Title: Older Adult Behavioral Health Initiative: Key Informant Report

Authors: Walter D. Dawson, D.Phil., Allyson Stodola, M.S.W., Jason Kyler-Yano, M.A., Serena Hasworth, M.P.H., Jaclyn Winfree, M.S., Linda Dreyer, M.S.W., M.P.H.

Date: July 20, 2020

Project Sponsors: Oregon Health Authority and Portland State University, Institute on Aging

Contents

Executive Summary

Overview of the Initiative. The Older Adult Behavioral Health Initiative (referred to as "the Initiative" in this report) comprises 24 Behavioral Health Specialists (referred to as "Specialists" in this report) who work in every county across Oregon and regularly engage with a variety of stakeholders who support older adults and people living with disabilities who have behavioral health (BH) needs.

The initial work to develop the Specialists positions began in 2015. This phase consisted of two main activities. First, contract entities wrote job descriptions for the Specialists, recruited qualified applicants, and made hiring decisions. Second, once in their position, Specialists were tasked with making the "business case" for the Initiative to potential community partners, obtaining their opinions about what the community needed to do to improve BH services for older adults, and inviting them to participate in the Initiative.

This second phase consisted of Specialists launching activities related to each of their job functions: improving coordination and collaboration among community partners, increasing the local workforce's knowledge and skills, providing consumer-focused education, and consulting on complex cases. Although Specialists were encouraged to use a community needs assessment to guide their work, they had considerable latitude about where and how to focus their efforts.

A team of researchers from Portland State University's (PSU) Institute on Aging (IOA) is contracted by the Oregon Health Authority (OHA) to evaluate the work of the Initiative. Between 2017 and 2019, a stakeholder survey was used to evaluate the work and impact of the Initiative. In 2020, the PSU Evaluation Team developed a qualitative survey and 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 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).

Goals. 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. In projects with a given time frame and defined measures of success, this phase typically consists of project leaders asking the questions, "To what extent

have things improved because of this effort? What can we point to as successes? How can we ensure that the gains we have made last over time?"

Participants. Forty-nine key informants participated in telephone interviews carried out by the PSU Evaluation Team between February 1, 2020 and April 30, 2020. The participants in the sample were drawn from the middle-level management of agencies that work to support older adults (including AAAs, ADRCs, and local APD offices) as well as community mental health programs (CMHPs). Participants were drawn from both rural and urban areas in Oregon and from a perceived range of involvement from the Initiative (see Table 1).

Table 1. Sample

Stratified random sampling of key informants by agency type, involvement level, and area

Agency Type		**APD**		**AAA-ADRC**		**CMHP**		
Involvement		**High**	**Med-Low**	**High**	**Med-Low**	**High**	**Med-Low**	**Area Subtotal**
Area	**Urban**	3	4	3	4	2	5	21
	Rural	5	5	4	4	4	6	28
Agency Type Subtotal		17		15		17		49

Findings. Several themes and important findings emerged from the data collected during these surveys and interviews of key informants. 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. The findings point to several perceived changes that have occurred due to the Initiative including improved behavioral health services for older adults and people living with disabilities, improved collaboration and coordination between local agencies, and a focus on workforce development. What role key informants' agencies may have played in facilitating those changes emerged from the findings including by providing resources (both directly and in-kind) to the Initiative, collaborating with other agencies, as well as directly collaborating with Specialists. The findings also suggest a number of improvements that would 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. At the community-level, the findings suggest a need for consistency in existing efforts (e.g., keep 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. Some of the systems-level findings include a need for additional resources for behavioral health, a need for formal agreements between agencies to more clearly define goals, and a need to prioritize the Initiative at the state-level.

Recommendations. Based on the main findings, we offer several recommendations for how the Initiative could improve services for older adults and people living with disabilities who have behavioral health needs. We also offer recommendations on how the Initiative could increase collaboration and coordination between agencies at the local level. Finally, we offer several systems-level improvements that would strengthen behavioral health services for older adults and people living with physical disabilities. We provide these recommendations in Section VI of this report.

Initiative – Local and Community-Level Recommendations

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

- Additional resources to support this population are needed. However, resources do not only include enhanced funding, but also the ways that funding streams operate.
- Increase collaboration between local agencies. Collaboration between local agencies needs to increase. Work far too often 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.
- 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 workforce development is needed, and that the Specialists are well-positioned to provide this within their local communities.

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

- Increased attention and focus on breaking down silos and doing systems work.
- Maintain consistency in current efforts. Focus on keeping the momentum going. There is a tremendous amount of great 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.

- Increase marketing. Specialists can help to advertise and share information about the services and needs of agencies in the community. 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.
- 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.

Systems-Level Recommendations

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

- Prioritize resources and funding for additional behavioral health services.
- Implement formal agreements between agencies such as memorandums of understanding (MOUs).
- Increase number of specialized long-term care facilities able to support older adults living with behavioral health needs.

Older Adult Behavioral Health Initiative
Key Informant Report, 2020

Overview of the Initiative

The Older Adult Behavioral Health Initiative (referred to as "the Initiative" in this report) comprises 24 Behavioral Health Specialists (referred to as "Specialists" in this report) who work in every county across Oregon and regularly engage with a variety of stakeholders who support older adults and people living with disabilities who have behavioral health (BH) needs.

The initial work to develop the Specialists positions began in 2015. This phase consisted of two main activities. First, contract entities wrote job descriptions for the Specialists, recruited qualified applicants, and made hiring decisions. Second, once in their position, Specialists were tasked with making the "business case" for the Initiative to potential community partners, obtaining their opinions about what the community needed to do to improve BH services for older adults, and inviting them to participate in the Initiative.

This second phase consisted of Specialists launching activities related to each of their job functions: improving coordination and collaboration among community partners, increasing the local workforce's knowledge and skills, providing consumer-focused education, and consulting on complex cases. Although Specialists were encouraged to use a community needs assessment to guide their work, they had considerable latitude about where and how to focus their efforts. Today, Specialists work in every county across Oregon to improve behavioral health services for older adults and people living with disabilities and their work is based on the unique needs of the local communities.

A team of researchers from Portland State University's (PSU) Institute on Aging (IOA) is contracted by the Oregon Health Authority (OHA) to evaluate the work of the Initiative. Between 2017 and 2019, a stakeholder survey was used to evaluate the work and impact of the Initiative. In 2020, the PSU Evaluation Team developed a brief survey and 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 with 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-ADRCs), and Community Mental Health Programs (CMHPs).

One of the primary goals of this evaluation instrument 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. Five years of programmatic operation is an excellent opportunity to take stock. In projects with a given time frame and defined measures of success, this phase typically consists of project leaders asking the questions, "To what extent have things improved because of this effort? What can we point to as successes? How can we ensure that the gains we have made last over time?"

Methods

The Oregon Health Authority asked the PSU Evaluation Team to develop an 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, we took a mixed-methods approach drawing on both quantitative and qualitative data and analytic methods. The quantitative data and analytic methods assess respondents' involvement with the Initiative across several aspects of the Specialists' work (our third evaluation goal). The qualitative data and analytic methods leverage respondents' experiences with and perceptions about the effects of the Initiative on the behavioral health of older adults and people with physical disabilities to gain detailed findings that address our first two evaluation goals. The agencies best positioned to have relevant experience with the Initiative and thus helpful perspectives on its effectiveness and areas for improvement are aging and behavioral health service agencies located across the state.

The PSU Evaluation Team focused our sample on middle-level managers and agency directors at local Area Agencies on Aging / Aging and Disability Resource Centers (AAA-ADRCs), Aging and People with Disabilities (APD) offices, and Community Mental Health Programs (CMHP). We identified the population of middle-level managers and directors from AAA-ADRC and APD offices using the contact information provided by Specialists, the October 2019 publication of "DHS Aging and People with Disabilities (APD) Branch Contact Information for APD and AAA Field Offices", and the DHS APD and AAA Local Offices Directory. We identified the population of key informants at CMHPs based on the contact information provided by the Older Adult Behavioral Health Project Director, supplemented by Google searches for specific names and contact information of middle managers. When an agency middle manager supervised staff from multiple counties, we assigned them to the county in which their main office was located. Then, we used stratified random sampling based on three grouping variables to construct our

sample. Grouping variables were agency type (i.e., AAA-ADRCs, APDs, and CMHPs), whether the agency was based in an urban or rural county (counties with a metropolitan area were grouped as urban), and level of involvement with the Initiative.

When we were unable to recruit a randomly selected respondent after at least three contact attempts we replaced them in the sample with the next respondent within the same strata based on random ordering. Additionally, when certain strata included fewer than the desired number of five key informants, we oversampled from the most similar strata (i.e., same urban/rural status and same agency type) to support a balanced sample. Participant recruitment began in mid-February and the recruitment deadline was extended from the end of March through early May 2020 due to disruptions from the emergence of the COVID-19 pandemic at recruitment agencies. Our final sample included 49 key informants out of a total recruited sample of 56. We aimed to interview an equal number of key informants for each strata with the goal of collecting equal amounts of information from each group. However, a lack of response from some groups in our sample, influenced the breakdown of our final sample in the direction of oversampling rural and medium-to-low involvement agencies. 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).

Data cleaning, management, and analysis were conducted using the R statistical software environment and the RStudio integrated development environment. Data cleaning was conducted using several “tidyverse" packages. Contingency tables were created using the “table" function in baseR, and chi-square and Fisher’s exact tests of independence were conducted using the “chisq.test" and “fisher.test" functions respectively (baseR).

Table 1. Sample

Stratified random sampling of key informants by agency type, involvement level, and area

Agency Type		**APD**		**AAA-ADRC**		**CMHP**		
Involvement		**High**	**Med-Low**	**High**	**Med-Low**	**High**	**Med-Low**	**Area Subtotal**
Area	**Urban**	3	4	3	4	2	5	21
	Rural	5	5	4	4	4	6	28
Agency Type Subtotal		17		15		17		49

Data Collection and Data Collection Tools

Quantitative Survey. The PSU Evaluation Team developed an online survey in Qualtrics. The survey was primarily administered electronically to reduce pressure on respondents to report positively biased ratings of their involvement with the Initiative to evaluators. This survey was administered prior to the telephone interviews or alternatively at the start of the telephone interview if the participant did not complete the survey in advance of the call. This survey included eight questions on a scale from 1 to 10 (see Table 2). The quantitative items touched on knowledge about behavioral health and the Initiative, behavioral indicators of involvement with the Initiative, and perceptions of the effectiveness of the Initiative. Depending on item wording, the scale from 1 to 10 either measured degree of knowledge (from *Not at all knowledgeable* to *Very knowledgeable*), frequency (from *We haven't started yet* to *We do this all the time*), and degree of effectiveness (from *Not at all effective* to *Extremely effective*). Additionally, at the end of the survey, participants had the opportunity to provide open-ended comments.

Table 2. Quantitative Survey Items

#	Items
1	Our staff is knowledgeable about the Initiative and its purpose.
2	Our staff is knowledgeable about behavioral health needs of older adults and people with disabilities.
3	Someone from our team attends meetings where the behavioral health needs of older adults and people with disabilities are on the agenda.
4	Our agency allocates resources so that our staff can attend training events that are organized by Behavioral Health Specialist(s).
5	Our organization provides in-kind support to the Initiative (e.g., space for training events, advertising, refreshments).
6	Our staff are using screening and assessment tools recommended by the Behavioral Health Specialist(s) with our organization's consumers.
7	Our staff participate in meetings with Behavioral Health Specialists to determine an appropriate course of action with consumers who present with complex care needs (e.g., multi-disciplinary teams, ad hoc meetings).
8	Overall, how would you rate the Initiative's effectiveness in improving services for older adults and people with disabilities who have behavioral health needs?

Qualitative Interview. The PSU Evaluation Team developed and conducted semi-structured telephone interviews with key informants (see Table 3). The interview script included seven open-ended questions, with several sub-questions and probes. Questions focused on several topics aimed at answering our evaluation questions. These topics included key informants' agency involvement with the Initiative currently and over time, perceptions of what is different now in key informants' communities as a result of the Initiative, and the ways in which the Initiative and the larger behavioral health and aging service systems could improve behavioral health services for older adults and people with disabilities.

Table 3. Qualitative Interview Questions

#	Interview Question
1	In your current position, how do your responsibilities connect to the Initiative?
	Probe: Has your role changed over time?
2	Has your agency's overall involvement with the Initiative changed over time?
	Probe if more involved: "What are some factors that have made it possible for your agency to be more involved with the Initiative?" *Probe if less involved: "What are some barriers to your agency being more involved with the Initiative?"*
3	How does the leadership of your agency learn about the activities of the Initiative?
4a	This Initiative has been up and running for five years. What, if anything, is different now for older adults and people with disabilities who have behavioral health needs in your community as a result of the Initiative (e.g., Evidence Based Practices, increased attendance at BH training events, engaging in complex case consultations)?
4b	How has your agency contributed to these changes
5	How could the Initiative better serve older adults and people with physical disabilities in your area?
6	Some of the greatest barriers we have identified in our evaluation of the Initiative involve coordination and collaboration among service agencies. How could the Initiative help improve coordination and collaboration in your community?
7	At a system level, what can be done to improve the behavioral health of older adults and people with disabilities in your area?
	Probe if issues but no solutions are proposed: What can be done to improve issue(s) shared by the respondent?

Data Analysis

Quantitative. Descriptive statistics were computed for each 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. Additionally, Item 8 (*Overall, how would you rate the Initiative's effectiveness in improving services for older adults and people with disabilities who have behavioral health needs?*) was not included in the total involvement score as it captured perceptions of the effectiveness of the Initiative, as opposed to key informants' involvement with the Initiative. The PSU Evaluation Team was interested in differences in involvement scores by urban or rural setting and agency type (APD, AAA-ADRC, and CMHP) and so compared means using Welch's t-test and one-way ANOVA respectively. A categorical indicator of involvement based on the total scores of key informants was created. 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 "low to medium" and "high" involvement ratings from total survey scores were compared with the "low to medium" and "high" ratings based on the Older Adult Behavioral Health Project Director's perception of community partner involvement across the state. Their initial ratings were used for stratifying our sample. A Fisher's exact test revealed that survey-based designation of involvement differed by OHA leadership ratings of involvement ($p < .01$) suggesting that the two methods of assessing involvement with the Initiative had significant overlap. The survey-based key informant involvement indicator was used to compare qualitative themes by the level of involvement with the Initiative.

Qualitative. 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. During the open coding phase, three researchers independently read through several interviews and identified meaningful information relevant

to the main study aims and created preliminary codes to describe that information. Preliminary codes were then compiled into open coding tables and briefly described in a sentence or less. The three coders then worked to develop an initial codebook by sharing their codes, organizing codes into higher-order themes that capture core concepts shared by multiple codes, and further developing the open code descriptions into theme definitions (and exclusion criteria when needed). The three researchers involved in open coding and codebook development then trained the two other coders on how to apply the themes to interview data and implement the dimensions and themes.

Once the codebook was developed, three iterative phases of coding and codebook development followed. Two groups of coders collaboratively coded two interviews in full to calibrate coders' understanding and application of the codebook, and to sharpen the definitions and any exclusion criteria in the cookbook. Coders discussed their interpretations of both the themes and definitions from the codebook and made further updates as needed. After this process, all of the coders met to discuss the updated codebook, reconcile differences in coding, and further refine the codebook. Then, coders engaged in a phase of parallel coding where all team members independently coded the same two interviews. The codebook was finalized after the coders discussed their parallel coding and made further revisions to the codebook themes and definitions. Coders used this final codebook to independently code a set of unique interviews.

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.

Key Findings

Quantitative Findings. The results of the survey questions were analyzed and matched with related themes that emerged from the interviews of key informants. These findings are reported by theme.

Qualitative Findings. A number of important findings emerged from the thematic analysis of the qualitative data carried out by the PSU Evaluation Team. The findings presented here include the most frequent codes and themes that emerged from this analysis. In addition, we offer some discussion of the less frequently cited findings as well as of selected non-coded findings deemed significant to report. When running Fisher's exact test of independence, few group comparisons were found to be statistically different. P-values are, therefore, reported only when the differences reflect statistical significance.

Connection to Initiative

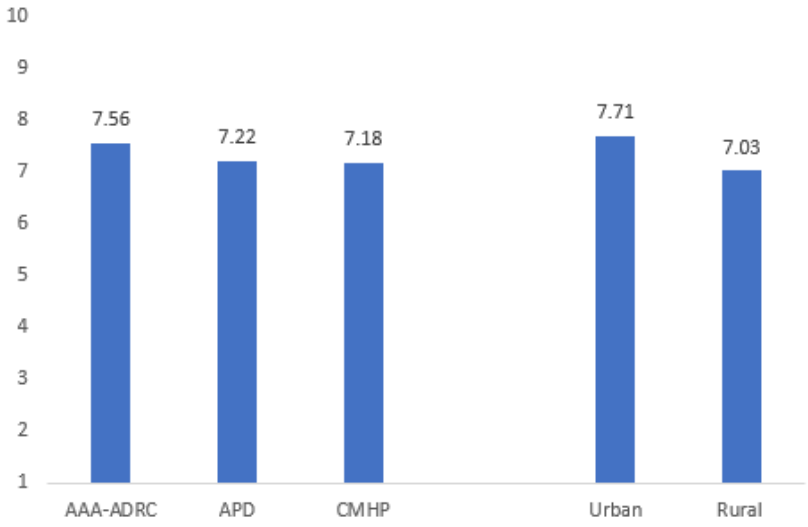
The PSU Evaluation Team asked the key informants how their specific responsibilities connected to the Initiative. Twenty-eight key informants (57%) indicated a high level of current personal involvement with the Initiative, while 10 (20%) indicated a medium-low level. This finding is important for understanding the key informants' level of knowledge about the Initiative.

The PSU Evaluation Team also asked the key informants if their role with the agency had changed with time. Twenty-seven key informants (55%) reported a change in their role, while 16 key informants (33%) reported no change in their role or that they were in the same role since their connection began. Some examples of change were being promoted, changing geographical location, or primary work assignments. This is an important question to help assess involvement with the Initiative and how involvement might have changed with time. Notably, some of the respondents had been a part of the Initiative since the beginning, while others were relatively new (e.g., less than a year).

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 1). 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 1. Staff Knowledge of Older Adult Behavioral Health Needs

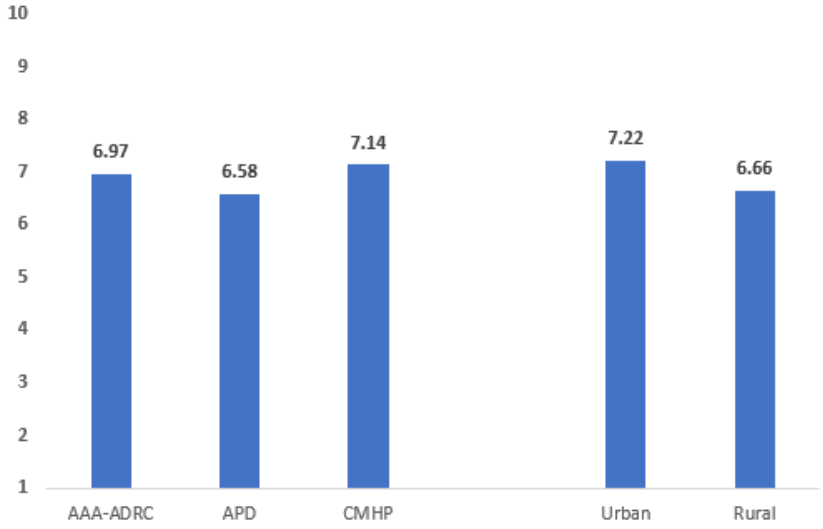


Theme: Involvement

Agency Involvement. The level of overall involvement of key informant agencies with the Initiative was important to understand the Initiative's reach. Some of the key informants had been involved with the Initiative since the beginning, while others were comparatively new in their involvement.

As described in the data analysis section of this report (page 11), we calculated an "overall involvement" score of the interview participants based on their responses to the quantitative survey. We combined five out of eight of these quantitative questions to develop the score. AAA-ADRC key informants had a mean involvement score of 6.97, ADP key informants had a mean involvement score of 6.58, and CMHP key informants had a score of 7.14. Based on the grouping of involvement scores, CMHPs were categorized as being overall highly involved, while CMHPs and APDs fell into the medium-low involvement range. There were no significant differences between these scores.

Figure 2. Overall Involvement by Agency Type



In order to better understand involvement, the PSU Evaluation Team asked key informants if their agency's involvement with the Initiative had changed over time.

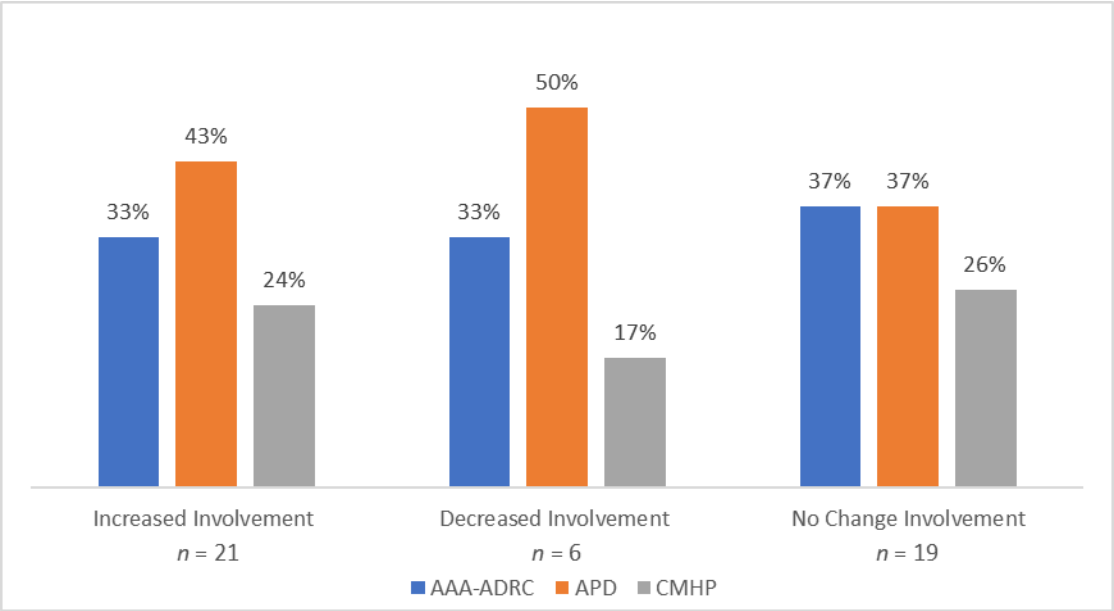
Involvement increased

Twenty-one key informants (42%) reported that their agency's involvement with the Initiative had increased with time. Of these, 15 respondents (71%) were with agencies based in rural areas, while six (29%) were urban. When comparing agency type, seven respondents from AAA-ADRCs (33%), nine from APDs (43%%), and five from CMHPs (24%) say their involvement increased. When compared by high and medium-low involvement with the Initiative, of those who say their involvement increased, 13 (62%) were from high involvement agencies and 8 (32%) were from medium-low involvement agencies.

Involvement decreased

Another six key informants (12%) indicated their agency's involvement with the Initiative had declined over time. Of these key informants, three respondents (50%) were with agencies based in rural areas, while three were with urban (50%). When comparing agency type, of those who reported a decrease in involvement, two respondents were from AAA-ADRCs (33%), three were from APDs (50%), and just one was from a CMHP (17%). When compared by high and medium-low involvement with the Initiative, three (50%) of key informants were from high involvement agencies and three (50%) of key informants were from medium-low involved agencies (see Figure 2).

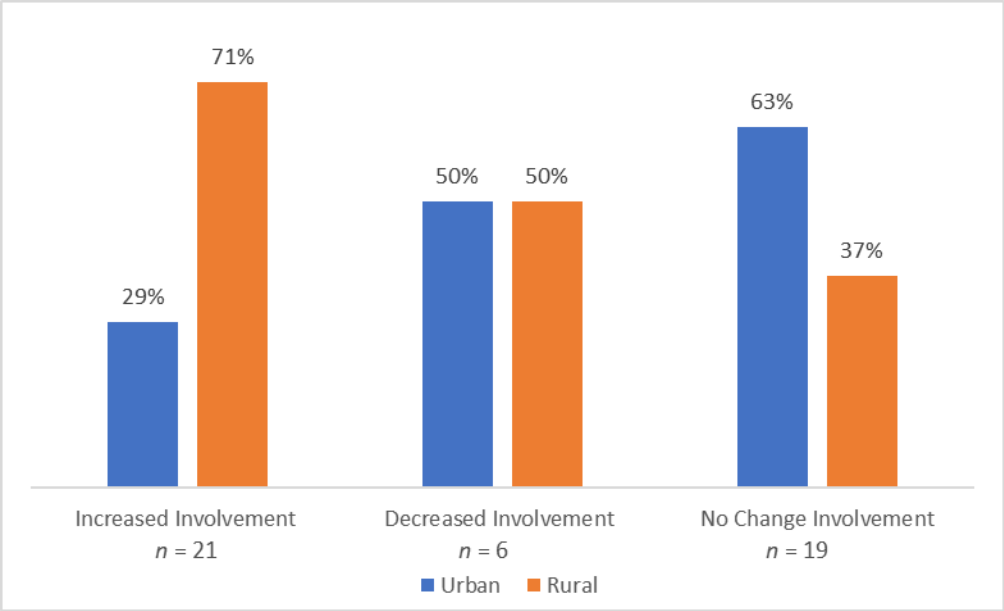
Figure 3. Perceptions of Change in Involvement by Agency Type (Percentages)



No change in involvement

A little over one-third (*n* = 19, 38%) of key informants reported no change in their agency's involvement. Of these respondents, seven (37%) worked for agencies based in rural areas, while over half (63%) were with urban agencies. When comparing agency type, of those who reported no change in involvement, seven AAA-ADRCs (37%) and seven APDs (37%) report this finding, while five CMHP (26%) respondents indicated their agency involvement did not change. When compared by high and medium-low involvement with the Initiative, of those who reported no change, 10 (53%) were from high involvement agencies while nine (47%) were from medium-low involved agencies reported no change in involvement (see Figure 3).

Figure 4. Perception of Change in Involvement with Initiative by Geography (Percentages)



Factors that Facilitate Involvement with the Initiative. Several factors that made it possible for agencies to be more involved with the Initiative were identified by the key informants. Due to the skip logic of the interview question about involvement, not all respondents provided information about the facilitating factors and barriers to involvement. However, the most frequently cited factors that promote involvement were the use of complex case consultations (CCCs) and increased coordination and collaboration.

Complex Case Consultations (CCC)

Nine respondents (18%) indicated that complex case consultations (CCCs) (e.g., MDTs) made it possible for them to increase involvement with the Initiative. The specific benefits of the CCCs included improvement of consumers' ability to navigate systems due to CCCs involving the Specialist. Of those, six key informants (67%) were based in rural areas, and three (33%) were based in urban agencies. The benefits of the CCCs to involvement with the Initiative were elucidated by one urban-based key informant:

> "As an agency, we are centered on person-focused planning. That includes a holistic approach – having everyone involved who can help with coordination for the client. There has been more involvement and communication over time. When I started, we were just starting to connect with the behavioral health Initiative. In the beginning, I think we had a few more meetings to get rolling. My role changed midstream as I became a member of the MDT team. I am regularly on those calls and am regularly consulting with other agencies and our Specialist as needed. This has changed and increased as the need for services has become greater." (APD, Urban)

When comparing agency type, three of the respondents (33%) who reported this benefit of CCCs were from AAA-ADRCs, four APDs (44%) and two CMHPs (22%) did. When compared by high and medium-low involvement with the Initiative, three 33%) were high involvement agencies, while six (67%) of respondents from medium-low involved agencies.

Coordination and Collaboration

Fifteen respondents, or about one-third of respondents (31%), indicated that inter-agency collaboration and coordination facilitated by the Specialist made it possible to increase their involvement with the Initiative. This includes benefitting from Specialist assisting agencies and staff with system navigation (i.e., helping navigate policies and processes across agencies and agency types), and promoting collaboration between agencies such as behavioral health and aging services. In terms of increased collaboration across agencies due to the Initiative, one respondent noted,

> "There was a long time when we never talked to other agencies; it was always crisis-driven before. Our Specialist has made a big difference in facilitating these discussions." (CMHP, Rural)

When comparing agencies based in rural and urban areas, of those agencies who reported that coordination and collaboration facilitated increased involvement, 11 (73%) of the key informants were based in rural areas, and four (27%) were based in urban agencies. When comparing agency type, five respondents (33%) were from AAA-ADRCs, six (40%) were from APDs, and four (27%) were from CMHPs. When compared by high and medium-low involvement with the Initiative, nine (60%) were from high involvement agencies, while six (40%) were from medium-low involved agencies.

Other Factors that Facilitate Involvement with the Initiative (coded)

Several additional factors that facilitate involvement with the Initiative were offered by key informants. These include workforce development, the use of evidence-based practices (EBPs), or other promising practices, as well as improved access to behavioral health care. According to one urban-based aging services agency,

> "We have become more involved with time. We have more referrals and more opportunities and places to refer our clients. There is now a wider base of referral resources. We also never had that multi-disciplinary team before or the death cafés, or opportunities for education or socialization – those opportunities just weren't there before the Initiative." (APD, Urban)

Additional Benefits (non-coded)

Other benefits reported by key informants included additional knowledge gained about what programs and services are available and how they potentially interact with other existing programs. For example, one key informant noted that the Specialist in their area had provided information on mental health programs and policies of which they did not have prior knowledge. Another benefit identified by key informants are additional programs such as Death Cafes, which are now offered through the Initiative.

Barriers to Involvement. Understanding the potential barriers to involvement with the Initiative is also highly valuable to supporting greater involvement with community partners and agencies. The PSU Evaluation Team coded several categories of barriers identified by the key informants. The most frequently reported barrier to involvement was a lack of collaboration from the Initiative.

Lack of Collaboration from Initiative

Eight respondents (16%) indicated that the level of collaboration between the Initiative and their agency could be improved through more involvement from the Initiative. This included some reports of difficulty engaging the Specialist or OHA to collaborate with their agency. Some examples provided include not being informed when a Specialist's role changes, a lack of availability of the Specialist, Specialist turnover, and the Specialist or OHA leadership communication style. According to one key informant,

> "Our involvement has changed because their [Specialists] work has changed. For example, the Specialist's position has been reduced so there is less they can do in terms of follow-up with clients….We understood what their role was at the beginning. It was very confusing because it was similar to what the Innovator Agents were supposed to be doing. It didn't seem like there was an effort to collaborate with us, from a policy perspective. We don't get any communication when their role changes." (AAA-ADRC, Urban)

When comparing agencies by rural or urban area, of those who indicated that lack of collaboration from the Initiative was a barrier, three key informants (38%) were based in rural areas, and five (63%) were based in urban. When comparing agency type, three respondents (38%) were from AAA-ADRCs, four were from APDs (50%), and one was from a CMHP (13%). When compared by high and medium-low involvement with the Initiative, three respondents (38%) were from high involvement agencies, while five (63%) were from medium-low involved agencies.

Other Barriers to Involvement (coded)
Other barriers to involvement with the Initiative included confusion about the Initiative's goals (7 or 14%), confusion about the Specialist's role (5 or 10%), and a lack of collaboration from key informants' own agencies (1 or 2%).

Confusion about the role of the Specialist was summed up by one respondent who stated,

> "Sometimes there is confusion around what we hear from the Initiative's leadership on what the involvement is, what [the Specialist's] actual role is, and what their involvement is with APD. Being in their office and having actual office time never transpired. What exactly do they want DHS or APD staff to specifically do? More direction about what it's all about is needed." (APD, rural)

This statement suggests that the Initiative could do more to provide greater clarity to partner organizations and agencies about the goals of the Initiative. It also suggests an opportunity for increased collaboration across agencies in terms of shared goals.

Additional Barriers to Involvement (non-coded)
There were other barriers to involvement reported by key informants that were not coded by the PSU Evaluation Team. Understanding some of these additional barriers could help support increased coordination and collaboration across Oregon.

The challenges to involvement due to geography were also noted by the key informants. Given the large areas that some Specialists must cover, involvement from community partners within those regions may be reduced. According to one key informant,

> "It is difficult to get staff to attend trainings that are two hours away." (CMHP, Rural).

This statement points to the vast distances that often must be covered by Specialists in rural and frontier regions which may limit the effectiveness of the Initiative in those regions. Bringing trainings directly to organizations in rural and frontier communities may be one way to mitigate this barrier to involvement.

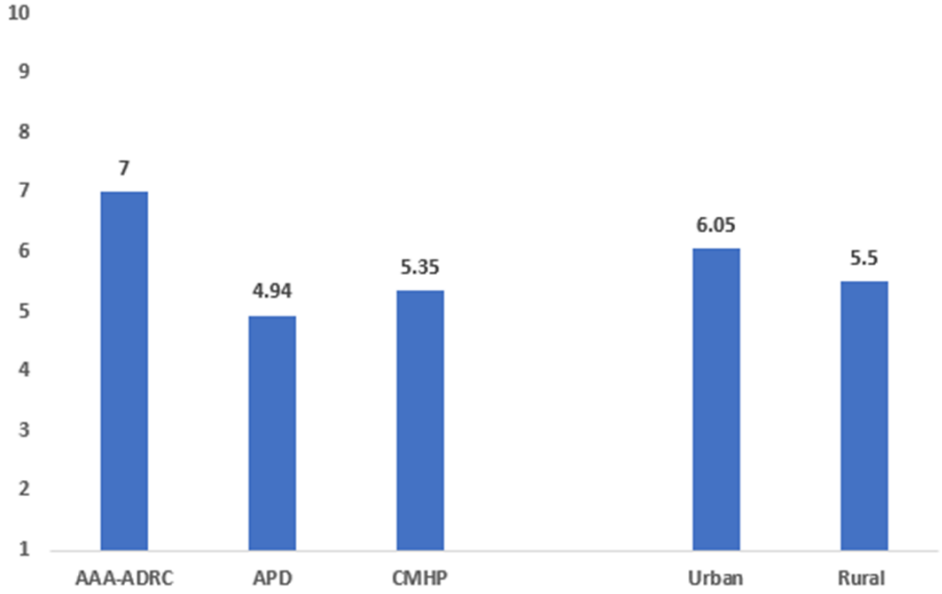
Another barrier identified is a potential mismatch between local community needs and the focus of the Initiative in specific communities. For example, one key informant noted that within their local community they "already have a good relationship [with partners] so we don't need help with that...so the Initiative has almost been kind of a burden." (APD, Rural). While this case may be outlier, it does suggest that the needs of local communities vary and that the

Initiative could consider making sure that the support that is offered squarely aligns with specific needs. Making sure that the Initiative is seen as a valuable resource to the local community is essential.

Theme: Communication

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.

Figure 5: Staff Knowledge about the Initiative and 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 4). 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.

The way that communication about the activities of the Initiative takes place is a potential measure of agency involvement. How agency leadership learns about the Initiative is particularly important to understand, therefore, the PSU Evaluation Team asked how the leadership of the key informants' agencies learn about the activities of the Initiative. The most frequently reported finding was that information transfer takes place on an ad hoc or 'need to know' basis (medium-low).

Leadership: Medium-Low

Twenty-six key informants (53%) indicated that their leadership is updated about the Initiative on an ad-hoc or need-to-know basis. Some examples of this level of communication include a meeting, a phone call, or an email that addresses a current event rather than a standing, regular meeting or call.

When comparing agencies by rural or urban area, of those key informants who indicated a medium-low level of communication with leadership, 17 (65%) were from agencies based in rural areas, and nine (35%) were from urban agencies. When comparing agency type, 12 respondents (46%) were from AAA-ADRCs, seven were from APD (27%), and seven (27%) were from a CMHP. When compared by high and medium-low involvement with the Initiative, 14 respondents (54%) were from high involvement agencies reported this finding, while 12 (46%) were from medium-low involved agencies. The similar number of high involvement agencies and medium-low involvement agencies who reported low-medium information exchange with their agency's leadership is somewhat surprising.

This type of communication could signal a lower level of involvement with Initiative, although it is difficult to determine if ad hoc knowledge transfer is indicative of lower involvement (that could simply be the way the organization operates). The ad hoc nature of some collaborations could be due to the Specialist role. For example, a CCC in which a consumer has an urgent need would require ad hoc communication. In this case, the ad hoc nature does not necessarily denote a lower level of involvement.

Leadership: High

Eleven key informants (22%) indicated that the transfer of information about the Initiative to their agency's leadership is high and that their leadership is updated about the Initiative on a regular basis. An example might be an in-person report about the Initiative as a routine item on a standing meeting agenda.

When comparing agencies who indicated a high transfer of information to leadership by rural or urban area, three of the key informants (27%) were from agencies based in rural areas, and

eight (73%) were from urban agencies, a statistically significant difference (p = .046). When comparing agency type, four respondents (50%) were from AAA-ADRC, one was from an APD (9%), and six (55%) were from a CMHP. When comparing by high and medium-low involvement with the Initiative, of the agencies who indicated a high level information transfer to leadership, 11 respondents (100%) were from high involvement agencies, while none were from medium-low involved agencies. Fisher's exact test of independence showed this finding to be statistically significant (p < .001). It is worth noting that only highly involved agencies reported a high level of communication about the Initiative with agency leadership.

Regular meetings and transfer of information about the Initiative through other routine agency activities may indicate higher involvement with the Initiative. Providing a regular forum to discuss the actions and activities of the Initiative by agency leadership may suggest a higher level of involvement from that agency.

Communication with Agency Staff

Communication with agency staff about the Initiative is also an important way to gauge agency involvement. Four key informants (8%) indicated that information about Initiative activities are routinely provided to agency staff. A few examples of this information include being informed of training events, programs in development, or agendas for MDT meetings. Over one-quarter (29%), or 14 key informants noted that information about Initiative activities is provided to agency staff on an ad hoc basis potentially indicating low levels of regular communication. Some examples of this type of information sharing with staff include notifications about training events, programs in development, and sharing of agendas for MDT meetings.

When comparing agencies who reported a low level of communication with staff by rural or urban area, eight key informants (57%) were from agencies based in rural areas, and six (43%) were from urban agencies. When comparing agency type, four respondents (29%) were from AAA-ADRCs, five were from an APD (36%), and five (36%) were from a CMHP. When compared by high and medium-low involvement with the Initiative, five (36%) were from high involvement agencies, while nine (64%) were from medium-low involved agencies.

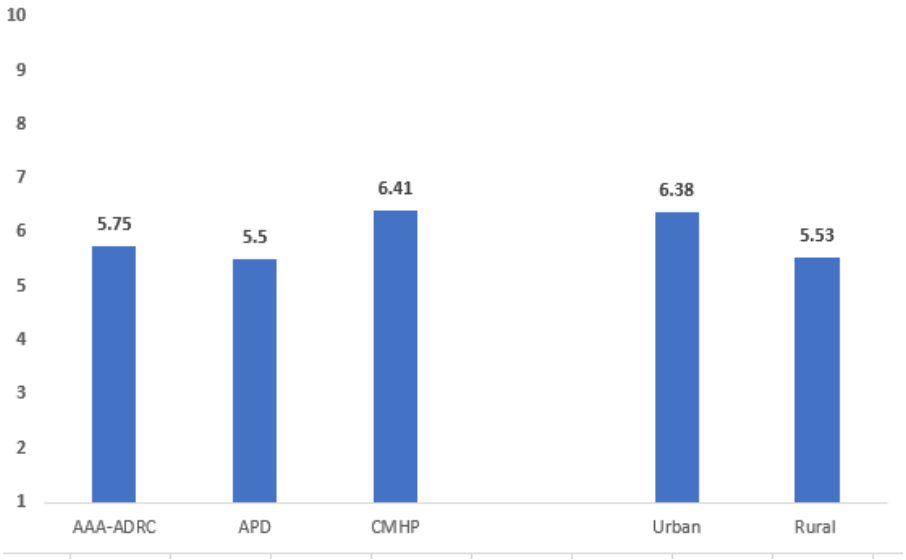
Other (non-coded)

One key informant noted that the Specialists are the primary source of information for the entire organization.

Theme: Perception of Change

Quantitative: 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 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 5). 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. The specific ways that the Initiative could improve were also analyzed and are discussed later on in this report.

Figure 6. Overall Effectiveness of the Initiative



Changes Since the Initiative Began

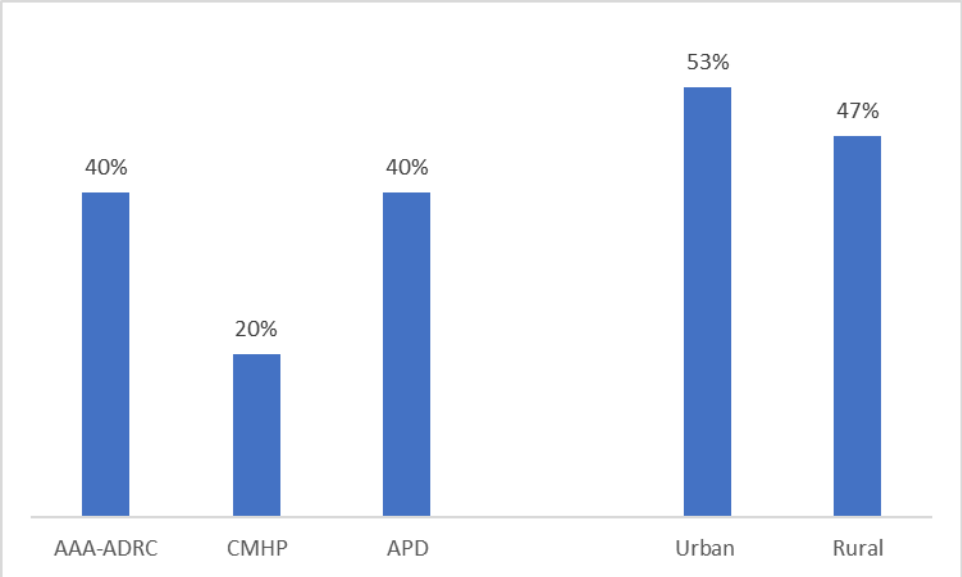
Key informants were asked to identify what, if anything, is different now for older adults and people living with disabilities who have behavioral health needs in their community as a result of the Initiative. Several differences were identified. The most prevalent change was an increase in behavioral health services offered in their community, which is a positive finding.

Specific Differences. Key informants shared several specific differences in their communities that are a result of the Initiative.

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).

Figure 7: Changes in Behavioral Health Services Since the Initiative Began (Percentages)



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 6). As one key informant explained,

> "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)

When compared by high and medium-low involvement with the Initiative, nine key informants (60%) were from high involvement agencies, while six respondents (40%) were from medium-low involved agencies. One key informant specifically noted,

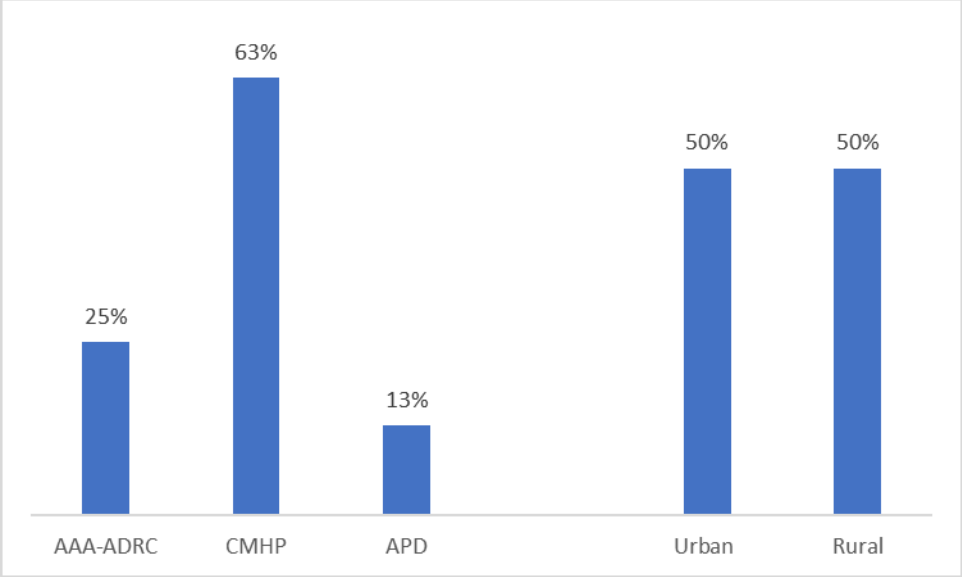
> "I do think the Initiative has had some positive results in the effectiveness of our high-risk team. The Specialist has often brought resources that other folks at the table weren't necessarily aware of. The team now has the ability to engage the right person to

have at the table. This has helped us bridge the gap between our local mental health agency and us and some of our population that is difficult to serve – those who may be homeless. Bridging the gap with APD. I think it made us more effective at identifying the barriers that exist and who we need to get to the table. The Specialist has helped us do better work more quickly." (AAA-ADRC, Urban)

However, about one-quarter (12) of key informants either reported that they were unsure if the changes they observed for older adults and people with disabilities were due to the Initiative or to another program. Most key informants who noted that they were unsure about whether changes could be attributed to the Initiative did not provide specific examples about changes in their community. These results point to an improvement in behavioral health services for older adults and people living with disabilities across Oregon, although if this improvement is a direct result of the Initiative is unknown.

Prioritizing Population (older adults and people living with disabilities)
Eight key informants (16%) indicated that older adults and people living with disabilities are now being identified as a priority in their community as a result of the Initiative.

Figure 8: Changes in Prioritization of the Population Since the Initiative Began (Percentages)



Of those who indicated an increase in the prioritization of older adults and people with disabilities, four respondents (50%) were based in rural areas and four (50%) were based in urban areas. When comparing by agency type, two respondents (25%) were from AAA-ADRCs, one was from an APD (13%), and five were from CMHPs (63%) reported this finding. When compared by high and medium-low involvement with the Initiative, six key informants (75%)

were from high involvement agencies, while two (25%) were from medium-low involved agencies reported this finding (see Figure 7).

One key informant provided some examples of the way older adults were being prioritized within their community,

> "I think the initiative has made our agency more aware of the older adult population and how they can be more creative in their service delivery. For example, we have a couple of clinicians who were going into care facilities and providing services at the facility instead of having older adult consumers transported to our agency. The agency also recognized the need for in-home services delivery (instead of having them come to us)." (CMHP, Rural)

Other Specific Differences (Coded)

Several other specific differences as a result of the Initiative were coded by the PSU Evaluation Team. The differences included an increased awareness of behavioral health issues in older adults and people with disabilities (7 or 14%), awareness of resources (7 or 14%), and non-behavioral health services (6 or 12%) including aging services and support services such as home repair, housing, medication management, and transportation.

According to one key informant, BH services had improved in their community:

> "…because of the Specialist's education out in the community to agencies who serve people with behavioral health 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 her community. I also think older adults with behavior 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)

Additional Differences (non-coded)

Other non-coded but significant examples of improved services in their communities were offered. One example is the delivery of volunteer services for seniors. The key informant noted that previously no other organization had volunteers. Another example of a new respite house for behavioral health that in part is due to collaboration by the Specialist with local partners.

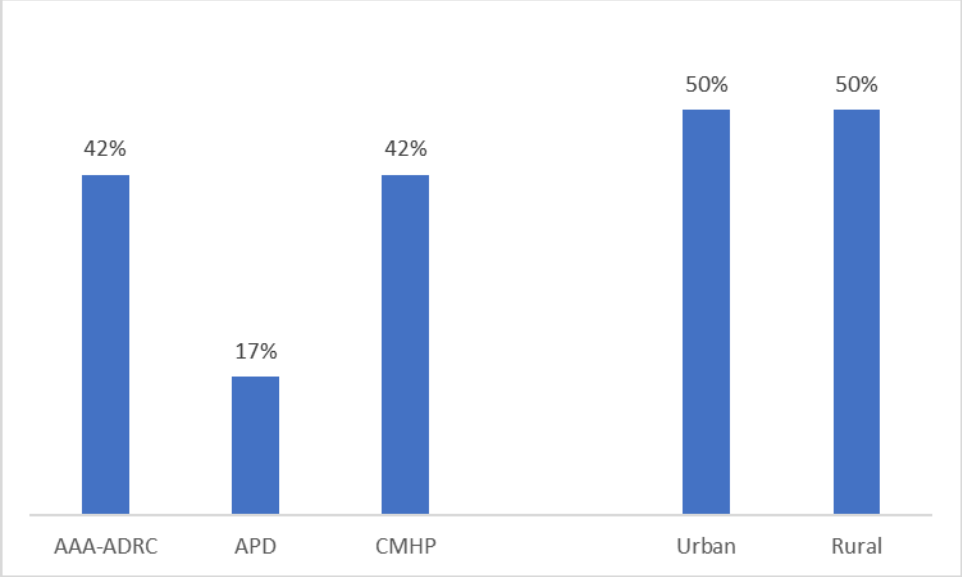
Specialist Job Functions

The Specialists' job functions were identified as a contributor to change. Examples of Specialist job functions include workforce development, community education, complex case consultations (CCCs), and promotion of collaboration and coordination. According to key informants, the most cited Specialist job functions that had contributed to change were workforce development and coordination and collaboration.

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 9: Workforce is More Knowledgeable due to the Initiative (Percentages)



Of those who reported that workforce is more knowledgeable due to the Initiative, twelve respondents (50%) were based in rural areas, and twelve (50%) were based in urban areas. When compared by agency type, ten respondents were from both AAA-ADRCs (42%) and CMHPs (42%), while four were from of an APD (17%) reported this change. When compared by agencies by involvement with the Initiative, 15 key informants (63%) were from high involvement agencies compared with nine (38%) who were from low-medium involved agencies (see Figure 8). In terms of enhanced workforce development as a result of the Initiative, one key informant stated:

> "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)

Increased workforce development is an important change as this helps providers to better serve the behavioral health needs of older adults and people living with disabilities.

Coordination and Collaboration

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.

Other Job Functions (Coded)

Other job functions of the Specialists that key informants indicated had contributed to change were providing community education (3 or 6%) and complex case consultations (8 or 16%).

Additional Differences (Non-Coded)

Interestingly, one key informant noted that as part of their work the Specialist in their community was now involving county commissioners in sub-groups related to improving services. This is an important example of work with local decision-makers to support better services for older adults and people living with disabilities who need BH services.

Initiative Outcomes

Specific consumer-related outcomes that are a result of the Initiative are difficult to precisely measure. The PSU Evaluation Team did not directly ask a question about perceptions of outcomes. However, a number of outcomes were offered unprompted by the key informants, which help show the diversity in potential outcomes. These perceived outcomes often parallel findings from other evaluations of the Initiative the Team has carried out. One example is a perception that behavioral health symptoms are recognized more often or more accurately in their community as a result of the Initiative. Six key informants (12%) reported this specific outcome.

Another outcome mentioned is a perception that consumers are experiencing fewer evictions from their homes as a result of the Initiative. This includes fewer evictions due to programs that help them with home repair, hoarding, and with legal support. Some key informants reported they now understand the referral options available to them in their area better due to the

Initiative. Another key informant reported that the safety of older adults as well as people living with disabilities is better supported in their community as a result of the Initiative.

We report these data with a note of caution. While these reports are positive, the (n) of key informants who identified these specific outcomes is small. It is therefore imprudent to say these changes have in fact taken place and if the change is a result from the Initiative.

Backward Steps In Progress

Some key informants indicated that there were areas where progress in behavioral health may have retreated in recent years. These backward steps were not a result of the Initiative. Nevertheless, these changes could undermine efforts to provide behavioral health services for older adults and people living with disabilities in the community. For example, one key informant noted,

> "This is not due to the Initiative, but behavioral health has closed a lot of their homes. These behavioral health consumers are no longer eligible for services in residential facilities. As a result, mental health staff were acting almost as guardians or representatives for many folks who were unable to make decisions for themselves." (AAA-ADRC, Urban)

This points to other events and actions that may have an impact on the work of the Initiative, but are out of the direct control of the Initiative. Nevertheless, Specialists can serve as advocates for older adults and people living with disabilities within their communities when these broader impacts occur. Further, the Specialist's special projects may be another way to potentially mitigate these systemic issues. While it is not always possible to create a special project that can address a systemic issue, the development of special projects may help ameliorate at least some impacts of these broader issues.

No Reported Change in Outcomes

Some key informants were unable to identify specific changes (either positive or negative) that they could point to as a result of the Initiative. A few others stated there has been little or no change in terms of outcomes. According to one key informant,

> "There is no change happening for 'moderate to severe" populations - there are still a lot of silos, still very cumbersome. More change is happening with folks with more mild behavioral health issues." (CMHP, Urban)

Agency Contributions to Change. Respondents were asked to report how their organization contributed to the changes they previously identified as a result of the Initiative. The three

most reported ways that agencies contributed to change were through collaboration with other agencies, the allocation of resources, and collaboration with Specialists.

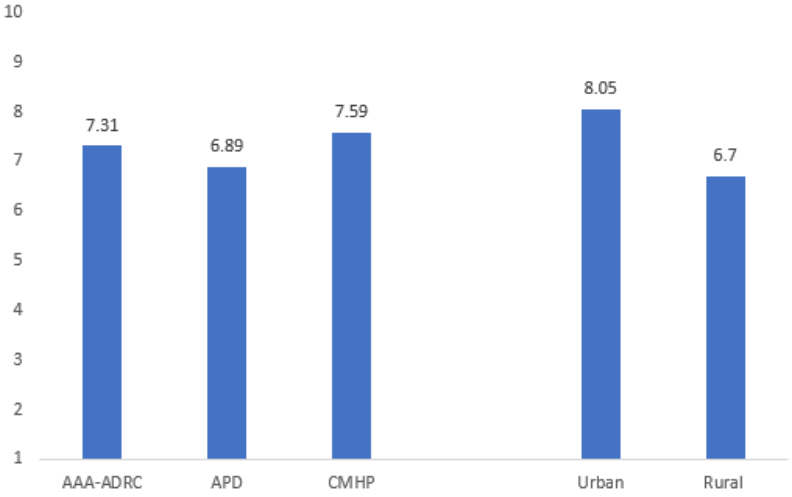
Specific Contributions of Agencies

Collaboration with Other Agencies

Fostering greater collaboration between agencies that serve older adults and people living with disabilities is a key element of the work and purpose of the Initiative. Quantitative and qualitative methods were applied to assess collaboration both with and from the agencies that the key informants represent.

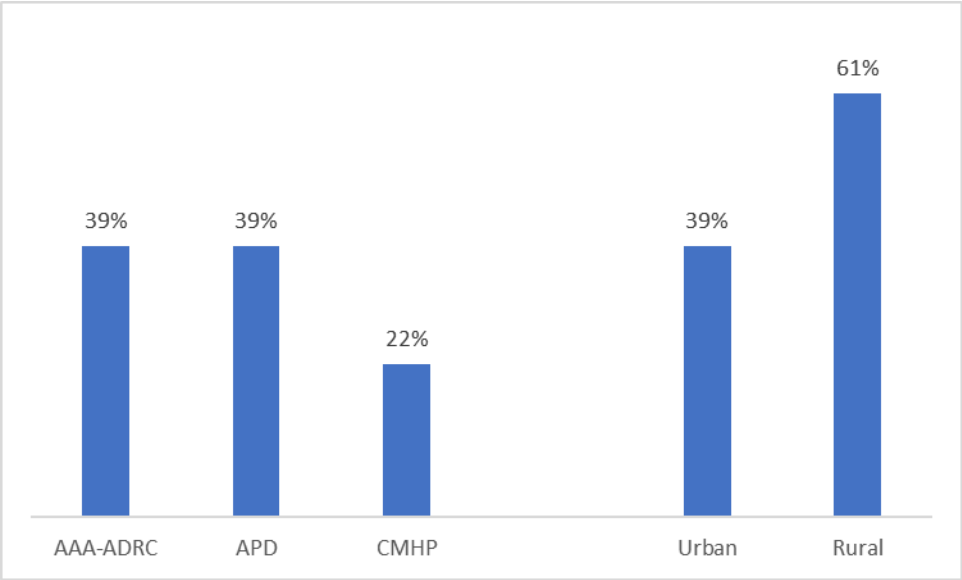
On a scale of one to ten, key informants were asked to rate the statement: someone from our team attends meetings where the behavioral health needs of older adults and people with disabilities are on the agenda. Key informants from AAA-ADRC offices had a mean score of 7.31 (*SD* = 3.16) and CMHPs had a mean score of 7.59 (*SD* = 2.53), while APD offices had a score of 6.89 (*SD* = 3.05). AAA-ADRCs and CMHPs both had mean scores of above seven, which suggests high collaboration between these agencies and the Initiative is taking place. When analyzed by geographic location, urban-based agencies had a mean score of 8.05 (*SD* = 2.64), while rural offices had a score of 6.70 (*SD* = 2.95) (see Figure 9).

Figure 10. Staff Attend Meetings



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.

Figure 11: Agency Contributed to Changes (Percentages)



When comparing agencies by rural or urban area, of those who reported that their agency contributed to changes, 11 key informants (61%) were located in rural areas, while seven (39%) were from urban-based agencies. When compared by agency type, seven respondents (39%) were from AAA-ADRC, four were from an APD (22%), and seven were from CMHPs (39%). When compared by involvement with the Initiative, 12 key informants (67%) were from high involvement agencies compared to six (33%) from low-medium involved agencies (see Figure 10).

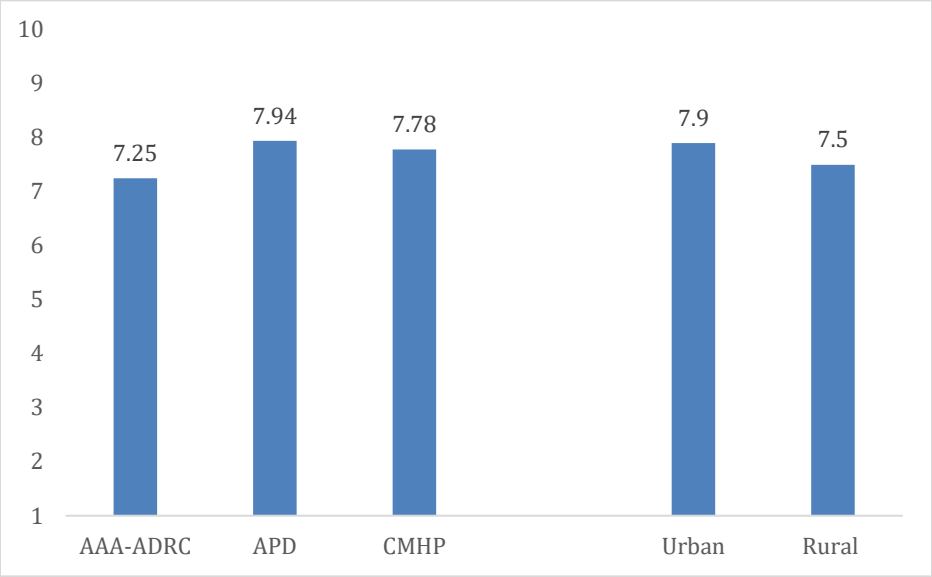
One key informant noted how collaboration with other agencies had improved BH services. They stated, “For behavioral health, we now refer to agencies in the county. One thing we created in our county is the senior peer support program. This was non-existence prior to the Initiative. If someone has an acute situation, and is experiencing grief, anxiety, depression due to life changes (e.g., death in their family) they can get support.” (AAA-ADRC, Rural)

Resource Allocation

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. The contract varies by agency. On a scale of one to ten, key informants were asked to rate this statement: our agency allocates resources so that our staff can attend training events that are organized by Behavioral Health Specialists. AAA-

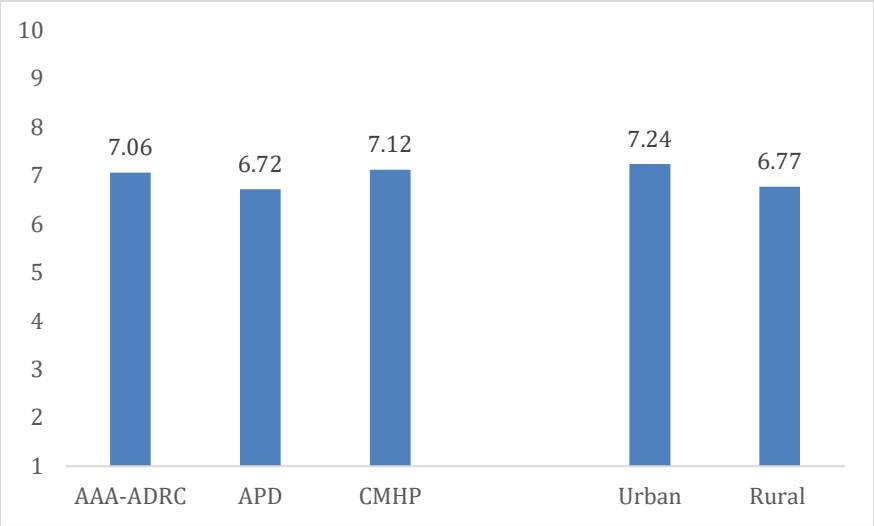
ADRCs had a mean score of 7.25 (*SD* = 3.00) and CMHPs had a mean score of 7.78 (*SD* = 1.96), while APD offices had a mean score of 7.94 (*SD* = 2.38). This suggests that all agency types have contributed resources so that their staff can participate in events and trainings hosted by the Initiative. When compared across geographies, rural agencies had a mean score of 7.50 (*SD* = 2.66), while urban agencies had a mean score of 7.9 (*SD* = 2.10) (see Figure 11). This suggests that both rural and urban based agencies contributed resources to the Initiative.

Figure 12. Agency Allocates Resources



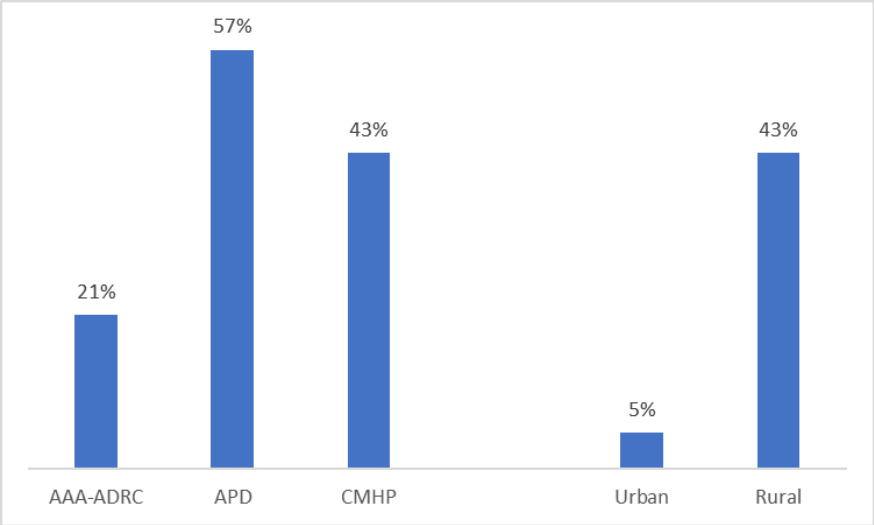
Key informants were also questioned about whether their organization provides in-kind supports to the Initiative. Specifically, key informants were asked to rate this statement on a scale of one to ten: our organization provides in-kind support to the Initiative (e.g., space for training events, advertising, refreshments). When compared by agency type, AAA-ADRCs had a mean score of 7.06 (SD = 3.45) and CMHPs had a mean score of 7.12 (SD = 3.33), while APD offices had a mean score of 6.72 (SD = 2.80). This suggests that both AAA-ADRCs and CMHPs have contributed in-kind resources at a high rate to support the Initiative. When compared by geography, rural agencies had a mean score of 6.77 (SD = 3.39), while urban agencies had a mean score of 7.24 (SD = 2.79) (see Figure 12). This suggests urban based agencies had contributed in-kind resources to the Initiative at a high rate.

Figure 13. Agency Provides In-Kind Support



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



One key informant described the resources they provided to the Initiative. They stated,

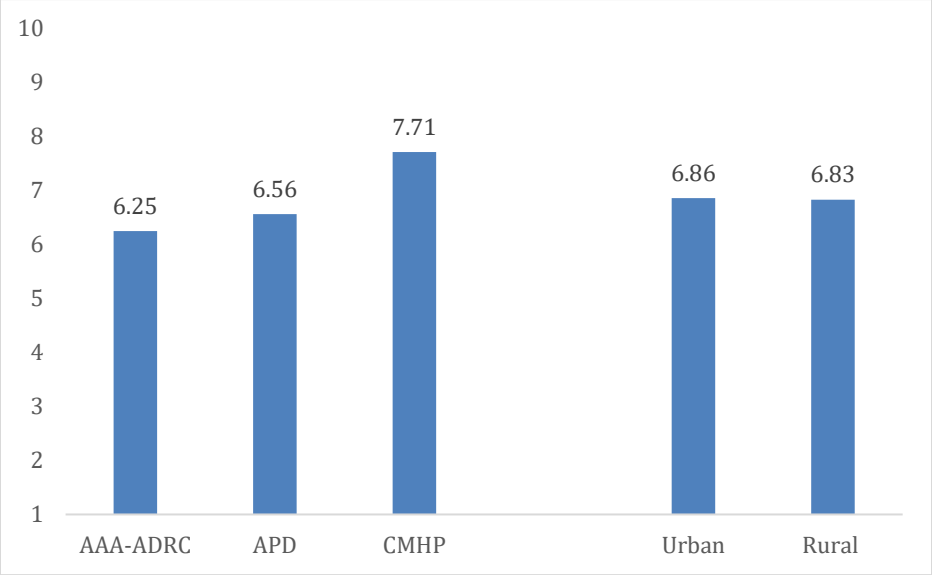
> "We provide space to provide the trainings, send our own staff members there, we are willing to partner – we put our name on the flyer to draw more attention, we meet with our Specialist, they organize community partner meetings, we are always willing to jump in and help with ideas." (APD, rural)

Collaboration with Specialists

Key informants were asked about their collaboration with Specialists. This was intended to help assess how the key informants' agencies might have contributed to the Initiative.

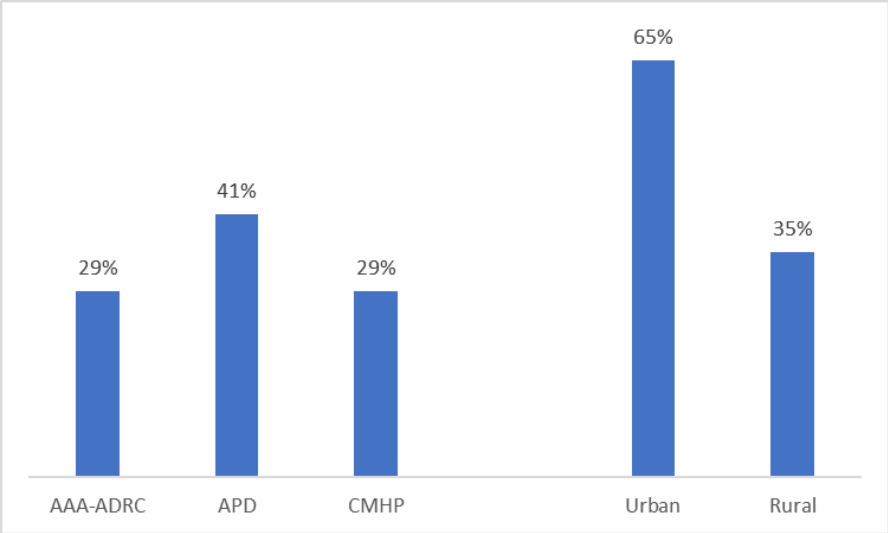
Key informants were asked to rate on a scale of one to ten this statement: our staff participate in meetings with Behavioral Health Specialists to determine an appropriate course of action with consumers who present with complex care needs (e.g., multi-disciplinary teams, ad hoc meetings). AAA-ADRCs had a mean score of 6.25 (*SD* = 3.55) and CMHPs had a mean score of 7.71 (*SD* = 2.73), while APD offices had a mean score of 6.56 (*SD* = 2.48). This suggests that all agency types have contributed resources so that their staff can participate in events and trainings hosted by the Initiative. When compared across geographies, rural agencies had a mean score of 6.83 (*SD* = 3.04), while urban agencies had a mean score of 6.86 (*SD* = 2.87) (see Figure 14).

Figure 15. Participate in Meetings – Complex Care Consultations (CCCs)



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 15).

Figure 16. 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)

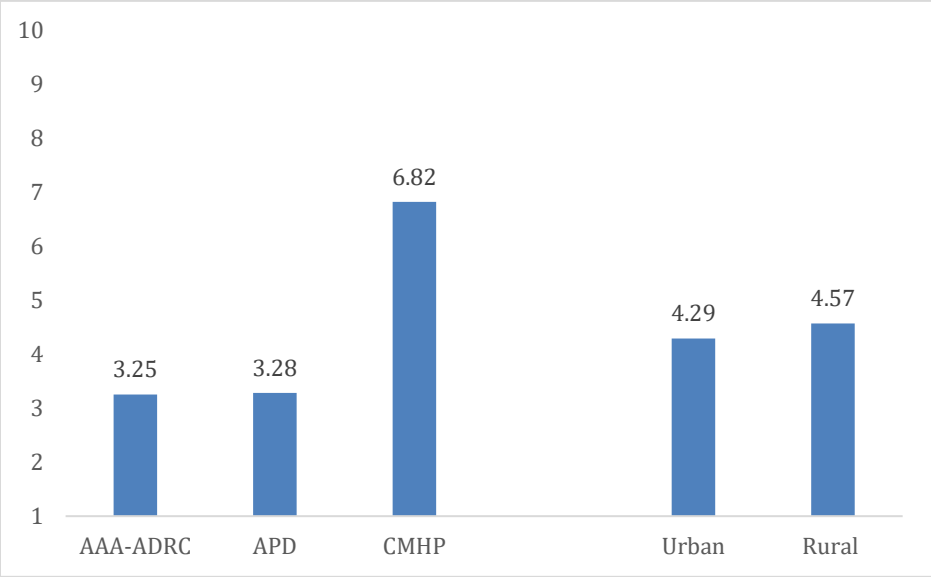
Other (Coded)

There are several additional ways that a key informant's agency could have supported change brought about by the Initiative. Other ways that agencies supported change were offered by key informants during the interviews. These included providing services, attending training (12 key informants or 24%), and by participating in CCCs (8 key informants or 16%). One key informant stated,

> "We allow staff time to attend the meetings and trainings they [the Specialists] have brought to the area. We make it a point to attend the high-risk meetings." (APD, Rural).

Key informants were asked to rate on a scale of one to ten this statement: our staff are using screening and assessment tools recommended by the Behavioral Health Specialist(s) with our organization's consumers. When analyzed by agency type, AAA-ADRCs had a mean score of 3.25 (*SD* = 2.98), APD offices had a score of 3.28 (*SD* = 2.47) and CMHPs a score of 6.82 (*SD* = 3.21). These scores are low comparatively. A one-way analysis of variance (ANOVA) showed this finding to be statistically significant (p <.001). When compared across geographies, rural agencies had a mean score of 4.57 (*SD* = 3.49), while urban agencies had a mean score of 4.29 (*SD* = 3.08) (see Figure 16). This suggests that both rural and urban based agencies were using the tools at a similar rate.

Figure 17. Staff Use of Screening & Assessment Tools



Additional Findings (non-coded)

One key informant noted their agency is now using tools for evaluations and assessments such as the SLUMS assessment and that they learned about these tools from the Specialist in their area. Another key informant stated they are advocating for pressing issues. They make sure people get the right information to bring about change.

Theme: Improvements Needed (Initiative – Local and Community)

How the Initiative might improve was an important theme built into the PSU Evaluation Team's interview. To better understand what improvement might look like at a local or community-

level, key informants were asked how the Initiative could better serve older adults and people living with physical disabilities in their area. In response, a multitude of improvements were offered by the key informants. The PSU Evaluation Team categorized these local improvements into different categories. The most prevalent were providing more resources, increased coordination and collaboration, and providing more workforce development.

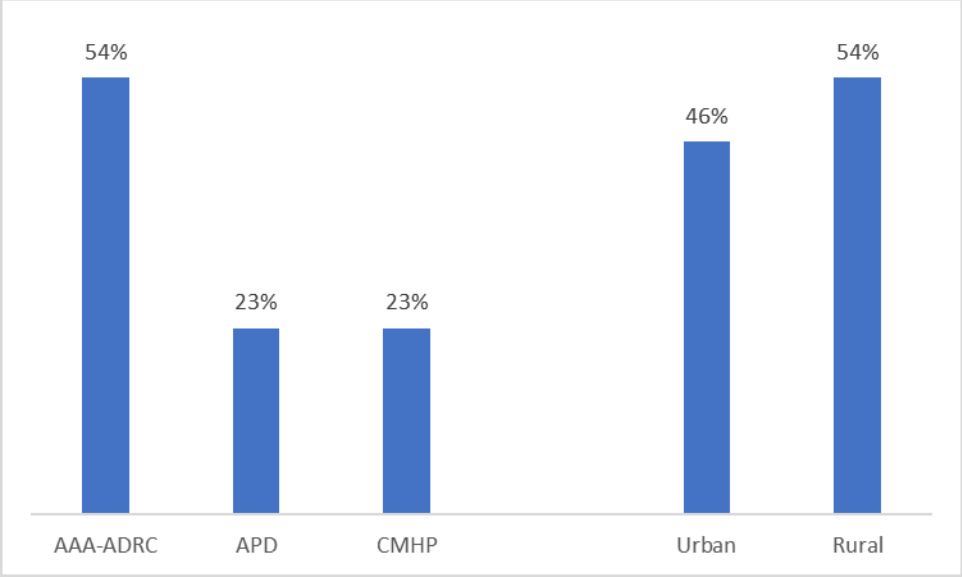
Specific Improvements

Prioritizing Funding and Resources for Older Adult Behavioral Health

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 17).

Figure 18. Increased resources going to their community



According to one key informant who noted the challenge with resources,

> "Part of the problem is just the mental health system and the lack of resources. If you don't have housing or treatment, you can't force folks [to access treatment], so what other approaches can you take? Maybe provide risk managers to try and help folks navigate the system. Build up trust with that person; some folks go a long way with some hand-holding." (APD, Urban)

Specific Recommendations

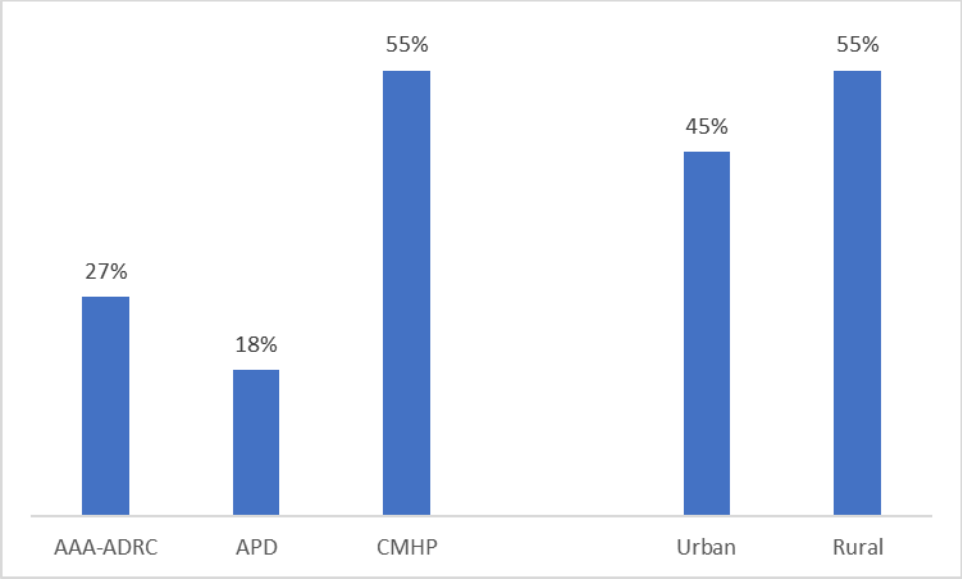
- Facilitate an increase in services to the older adult population who are not attached to any one service agency (e.g., behavioral health or aging services).
- The Initiative should become more of a leader in efforts to help bring down barriers which cause people to fall through the cracks. Specialists could use their knowledge and expertise to analyze the gaps that exist in their regions and they could serve as a resource for community leaders around the need for increases in housing, transportation, guardians, and services for people who are ineligible for Medicaid but need support.

Coordination and Collaboration

Eleven respondents (22%) reported the Initiative could do more to increase collaboration between agencies. Some examples of increased collaboration included facilitating joint meetings and groups between agencies, advertising agency services to each other, and assisting agencies and staff with system navigation (i.e., helping navigate policies and processes across agencies and agency types).

Of those who suggest that the Initiative could increase collaboration between agencies, six respondents (55%) were from rural-based agencies, and five (45%) were from urban-based agencies. When compared by agency type, three respondents (27%) were from AAA-ADRCs, two (18%) were from an APD, and six (55%) were from CMHPs (see Figure 18). When compared by involvement with the Initiative, 10 key informants (91%) were from high involvement agencies and only one (9%) was from a low involvement agency. Fisher's exact test of independence showed this finding to be statistically significant (p =.013).

Figure 19. Increase Coordination and Collaboration (Percentages)



According to one key informant, "I kind of look at the initiative as bridging DHS and OHA – I see it as very valuable, but it still struggles." (APD, Rural)

This suggests the Initiative could do more to serve as an effective bridge between the two agencies.

Specific Recommendations:

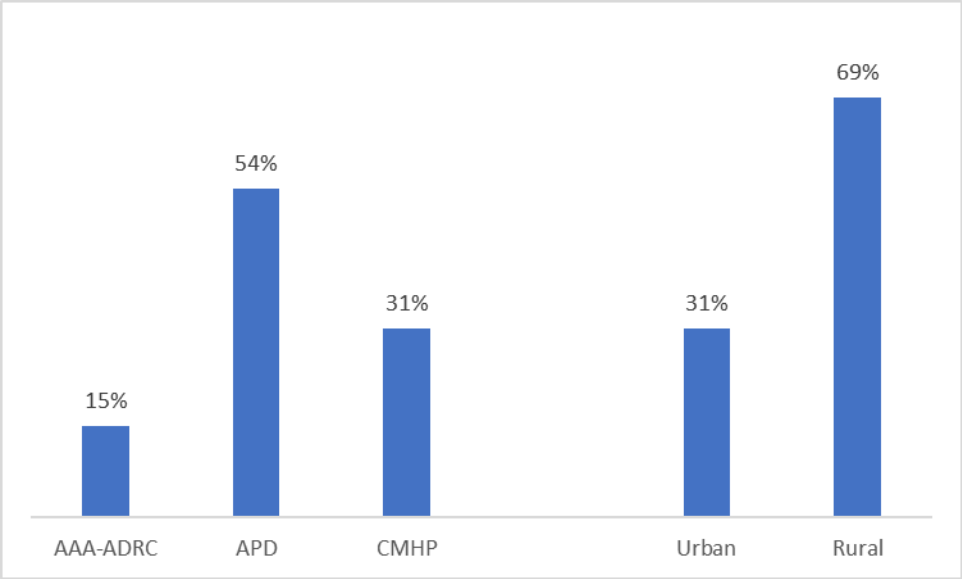
- Greater focus on engagement between primary care and behavioral health care, especially in rural areas.
- Provide more services where older adults are located, including senior centers, assisted living facilities, and individual's own homes to assess their needs.
- Develop local stakeholder taskforces to identify and address the needs of the population.
- More clear communication from the Specialists and leadership about the services the Initiative provides, the intended goals and outcomes of the Initiative, and the incentives for participation.
- Specialists should shadow community partner organizations (e.g., Adult Protective Services) to better understand their system, and spend designated time at community partner organizations.

Workforce Development

Thirteen key informants (27%) stated the Initiative could better serve consumers in their area by increasing the number of workforce development events. Some examples of workforce

development support suggested by the key informants were more training on practical skills and knowledge such as evidence-based practices to support behavioral health.

Figure 20: Recommendation - Workforce Development



Of those who suggest that the Initiative increase the number of workforce development events, nine respondents (69%) were from rural agencies, while four (31%) were urban based respondents. When compared by agency type, 2 respondents (15%) were from AAA-ADRCs, seven (54%) were from an APD, and four (31%) were from CMHPs (see Figure 19). When compared by involvement with the Initiative, six key informants (46%) were from high involvement agencies, compared to seven (54%) who were from low-medium involved agencies. According to one key informant:

> "We find the assisted living homes, the staff are not prepared to handle some of the challenges that come with dementia (they often say that it's a mental health issue) can be a challenge to explain the differences – if some kind of psychosis is usually related to dementia... How to work with individuals and have flexibility. Our assisted living homes are not very good at this; they often send people to the emergency room. Our Specialist has done outreach and asked if they would participate in training. But to my knowledge, it has not been utilized." (CMHP, Rural).

This suggests the need for increased workforce development training in long-term care settings such as assisted living.

Specific Recommendations:

- Provide education for facility staff who have consumers with significant mental health issues so they can successfully live in licensed long-term service and support settings such as assisted living.
- Advocate with university graduate programs in counseling and social work to help develop a more age-competent workforce.
- Continue to provide workforce development. When possible, go directly to agencies to provide those training.
- Provide training to entities not typically reached such as law enforcement.
- Offer training for providers about resources to support people who have behavioral health issues and are not Medicaid eligible.

Other Recommendations (coded)

According to the key informants, other supports that could be provided by the Initiative in their local area included additional marketing (10 or 20%), increasing Specialist availability (10 or 20%), and by increasing Specialist "Boots on the Ground" (9 or 18%). Less commonly cited ways to bring about improvement included: increasing the number of complex case consultations (CCCs) offered (2 or 4%) or providing more community education (3 or 6%).

Specific Recommendations

- Develop a crisis team to address the needs of consumers in acute crisis situations. Specialists could intervene in situations where a consumer might instead be sent to the corrections system (e.g., jail) or the emergency department (ED).
- Specialists could act as "risk managers" to help older adults and people living with disabilities who have behavioral health needs navigate the service system.
- Communicate regularly with community partners about the work the Specialists have been doing in their community and around the state. Community partners would like more information about how to bring trainings or other projects provided by the Specialists across the state into their own community.
- Increase the number of Specialists so more work can be accomplished. This is especially important in areas where Specialists cover multiple counties and have reduced availability due to travel time.

Additional Improvements (non-coded)

Several other ideas for how the Initiative could better serve older adults and people living with disabilities were offered by key informants. One recommendation that focused on increasing Specialist availability was to increase the number of Specialists so that more work can be

accomplished. This is especially important in areas where Specialists cover multiple counties and have reduced availability due to travel time.

Another recommendation focused on systems-level enhancements. The Initiative could become more of a leader in efforts to help bring down barriers that may cause people to 'fall through the cracks' in our social systems. In particular, Specialists could become a resource helping to educate local leaders on ways to support increases in housing, transportation, guardians, and other supportive services for people who are ineligible for Medicaid but need supports.

One respondent specifically noted the need to "somehow assist with the Medicaid issue. If older adults don't have Medicaid and can't travel to their appointments, they have to pay for expensive transportation or case management assists." (CMHP, Urban)

This statement highlights the continued service gaps that exist in the ability to support non-Medicaid enrolled individuals who are served by the Initiative. This issue has been identified in previous evaluation efforts carried out by the PSU Evaluation Team.

Specific Recommendations

- View the systems from a local, regional, and state level to address some of the big issues and barriers around the state system. Designate a regional coordinator to gather this information (e.g., gaps and/or barriers that cannot be addressed at a lower level) and provide it to the Initiative's advisory council and leadership.
- Increase attention focused on breaking down silos and doing systems work. Specialists are often 'in the weeds' carrying out training and case consultation.

Theme: Improvements Needed (Initiative – Coordination and Collaboration)

Building on the theme of possible avenues for improvement, key informants were asked how the Initiative could help improve coordination and collaboration within their communities. The PSU Evaluation Team grouped the responses into several categories. The most prevalent suggestions for how the Initiative could improve coordination and collaboration within the community were: promoting involvement from other agencies in the community, keeping the momentum going with current efforts (or maintaining consistency), and by marketing the services and needs of other agencies.

Improve Coordination and Collaboration

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)

Of those who suggested promoting involvement from other agencies as a way to improve collaboration and coordination, eleven respondents (61%) were located in rural areas, while seven (39%) were urban-based respondents. When compared by agency type, five respondents (28%) were from AAA-ADRCs, five (28%) were from APDs, and eight (44%) were from CMHPs. When compared by involvement with the Initiative, nine respondents 50%) were from high involvement agencies, and nine (50%) were from medium-low involved agencies.

Keep The Momentum Going (Consistency)

Another 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)

Of those who suggested continuing with existing efforts to improve collaboration and coordination, nine respondents (69%) were from agencies located in rural areas, while four (31%) were from urban-based agencies. When compared by agency type, three respondents (23%) were from AAA-ADRCs, two (15%) were from APDs, and eight (62%) were from CMHPs.

When compared by involvement with the Initiative, nine respondents (69%) were from high involvement agencies and four (31%) were from medium-low involved agencies.

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 respondent,

> "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)

Of those who suggested marketing the services and needs of agencies as a way to increase collaboration and coordination, only one key informant (14%) was from an agency in a rural area and six (86%) were urban-based. Performing a Fisher's exact test of independence showed this finding to be statistically significant (p = .036). It is possible that the key informants from rural communities were more likely to be aware of the services offered and the needs of other partners in their community due to the smaller communities.

When compared by agency type, four respondents (57%) were from AAA-ADRCs, two (29%) were from APDs, and one (14%) was from a CMHP. When compared by involvement with the Initiative, four respondents (57%) were from high involvement agencies and three (43%) were from medium-low involved agencies.

Other Recommendations (Coded)

Several other recommendations for ways the Initiative could help improve collaboration and coordination were coded by the PSU Evaluation Team including collaborative trainings (6 or 12%), bringing decision makers to the table (3 or 6%), and formal agreements between agencies such as MOUs (5 or 10%). In terms of collaborative trainings, one key informant commented,

> "The Specialist does some amazing trainings in our community. Mental health first aid training for example. The Specialist will even come to your agency to provide the

> training. There needs to be more time for things like that... Just to be able to have more tools in your toolbox like that would be hugely beneficial." (APD, Rural)

Additional Improvements (Non-Coded)

Several additional recommendations were offered but that were not captured in the themes coded by the PSU Evaluation Team. These recommendations are important for thinking through the way the Initiative could be most impactful. One recommendation noted that guidance is needed for non-clinical staff about resources and system navigation. Another key informant recommendation focused on the need to identify referral pathways and create feedback loops, so that people can get the supports and access to services they need. One respondent summed up the challenges facing older adults living with behavioral health needs:

> "Consumers get passed back and forth between older adult and behavioral health; there needs to be a better bridge between the two types of agencies that would allow them to partner together." (CMHP, Rural)

Additional barriers to coordination and collaboration

It is important to note that the Initiative has seen considerable turnover among the Specialists, and it takes time for a new Specialist to orient themselves to the variety of community partners who work within relevant local service agencies. Learning about the complex needs within each unique county also takes time. Depending on the amount of time that lapses between a Specialist's resignation and a new hire, new Specialists are not always able to receive training from the previous Specialist about community needs or introductions to community partners.

In some cases, due to the unique skill set required of the Specialists, a considerable amount of time might lapse before a new Specialist is hired and additional effort is needed to re-engage community partners. Maintaining engagement of key community partners can be challenging due to other external factors such as competing interests (the project no longer matching their organization's goals or other projects assuming priority in their organization), or an engaged stakeholder might move to a different organization without a replacement. In some instances, a stakeholder might be assigned to work with the Initiative who is unable to commit the organization to any course of action.

Theme: Improvements Needed (Systems Level)**

An important issue-area to better understand is systems-level improvements that might reach beyond the Initiative, but could improve the behavioral health of older adults and people with physical disabilities. Key informants were therefore asked what can be done to improve the behavioral health of older adults and people with physical disabilities in their area at a systems-level. The responses were organized by the PSU Evaluation Team into five overarching topics prioritization, coordination and collaboration, resources, workforce, and gaps in services with multiple sub-categories for each of the five.

Prioritization

Prioritizing Older Adults

Nine respondents (18%) reported that prioritizing older adults at a systems level would lead to improved behavioral health in their community. This includes making more specialized services available to older adults, efforts to bring about more societal awareness of aging issues such as the unique needs of older adults and understanding of how existing programs such as Social Security and Medicare are intended to support specific social needs (e.g., retirement and health care), as well as state programs that are focused on the needs of older adults. According to one key informant,

> "I think most program managers would agree that we lack specific services for older adults." (AAA-ADRC, Urban)

Of those who recommended prioritizing older adults, five key informants (56%) were from agencies located in rural areas and four (44%) were urban-based respondents. When compared by agency type, five respondents (56%) were from AAA-ADRCs, three (33%) were from APDs, and one (11%) was from a CMHP. When compared by involvement with the Initiative, four respondents (44%) were from high involvement agencies and five (56%) were from medium-low involved agencies.

Prioritizing Behavioral Health

Another nine respondents (18%) indicated there is a need to prioritize behavioral health at a systems level. This includes more societal awareness about BH issues such as de-stigmatizing mental illness and substance use disorders and raising awareness of how to better support people who are living with these needs. The systematic lack of awareness and stigma that surrounds mental illness was addressed by one key informant who stated,

> "Behavioral health issues often just get swept under the rug." (AAA-ADRC, Urban).

Of those who suggested prioritizing BH as at a systems level, three key informants (33%) were from agencies located in rural areas and six (67%) were urban-based respondents. When compared by agency type, four respondents (44%) were from AAA-ADRCs, three (33%) were from APDs, and two (22%) were from CMHPs. When compared by involvement with the Initiative, six respondents (67%) were from high involvement agencies and three (33%) were from medium-low involved agencies.

Other Recommendations

Several additional recommendations were offered by the key informants. For example, the need to prioritize older adults in education. For instance, prioritizing older adults in social work and counseling education would lead to improvements in awareness of need, service delivery, and ultimately in outcomes. According to one key informant,

> "Education around older adults is needed in your social work and counseling schools. This is a pretty specific population; it is important to be savvy about physical health and behavioral health." (CMHP, Urban)

The Initiative may have an opportunity to partner with Oregon-based higher education programs such as social work to help facilitate this recommendation.

Another 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)

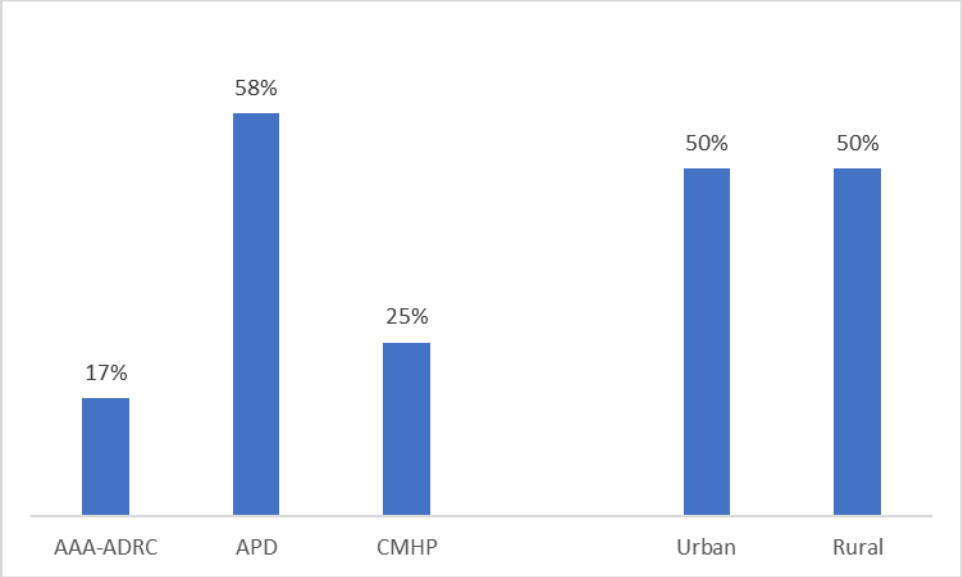
This suggests that further prioritization of the Initiative would benefit the Initiative in its work to support the behavioral health needs of older adults and people living with disabilities in Oregon.

Coordination and Collaboration

Formal Agreements Between Agencies

Twelve key informants (24%) indicated that formal agreements between agencies (e.g., MOUs) would help improve BH 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 21: Formal Agreements Between Agencies (Percentages)



Of those who recommended establishing formal agreements between agencies, six key informants (50%) were from agencies in rural areas and six (50%) were urban-based. When compared by agency type, two respondents (17%) were from AAA-ADRCs, seven (58%) were from APDs, and three (25%) were from CMHPs (see Figure 20). When compared by involvement with the Initiative, six respondents (50%) were from high involvement agencies and six (50%) were also from medium-low involved agencies. According to one key informant:

> "I think the hardest challenge we have is that we're at cross-purposes between APD and mental health. Our rules don't line up." (AAA-ADRC, Rural)

> Another key informant stated, "An MOU between APD and Mental Health would be nice; I would love to be involved in those conversations. There are too many policies that just don't make sense." (APD, Rural)

This suggests that formal agreements are needed for clarity of roles, but also in order to make sure coordination and collaboration takes place between multiple agencies.

Coordination Between Service Agencies

Ten key informants (20%) indicated that coordination among service agencies could improve and increase. For example, systems could improve if agencies worked together and identified what resources they can bring to the table. Some possible reasons for a lack of collaboration between agencies include inter-agency historical issues, tension, a lack of knowledge about other agencies.

Of those who recommend improving coordination among service agencies, an equal number of rural area respondents (5 or 50%) stated this would help as did their urban-based counterparts (5 or 50%). When compared by agency type, four respondents (40%) were from AAA-ADRCs, one (10%) was from an APD, and five (50%) were from CMHPs. When compared by involvement with the Initiative, six respondents (60%) were from high involvement agencies and four (40%) were from medium-low involved agencies (18%). One key informant suggested,

> "We should have some kind of wraparound group with more intensive services for this population. We should have a designated peer support person just for older adults." (CMHP, Rural)

Resources. Adequate resources to provide services is essential. It is unsurprising this was the most frequently reported systems-level improvement mentioned by the key informants. Seventeen respondents (35%) suggested that more resources and funding would improve BH services for consumers. Specific examples of resources include funding to allow service providers to have more time to observe, follow-up on, and provide services to consumers, assist with items such as ramps, moving expenses, and other non-BH needs, stay up to date on new information in the field and community and take advantage of what the Initiative has to offer.

Of those who suggest greater allocation of resources, nine key informants (53%) were from agencies in rural areas while eight (47%) were urban-based. When compared by agency type, ten respondents (59%) were from AAA-ADRCs, 3 (18%) were from APDs, and 4 (24%) were from CMHPs. When compared by involvement with the Initiative, nine respondents (53%) were from high involvement agencies and eight (47%) were from medium-low involved agencies.

Other Resources (Coded)

Other resource-related responses coded and reported during the key informant interviews included the need for a new Medicaid Waiver (8%) and an expanded number of Medicare-enrolled providers (16%). The need for more providers who are able to bill Medicare is a

reoccurring recommendation that has been cited in previous Initiative evaluations. According to one respondent,

> "Medicare's resistance to reimbursement of telephone-based services as rather than video-services which is often an issue for older adult consumers." (CMHP, Rural).

This statement points to the continued challenges that exist with licensure and billing for Medicare, an issue that is beyond the scope of local policymakers' jurisdiction. However, several changes have been made recently by the Centers for Medicare & Medicaid Services (CMS), allowing expanded clinical licenses that can support substance use disorder treatment as well as expanded access to behavioral telehealth services, including expanded access and reimbursement for telephone-based services, in response to the COVID-19 pandemic (Centers for Medicare & Medicaid Services, 2020).

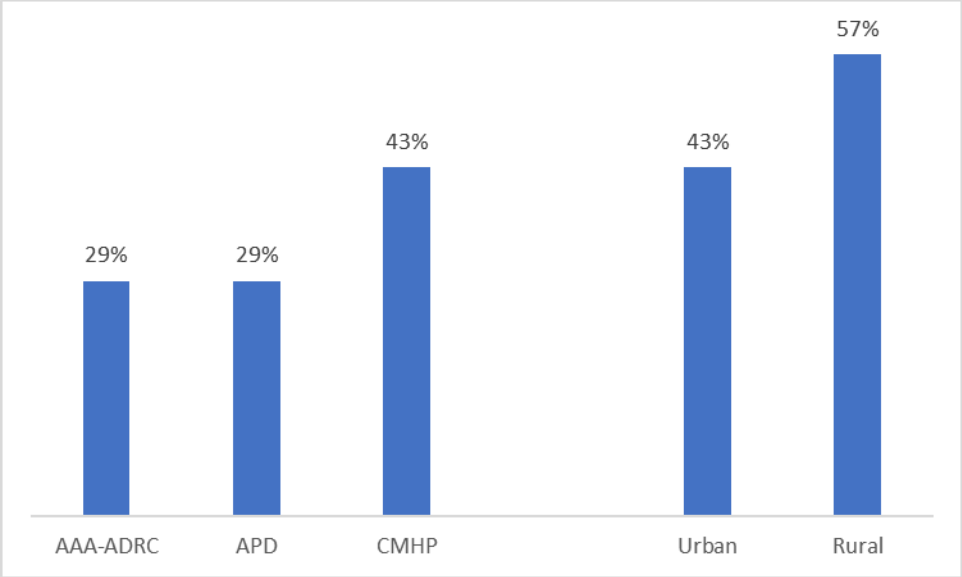
Workforce

Care Coordinator / Boundary Spanner

The workforce that provides behavioral health services to older adults and people living with disabilities could use additional support. Seven key informants (14%) reported that more care coordinators and boundary spanners are needed. In other words, having staff who have worked in the different systems and understand what different agencies are facing would lead to improvement in services. Specific jobs that fall under this grouping are care coordinator, case manager, and risk managers. One key informant explained the need for care coordinators or boundary spanners. The key informant stated,

> "We all agree what the patient needs. But time it takes to figure it out is prohibitive. Most workers can't really spend that much time on one individual case." (APD, Urban).

Figure 22: Workforce: Care Coordinator or Boundary Spanner (Percentages)



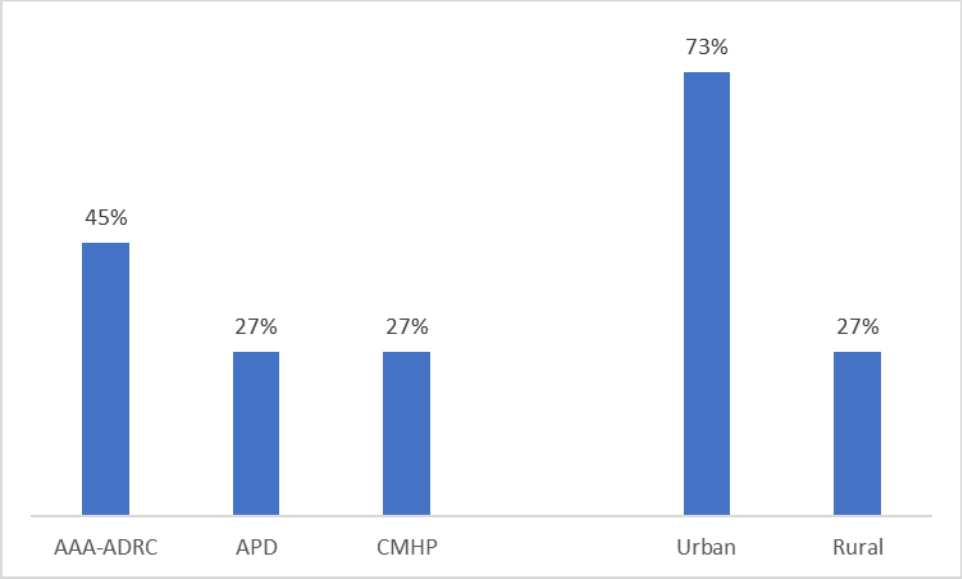
Of those who suggest that more care coordinators and boundary spanners are needed, four key informants (57%) were from agencies in rural areas and three (43%) were urban-based. When compared by agency type, two respondents (29%) were from AAA-ADRCs, two (29%) were from APDs, and three (43%) were from CHMPs (see Figure 21). When compared by involvement with the Initiative, one respondent (14%) was from a high involvement agency and six (86%) were from medium-low involved agencies. Fisher's exact test of independence showed this finding to be statistically significant (p = 0.036).

Gaps in Services

Specialized older adult behavioral facilities

It is a widely held belief that there are not enough specialized care facilities for older adults living with BH issues in Oregon compared to the need. Unsurprisingly, the need for more Specialized OA BH Facilities was the most frequently cited way to address gaps in services with 11 (22%) respondents reporting this need.

Figure 23: Gaps in Services – Specialized Older Adult Behavioral Health Facilities (Percentages)



Of those who identified a lack of specialized care facilities for older adults living with BH issues, three key informants (27%) were from agencies in rural areas, while eight (73%) were urban-based. Performing Fisher's exact test of independence showed this finding to be statistically significant (p = 0.046). When compared by agency type, five respondents (45%) were from AAA-ADRCs, three (27%) were from APDs, and three (27%) were from CMHPs (see Figure 22). When compared by involvement with the Initiative, eight respondents (73%) were from high involvement agencies and three (27%) were from medium-low involved agencies. According to one key informant:

> "We need integrated care. Need to be able to offer care in the same settings for physical and mental health care. The goal is to have a site for older adults that has inpatient and outpatient care services daycare." (APD, Urban)

Other Gaps (coded)

Several other recommendations for systems-level improvement to address perceived service gaps were coded by the PSU Evaluation Team. These recommendations focused on improving non-emergency transportation including qualified drivers to transport older adults with BH needs (5 key informants or 10%), additional housing support for consumers with behavioral health needs (6 key informants or 12%), and more in-home care services (4 key informants or 8%).

Additional Gaps in Services (Non-Coded)

Other gaps and recommendations were offered by the key informants that included: the need for more funding for more evidence-based mental health programs and interventions and the need to address the issue of consumers falling between the cracks of aging and BH services for examples for BH clients not being accepted by a nursing facility so they are placed in an inappropriate care setting that may not be equipped to handle their behavioral health needs. A lack of services in rural areas of Oregon was also often noted by key informants, particularly by those based in rural areas of the state. One key informant said:

> "No shelter, no respite, no psychiatric hospital, no hold hospital… we don't have a lot of things that larger counties and cities have." (CMHP, Rural)

Summary and Recommendations

Summary

Agency involvement with the Initiative appears to have increased or held steady since the beginning of the program five years ago. The greatest increase in involvement has been amongst agencies in rural areas of the state. However, according to the key informants interviewed and surveyed, a number of improvements are needed to maximize the potential of the Initiative and to improve services for older adults and people living with disabilities who have behavioral health needs in Oregon. The PSU Evaluation Team found seven of the findings to be statistically significant (see Appendices).

Recommendations

The findings resulting from the analysis pointed to several areas for potential improvement. Several recommendations for how to continue to enhance the effectiveness of the Initiative and improve behavioral health services for older adults and people living with disabilities. These recommendations include community-level steps that can be taken by the Specialists and the Initiative leadership in partnership with the local communities to increase effectiveness. The recommendations also include systems-level improvements that may go beyond the Initiative, but are critical for improving behavioral health services for older adults and people living with disabilities in Oregon. These build on the successes that have already occurred.

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.

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.

Systems-Level Recommendations

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.

References

Centers for Medicare & Medicaid Services (2020). Further Expand Telehealth in Medicare. CMS.gov. April 30. Accessed July 17, 2020. Available from: <https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid>.

Appendices

Appendix A: Statistically Significant Findings

Finding	Statistical Significance: Fisher's Exact Test of Independence / One-way analysis of variance (ANOVA)
Communication with Agency Leadership: **High**	($p < .001$) (Fisher's)

Level of Involvement: 11 respondents (100%) were from high involvement agencies, while none were from medium-low involved agencies.	
Survey: "Agency staff use screening and assessment tools recommended by the Specialists" Agency Type: AAA-ADRCs had a mean score of 3.25 (SD = 2.98), APD offices had a score of 3.28 (SD = 2.47) and CMHPs a score of 6.82 (SD = 3.21).	(*p* <.001) (Anova)
Improvements (Initiative Level Need)*:* Coordination and Collaboration Level of Involvement: 10 key informants (91%) were from high involvement agencies and only one (9%) was from a medium-low involvement agency.	(*p* =.013) (Fisher's)
Improvements (Initiative Level Need): Marketing Geography: One key informant (14%) was from an agency in a rural area and six (86%) were urban-based.	*(p* = .036) (Fisher's)
I**mprovements (Systems Level Need) Workforce: Care Coordinator / Boundary Spanner** Level of Involvement: One (14%) from a high involvement agency and six (86%) were from medium-low involved agencies	(*p* = 0.036) (Fisher's)
Improvements (Systems Level Need): Specialized older adult behavioral health facilities Geography: Three key informants (27%) were from agencies in rural areas, while eight (73%) were urban-based agencies.	(*p* = 0.046) (Fisher's)