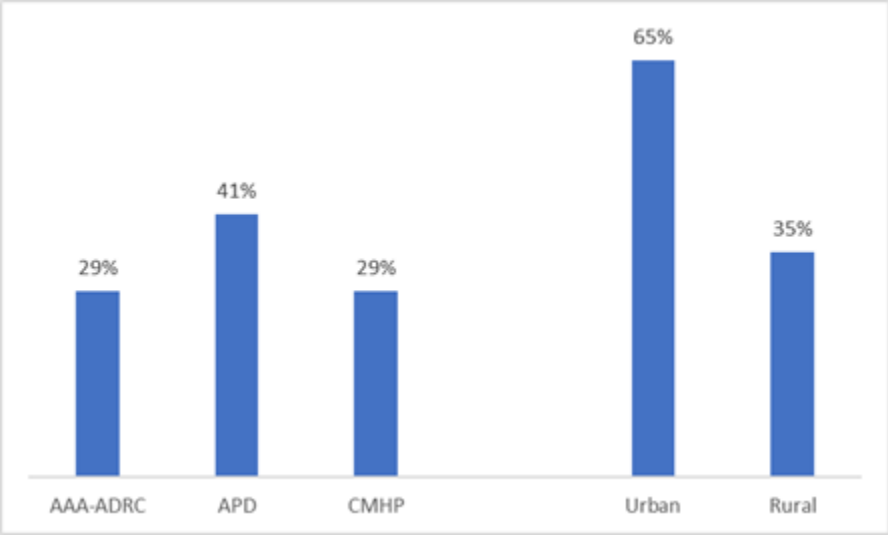
Eighteen respondents (37%) reported that their agencies contributed to the changes brought about by the Initiative by collaboration with other agencies. Examples of collaborations included reports of creating stronger partnerships, attending more joint meetings, increasing the sharing of information, and increasing problem solving with other agencies. Formal agreements with other agencies (e.g., MOUs) to support the work of the Specialist were also identified.

**Collaborating with the Specialists**

Seventeen respondents (35%) reported supporting change through collaborating directly with Specialists. Examples of collaboration provided by respondents included co-presenting or co-planning on training or building collaborative groups with Specialists. Respondents located in rural areas (6 or 35%) were less likely than their urban-based respondents (11 or 65%) to say they contributed to change by collaborating with Specialists. When compared by agency type, five respondents (29%) were from AAA-ADRCs, while seven (41%) were from an APD, and five were from CMHPs (29%). When compared by involvement

with the Initiative, 11 key informants (65%) were from high involvement agencies, compared to six (35%) who were from low-medium involved agencies (see Figure 14).

**Figure 15.** ***Contribution to Change – Collaboration with Specialists (Percentages)***




In describing collaboration with the Initiative and with the Specialist in their community, one key informant explained, "…we are encountering more older adults who have chronic mental health needs and addiction challenges. Right around when the OABHI came on board, we were just starting to struggle to serve these folks. So as the population we serve has changed over time, the Initiative has helped us to build those relationships and understand how aging and Mental health and all of the service systems are related and combined. Our role in this has been our willingness to engage and learn." (APD, Urban)

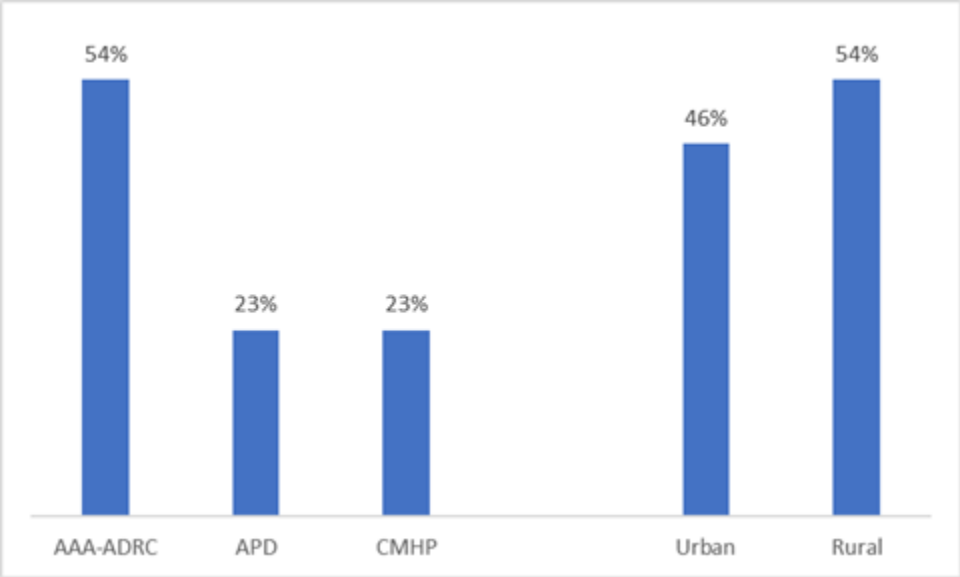
**Improvements - Local Level**

The findings also suggest a number of improvements that could better support the behavioral health needs of older adults and people living with disabilities within the local communities served by the Specialists as well as at a systems-level. Some of the systems-level findings include a need for **sustained resources to support behavioral health**, a need for **formal agreements between agencies (MOUs)** to more clearly define goals, and a need to **prioritize the Initiative at the state-level**.

A lack of resources including funding at the state or community-level could hinder the work of providers to support older adults and people living with disabilities who also have

behavioral health needs. Resources varied from funding for services to more specifics such as affordable housing. Thirteen key informants (26%) stated the Initiative could better serve consumers by increasing resources going into their community. Of those who recommended that the Initiative increase resources going into the community, seven (54%) were rural-based respondents, and six (46%) were urban-based respondents. When compared by agency type, 7 respondents (54%) were from AAA-ADRCs, three (23%) were from an APD, and three (23%) were from a CMHP. When compared by involvement with the Initiative, eight key informants (62%) were from high involvement agencies, compared to only five (38%) from a low-medium involved agency (see Figure 15).

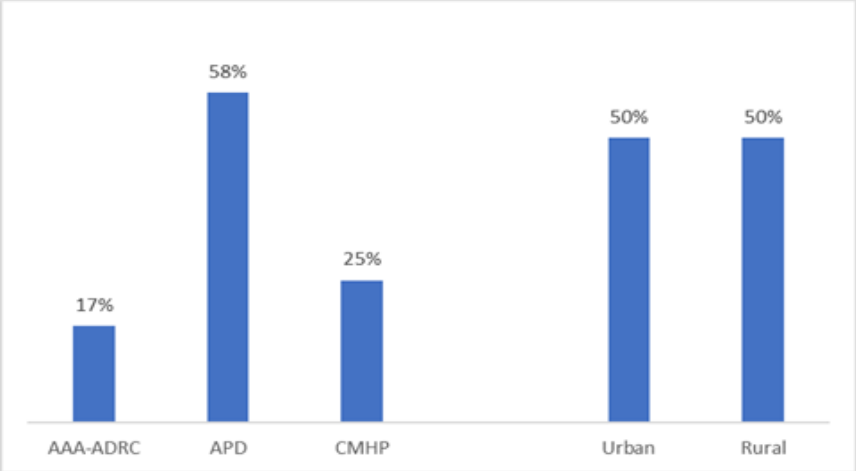
**Figure 16.** ***Increased resources going to their community***




***Formal Agreements Between Agencies***

Twelve key informants (24%) indicated that formal agreements between agencies (e.g., MOUs) would help improve behavioral health services for older adults and people living with disabilities. The formal agreements would include aligning purposes and policies between agencies (e.g., to prevent unnecessary client transfer) and establishing expectations for collaboration.

**Figure 17.** ***Formal Agreements Between Agencies***




Another (non-coded) recommendation was for the state to prioritize the Initiative. For instance, if leadership of agencies and central offices clearly prioritized the Initiative then on the ground people could also prioritize that work (i.e., behavioral health needs of older adults and people living with disabilities). One key informant was very clear about how to prioritize the Initiative at the state level. They stated,

> "If there were communications from Central Office about the Initiative that talked about it and said clearly, "we want you to be involved," that would help. If it doesn't come from Central Office, people won't think it's a priority." (APD, Rural)

This suggests that further prioritization of the Initiative at the state-level would benefit the Initiative in its work to support the behavioral health needs of older adults and people living with disabilities in Oregon.

**Community-Level Recommendations**

At the community-level, the findings point to a need for **maintaining consistency in existing efforts** (e.g., keeping the current momentum going for what is already working), promoting involvement of other agencies within the Specialists community, and an increased awareness of need and resources through **marketing**.

***Keep the Momentum Going (Consistency)***

Thirteen key informants (27%) suggested the Initiative could improve collaboration and coordination in their communities by ensuring consistency in existing efforts. In other words, the Initiative should focus on keeping the momentum going. Some examples offered include agencies maintaining consistent collaboration (e.g., keeping regularly scheduled meetings with

Specialists), continuing to contribute to collaborative efforts that are already underway, and retaining Specialists. One key informant stated:

> "I think we just need to keep doing more of what we're doing now. We're dependent on consistency…" (AAA-ADRC, Urban)

***Promote Involvement from Other Agencies***

Eighteen key informants (37%) reported the Initiative could improve collaboration and coordination by promoting involvement from other agencies within their community. Some examples provided were: the Initiative could encourage other agencies to attend, contribute to, and prioritize collaborative efforts (e.g., promoting shared goals and mutually beneficial outcomes to encourage collaboration), and it could help to repair relationships between agencies that may have been strained. In terms of prioritizing collaborative efforts, one respondent said,

> "It would be great to have a group where struggling facilities – and some of our staff, APD, housing people, and SUDs people get together – to see if we could do anything. Would be great to come up with a pilot project where we would do interdisciplinary services for people in nursing homes – such as SUDs treatment, case management, mental health services, ICC people in a really enhanced way." (CMHP, Urban)

***Marketing***

Seven respondents (14%) reported the Initiative could improve collaboration and coordination through marketing the services and needs of other agencies. In other words, the Initiative can help advertise and share information about the services and needs of agencies in their community to improve coordination and collaboration. Examples of these types of improvement included advertising what services are available, what services are needed, agency roles, and agency billing abilities in terms of Medicare and insurance coverage. According to one key informant,

> "Advertising the Initiative probably won't achieve the end result, but we do need a common elevator speech that everyone uses - branding for example so that people have a consistent experience with the Initiative." (APD, Rural)

This suggests there is a continued opportunity to increase awareness of what the Initiative can offer to community partners as well as what those other community partners need and can provide in return**.**

**Initiative – Local and Community-Level Recommendations**

I. To Better Serve Older Adults and People Living with Disabilities with Behavioral Health Needs:

| | |
|---|---|
| **Recommendation 1** | Sustained investment to support this population is essential. Investment also means improving the ways that funding streams operate. |
| **Recommendation 2** | Increase collaboration between local agencies. Collaboration between local agencies needs to increase. Work remains siloed. The Specialists can promote increased collaborations through facilitating joint meetings and groups between agencies, advertising agency services to each other, and assisting agencies and staff with system navigation across agencies and agency types. |
| **Recommendation 3** | Focus on workforce development. A clear outcome of the Initiative has been enhancements to the workforce that provides services to older adults and people living with disabilities with behavioral health needs. However, it is also clear that more improving workforce development is needed, and that the Specialists are well-positioned to provide this within their local communities. |

**Community-Level Recommendations**

II. To Increase **Coordination and Collaboration** between aging services agencies and behavioral health agencies:

| | |
|---|---|
| **Recommendation 1** | Increased attention and focus on breaking down silos and doing systems work. |
| **Recommendation 2** | Maintain consistency in current efforts. Focus on keeping the momentum going with what is working. There is a tremendous amount of work that has occurred including workforce development, building partnerships, and the breaking down of silos that separate agencies. While it is clear additional efforts are needed to bring about change, it is also imperative that existing successes be continued. |
| **Recommendation 3** | Increase marketing. Specialists can help to advertise and share information about the services and needs of agencies in their communities. There continues to be an opportunity to increase awareness of what the Initiative can offer to community partners as well as what those other community partners need and can provide. |
| **Recommendation 4** | Consider developing an internal database with information about key stakeholders, training materials, and other transitional documents so that new Specialists can continue coordination and collaboration efforts when turnover occurs. |

III. The Systems Level Changes that are needed to improve behavioral health for older adults and people living with disabilities:

| | |
|---|---|
| **Recommendation 1** | Prioritize resources and funding for additional behavioral health services across Oregon. This goes beyond funding to include the way the financing systems operate including a new Medicaid Waiver that can better support behavioral health. The COVID-19 pandemic's impact on the economy and therefore on the state budget governments may complicate efforts to increase funding. Nevertheless, the mental health impacts of COVID-19 make this an even more salient need right now. |
| **Recommendation 2** | Implement formal agreements between agencies such as memorandums of understanding (MOUs). These formal agreements will help to better align purposes and policies between agencies and establish clear expectations for collaboration across agencies. The binding nature of these agreements is needed to ensure collaboration and coordination takes place between agencies. |
| **Recommendation 3** | Increase the number of specialized long-term care facilities that are able to support older adults living with behavioral health needs. The lack of facilities is particularly acute in many rural and frontier areas of Oregon. Special Medicaid contracts between the State and local providers to serve populations with behavioral health needs including both serious mental illness and substance use disorders are needed to increase the availability. The direct care workforce would also benefit from additional training to obtain the tools they need to support this population. |

## Recommendations

**Recommendation 1: Enhance Role of the Initiative and Specialists**

- Elevate the organizational-level role of the Specialist position and provide more support from leadership to the Specialists.
- Clarify the mission and goals of the Initiative as well as the job expectations and measures of success for the Specialists.
- Increase the role flexibility of the Specialists so that they are able to better adapt to the specific needs of the local communities they serve.

**Recommendation 2: Augment Specialist Job Functions**

- Increase collaboration between local aging and behavioral health service agencies.
- Continue to focus on workforce development.
- Increase attention and focus on breaking down silos between behavioral health and aging service organizations.
- Maintain consistency in current efforts with what is working well including workforce development and increasing awareness of the behavioral health needs of older adults.

**Recommendation 3: Carry Out Marketing and Outreach**

- Advertise and market the Initiative at the local-level where Specialists work.
- Ensure that community partners are aware of what the Specialists and the Initiative are able to offer.

**Recommendation 4: Address Gaps in Services**

- Housing and transportation continue to be identified as major service gaps across Oregon. Providing more specialized long-term care facilities for older adults with behavioral health needs would help. Specialized (or enhanced) Medicaid contracts can be a tool to help induce the supply of providers who provide these types of services. Collaborate with the Department of Human Services to recruit providers who are able and willing to provide these enhanced services.

## Policy Options to Address Gaps and Needs

The PSU Evaluation Team carried out a review of other state and local policies and programs aimed at addressing the issues identified within the collected data. Based on this review, several micro-level (or local level) programs and interventions that could be implemented within the Specialists' communities are offered as well as meso-level (or county-level) and macro-level (or state-level) options. These programs and policies are presented below.

**Table 15.** ***Micro-level interventions to support behavioral health for older adults and people with disabilities***

***Specialists' approaches*:**

| | |
|---|---|
| **Program name** | Resident Services Navigator Pilot |
| **Population served** | Older adults in need of care coordination services |
| **Scope** | Interns from local colleges and universities provide one-on-one health navigation, as well as training to HUD communities. The interns receive supervision from Cascade Behavioral Health and Senior and Disability Services. The Specialists provide training to the interns focused on navigating the behavioral health system and the healthcare system in general. |
| **Intent** | The project provides direct health navigation services through Homes for Good to the residents of two Department of Housing & Urban Development (HUD) communities. |
| **Recommendation addressed by this intervention** | Address Gaps in Services |

***Interventions in other states:***

| | |
|---|---|
| **Program name** | Unseen Images, Untold Stories: Using Photovoice to Capture the Lives of LGBT Elders |
| **Population served** | LGBTQ older adults |
| **Scope** | The program requires 1 to 2 percent of a staff person's time plus marketing and communications work. |
| **Intent** | This program and exhibition used a grassroots approach to displaying photography in order to initiate community conversations on key issues. |
| **Recommendation addressed by this intervention** | Address Gaps in Services |

**Table 16.** ***Macro-level interventions to support behavioral health for older adults and people with disabilities***

***Specialists' approach*:**

| | |
|---|---|
| **Program name** | Expansion of Mental Health First Aid (MHFA) programming |
| **Population served** | Older adults experiencing a mental health condition |
| **Scope** | Two, eight-hour trainings provided at no cost to staff and/or volunteer |

| | |
|---|---|
| **Intent** | To train staff and volunteers in the Older Adult curriculum provided in MHFA training. This training aims to provide staff with knowledge to effectively respond to older adults who may be experiencing a mental health condition. Specialists in Polk, Lane, Linn-Benton, Klamath, Washington, Marion, Yamhill and Multnomah counties are certified to deliver MHFA. |
| **Recommendation addressed by this intervention** | To Better Serve Older Adults and People Living with Disabilities with Behavioral Health Needs |

***Interventions in other states:***

| | |
|---|---|
| **Program name** | EZ Fix Program |
| **Population served** | Older adults and adults with disabilities currently residing in their own homes |
| **Scope** | Volunteer-based program |
| **Intent** | This program helps older adults and adults with disabilities remain safely in their homes by providing minor home repair and housekeeping services in rural eastern Maine. |
| **Recommendation addressed by this intervention** | To better serve older adults and people living with disabilities with behavioral health needs |

**Table 17.** ***Meso-level interventions to support behavioral health for older adults and people with disabilities***

***Specialists' approaches*:**

| | |
|---|---|
| **Program name** | Public Guardianship and Conservator Development Project |
| **Population served** | Older adults in need to guardians and conservators |
| **Scope** | Group of agencies and community partners held a regional summit in November, helped produce a report early this year, and is currently working to transform the project into its own non-profit organization. |
| **Intent** | The project aims to increase the number of public guardians and conservators in Central Oregon. The project brings together relevant agencies and community partners to establish its own nonprofit guardianship organization. |
| **Recommendation addressed by this intervention** | Implement formal agreements between agencies such as memorandums of understanding (MOUs). |

***Interventions in other states*:**

| | |
|---|---|
| **Program name** | Enhanced Supportive Services Program: Collaboration and Contracting to Improve Housing Stability and Health |
| **Population served** | Older adults at-risk of eviction |
| **Scope** | Total program cost: $125,000. Includes a full-time geriatric support services coordinator, 20 hours of nursing weekly and the costs of embedded evidence-based programs. The program can be replicated by other AAAs that partner with housing and/or housing management partners, particularly those that can secure resources from HUD or other funders. |
| **Intent** | This model helps older adults avoid evictions, reduces emergency room visits and unnecessary 911 calls, and improves the overall health and well-being of residents. The onsite nurse consults with residents on health care questions and issues and directs them to the most appropriate level of care. |
| **Recommendation addressed by this intervention** | Implement formal agreements between agencies such as memorandums of understanding (MOUs). |

## Summary and Conclusions

After five years of operation, there are several achievements the Initiative and the Specialties can point to in their work to improve the behavioral health of older adults and people living with disabilities in Oregon. Across the multiple sources of data collected by the PSU Evaluation Team, it is clear there is tremendous overlap in how stakeholders and Specialists view the barriers that exist as well as in the potential opportunities to address these barriers.

Based on the findings, this report provides several recommendations for ways the Initiative and the Specialists can build on the successes of the past five years. In short, there is a need focus on enhancing the role of the initiative and specialists, augmenting the Specialist job functions, carrying out additional marketing and outreach, and continuing to focus on addressing gaps in services. Several examples from other states and localities that may be applicable to the Oregon context are provided where new programs and interventions could be implemented. These are offered in terms of local level and systems level options. At the local level, programs and interventions that could be implemented by the Specialists' within their communities are provided. Examples are also offered that could be implemented as a county-level as well as at the state-level. This multi-level approach is needed to help facilitate continued improvement in the behavioral health for older adults and people living with disabilities in Oregon.

## References

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