Final Report 2019-2021

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

Portland State Institute on Aging

Oregon Health Authority

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

Date: June 30, 2021

Project Sponsors: Oregon Health Authority and Portland State University Institute

Acknowledgments: We would like to acknowledge two former Portland State University Institute on Aging staff, Linda Dreyer, M.S.W., M.P.H., Research Associate, and Margaret Neal, Ph.D., Principal Investigator, for their contributions to the evaluation of the Behavioral Health Initiative for Older Adults and People with Physical Disabilities. We would also like to acknowledge Nirmal Dhar, M.S.W., Oregon Health Authority, who has served as the Project Director of the Initiative since its inception, for her contributions to the development of the evaluation instruments.

Table of Contents

Part I. Introduction & Purpose……6
Data Sources……6
Part III. Key Findings ……10
Part IV. Recommendations……89
Part V. Policy Options……95
Part VI. Summary and Conclusions……103

Appendices (available upon request)

Appendix A. Specialist Quarterly Reporting Form……A1
Appendix B. Specialist Quarterly Report Full Analysis……A2
Appendix C. Complex Case Consultation Form……A3
Appendix D. Complex Case Consultation Full Analysis……A4
Appendix E. Key Informant Interview Instrument……A5
Appendix F. Key Informant Interview Full Analysis……A6
Appendix G. Specialist Interview Instrument……A7
Appendix H. Specialist Interview Full Analysis……A8
Appendix I. Post-Training Evaluation form……A9
Appendix J. Post-Training Evaluation Full Analysis……A10
Appendix K. Follow-up Evaluation form……A11
Appendix L. Follow-up Evaluation Full Analysis……A12
Appendix M. Community Education Evaluation form……A13
Appendix N. Community Education Evaluation Full Analysis……A14

List of Figures

1. Specialists' ratings of multi-disciplinary team barriers
2. Specialists' ratings of stakeholder engagement
3. Specialists' ratings of community capacity
4. Specialists' ratings of multi-disciplinary team barriers
5. Specialists' ratings of indicators of success
6. Specialists' ratings of support for training from stakeholders
7. Specialists' ratings of training barriers
8. Specialists' ratings of training outcomes
9. Means of pre-training knowledge, knowledge gains attributed to training, and confidence items across periods
10. Respondents who agree or strongly agree with each statement by reporting period, excluding "don't know" and "not applicable" responses
11. Self-reported change in Involvement across time by agency type
12. Overall Effectiveness of the Initiative

List of Tables

1. Top Five Barriers According to Specialists
2. Percentage of Specialists Reporting Infrastructure Barriers
3. Percentage of Specialists Reporting Service and Program Barriers
4. Percentage of Specialists Reporting Policy and Systems Barriers
5. Percentage of Specialists Reporting Lack of Providers Barriers
6. Perceived Community Partner Involvement in Coordination and Collaboration Activities
7. Respondents' organization/agency
8. Knowledge Rating Before Attending the Training
9. Knowledge after the Training
10. Confidence to use knowledge gained in work
11. Participant perception of training/workshop characteristics
12. Participant perception of trainer(s): July 2019 through December 2020 data only
13. Participant perception of training environment
14. Means of post-training evaluation items over time
15. Respondent credentials
16. Response patterns for all training participants with names on rosters by quarter
17. Community Event Evaluation Questions
18. Community Education Evaluations from July 2019 to December 2020
19. Gender of Consumers Involved in Consultations

20. Race/ethnicity (2020 Q3 & 2020 Q4 only)
21. Structure of the complex case consultation
22. Referral Sources
23. Prevalence of diagnosed or suspected/diagnosis pending problems/issues reported per consumer (excluding “Other” categories)
24. At least one diagnosed or suspected/diagnosis pending problems/issues reported by broad categories
25. Percent of issues/problems reported by the Specialists by Reporting Period
26. Specialist’s actions during the consultation
27. General recommendations for the consumer emerging from the case discussion
28. Key Informant Sample
29. Stakeholder survey response status
30. Stakeholders’ Work Region
31. Stakeholder Initial Year of Involvement with the Initiative by Organization Type
32. Stakeholder Change in Involvement Over Time
33. Change in BHI Involvement by Stakeholder Organization Type
34. Stakeholders’ Barriers to Attending Training Events Organized by the Specialists
35. Average training involvement of AAA, APD, and CMHP stakeholders
36. Specialist Perceptions of Barriers to Training Events
37. Stakeholders’ Perceptions of Populations with High Unmet Needs
38. Stakeholders’ Perceptions of MDTs organized by a Specialist
39. Specialist ratings of MDTs
40. Distribution of community partner / stakeholder group ratings
41. Stakeholder Perceptions of the Impact of the Initiative
42. Specialist Perceptions of the Impact of the Initiative
43. Stakeholders’ Rating of the Overall Effectiveness
44. Specialists’ Rating of the Overall Effectiveness
45. Micro-level interventions to support behavioral health for older adults and people with disabilities
46. Micro-level interventions to support behavioral health for older adults and people with disabilities: Interventions in other states/countries
47. Macro-level interventions to support behavioral health for older adults and people with disabilities: Specialists’ approach
48. Macro-level interventions to support behavioral health for older adults and people with disabilities: Specialists’ approach Interventions in other states/countries

49. Meso-level interventions to support behavioral health for older adults and people with disabilities: Specialists' approaches
50. Meso-level interventions to support behavioral health for older adults and people with disabilities: Interventions in other states/countries
51. Meso-level interventions to support behavioral health for older adults and people with disabilities: Interventions in other states/countries
52. Meso-level interventions to support behavioral health for older adults and people with disabilities: Interventions in other states/countries

Introduction

Each year, the Portland State University (PSU) Institute on Aging (IOA) evaluation team reports results from the multi-year evaluation of the Behavioral Health Initiative for Older Adults and People with Disabilities. The intent is to provide the Older Adult Behavioral Health Specialists (referred to as 'the Specialists' in this report) with data about their work and the Initiative so the Specialists may build on the many successes achieved so far as well as identify areas of possible improvement. This report focuses on what appears to be working well and what areas may need additional focus or improvement.

In the Spring of 2020, the world turned upside down when the World Health Organization (WHO) declared COVID-19 a global pandemic (Cucinotta, et al, 2020). The events of the past 18 months have been truly unprecedented. The COVID-19 pandemic has exacerbated existing behavioral health needs. As many as one-fourth of all older adults in the United States now report experiencing anxiety or depression (Koma, et al., 2020). Undeniably, the pandemic has greatly impacted the delivery of behavioral health services in Oregon. The COVID-19 pandemic has also impacted the work of the Initiative as well as that of the Specialists. These impacts have produced new challenges as well opportunities to reach individuals in need of behavioral health services in ways unimaginable prior to the pandemic.

The data to support the findings and recommendations provided in this report are drawn from multiple sources. A full list of sources are listed in detail below. These build on data collected over multiple years as well as emerge from new data sources (e.g., the key informant interviews) developed and implemented in the most recent evaluation period.

Sources of Data

Evaluation data on the Initiative has been gathered from the Specialists through a variety of sources since 2016. These include qualitative and quantitative quarterly reports, complex case consultation reporting instruments detailing consultations Specialists organized or participated in, rosters to collect information about every workforce development training Specialists planned, hosted, or facilitated, and semi-structured interviews with all Specialists. Evaluation data were also collected from workforce development and community education event participants via a post-training evaluation and two-month follow-up evaluation.

Another continuous data source on the Initiative are stakeholder surveys. These data, however, were not collected during this phase of the evaluation. Instead, the PSU Evaluation Team developed a new evaluation instrument focused on targeted groups of Initiative

stakeholders. Data were collected from Initiative stakeholders through semi-structured key informant interviews.

Quarterly Reports

The Specialists submit reports on a quarterly basis. Three of the four quarterly reports mostly consist of open-ended qualitative questions about successes and challenges related to their core job functions. The reports are also used to collect information about multidisciplinary teams, evidence-based practices, community education training events, and plans for the upcoming quarter. One of the four quarterly reports mostly consists of quantitative scaling items to assess the Specialists' perception of progress in systems changes and outcomes, the state of behavioral health services for older adults and people living with disabilities in their communities, and coordination and collaboration among community partners. The most recent quarter of quantitative data described in this report is from July through September 2020.

Training: Workforce Development

Workforce development training is aimed at enhancing the behavioral health-related knowledge and skills of aging services, health services, mental health services, and other professionals. Training participants who attend workforce development events planned, hosted, or presented by a Specialist sign a roster which collects information such as participants name, title, and email address. Participants then receive an electronic post-training evaluation from PSU within three days of receiving the roster from the Specialist. Participants provide information about their perceptions of the training, and summaries are then shared with the Specialist so they can determine how to improve future events. From July 2019 through December 2020, 311 workforce development training events were planned, conducted, or sponsored by the Specialists, with an average of 52 events per quarter. The post-training evaluation response rate remains relatively steady, at about 40%. Between October 2017 and December 2020, a total of 6,048 training participants (not unique cases) fully completed the online evaluation of the training.

Two months after the training event, training participants also receive a 2-month follow-up survey which assesses how they incorporated knowledge learned from training into their professional practice. This survey has a lower response rate, ranging from 19% to 26%. As of October 2017, a total of 3,011 training participants (not unique cases) fully completed the follow-up training evaluation.

Training: Community Education

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

Between October 2017 and December 2020, Specialists distributed the PSU evaluation form for 127 training events, and evaluations were completed by 1,595 (not unique cases) community stakeholders. Between July 2019 and December 2020, Specialists distributed the PSU evaluation form for 29 events, and these were completed by 426 community members (not unique counts).

Complex Case Consultations (CCC)

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

Specialists across Oregon used a data entry tool to collect information about each CCC in which they participated between October 2017 and December 2020. From October 2017 through December 2020, Specialists reported participating in a total of 4,627 CCCs that took place in at least 30 counties. During the most recent reporting period from July 2019 through December 2020, Specialists reported participating in a total of 1,993 CCCs that took place in at least 28 counties.

Specialist Interviews

In the fall of 2019, the PSU Evaluation Team conducted telephone interviews with each of the Specialists. One goal of these interviews was to collect detailed information on their "special projects", which were loosely defined as the most significant projects the Specialist has worked on in their position. Specialists were asked about the purpose, community partner involvement, and their contributions to the project, as well as strategies used to overcome

project challenges. Other questions included the Specialists' opinions about what would make the Initiative more successful and strategies and barriers to implementing projects in their communities. The Specialists' projects were analyzed and grouped into four categories: 1) improving access to behavioral health care, 2) increasing workforce knowledge and skills, 3) engaging community partners, and 4) working upstream on primary prevention. Descriptions of these projects were included in infographic factsheets and provided to the Specialists so they can share more information about the Initiative with stakeholders and community partners. Specialist data are also used to develop recommendations and provide examples of key findings.

Key Informant Interviews

At the request of OHA we developed an evaluation 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, a brief survey and qualitative interview instrument were developed to gather open-ended data from directors and managers of key stakeholder agencies. These key informants are a subset of stakeholders (referred to as "key informants" in this report) work for aging services or behavioral health agencies that interact with Specialists most often: local Aging and People with Disabilities (APD) offices, Area Agencies on; Aging-Aging and Disability Resource Centers (AAA-ADRCs), and Community Mental Health Programs (CMHP).

The final sample included 49 key informants out of a total recruited sample of 56. We sought to interview an equal number of key informants for each stratum to collect equal amounts of information from each group however, 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).

Stakeholder and Specialist Survey

Between April 1st and May 4th, 2021, both community stakeholders and Specialists across Oregon completed an online survey that asked about the impact of the Initiative, as well as what is working well and how it might improve. In addition, the survey provides information about how stakeholders work with the Specialists on Initiative activities. Stakeholders and Specialists also provided general perspectives about the state of behavioral health services for older adults and people with disabilities in Oregon. The findings are intended to contribute to a

better understanding of how the Oregon Health Authority (OHA) and the Specialists can best address the behavioral needs of older adults and people with physical disabilities in Oregon and best collaborate with professionals from community partner organizations. Different questions were displayed to the stakeholders and Specialists depending on their position, and stakeholders were displayed certain sets of questions depending on their engagement in specific Initiative activities. Comparable survey items are described in this report.

We distributed Stakeholder Surveys in 2017, 2018, and 2019 assessing the impact of the Initiative, how it might improve, and the greatest community successes and barriers. Over time, minor design changes were made to the survey and changes among stakeholder perspectives were analyzed. The 2021 Survey is significantly different from the previous questionnaires. The new instrument takes less time to complete and includes skip patterns to assess stakeholders' perspectives only on the specific activities in which they participated. In contrast to the old versions of the instrument, the new survey instrument excludes many items that assess systems-level issues that the Specialists cannot directly address through their work. A key reason significant changes were made to the survey was to compare stakeholder responses to those from the Specialists.

A total of 763 unique emails were successfully sent to stakeholders, and of those valid cases, 18% (*n* = 137) either partially or fully completed the survey. We emailed questionnaires to all 21 Behavioral Health Initiative Specialists. Thirteen of the 21 Specialists (62%) partially (5%, *n* = 1) or fully completed (57%, *n* = 12) the survey.

Key Findings

Quarterly Reports

Barriers and Gaps in Services

Specialists were asked about each of 16 barriers to serving older adults and people with disabilities who have behavioral health needs that emerged from the 2014 needs assessment. These barriers comprised four categories: (1) physical infrastructure, (2) lack of services and programs, (3) lack of providers, and (4) policy and systems issues. For each barrier, Specialists were asked about the degree to which each was a barrier in their community with the following response categories: (1) "Not at all", (2) "not very much", (3) "to some extent", (4) "to a fair extent", and (5) to a great extent." We treated Specialists' scoring of 4 ("to a fair extent") or a 5 ("to a great extent") as identifying the item as a barrier. As such, when we discuss the percentage of Specialists who identified a barrier as such, we are talking about those Specialists who scored that issue as impacting their community either "to a fair extent" or "to a great

extent". These questions were asked of Specialists every quarter from Q3 2016 through Q2 2017, only during the second and fourth quarters of each year from 2017 through 2019, and only in the third quarter of 2020. Data points presented in tables consist of the second quarter for each of 2020, 2019, 2018, and 2017, and the third quarter of 2016 (the first quarter Specialist Quarterly Report data were collected). While only these select data points are presented in tables, fixed-effects regression analyses describing change across time include all quarters where data were collected.

In the most recent quarter (2020 Q3), the top five challenges reported by Specialists were 1) lack of affordable housing (85%), lack of BH services in LTC (76%), restrictive eligibility criteria (73%), lack of BH services specific to the population (73%), lack of integration (67%) (see Table 1). Across all quarters from 2016 to 2020 shown here, a lack of affordable housing continues to be the greatest barrier to serving older adults and people living with disabilities who have behavioral health needs, with between 85% to 100% of Specialists reporting this as a barrier.

Table 1. Top Five Barriers According to Specialists

#	2016 Q3	2017 Q2	2018 Q2	2019 Q2	2020 Q3
1	Lack of affordable housing (92%)	Lack of affordable housing (94%)	Lack of affordable housing (100%)	Lack of affordable housing (97%)	Lack of affordable housing (85%)
2	Providers not accepting Medicare (92%)	Lack of transportation (77%)	Lack of BH services in LTC (88%)	Restrictive eligibility criteria (83%)	Lack of BH services in LTC (76%)
3	Lack of transportation (88%)	Restrictive eligibility criteria (71%)	Restrictive eligibility criteria (88%)	Lack of BH services in LTC (69%)	Restrictive eligibility criteria (73%)

4	Lack of BH services specific to the population (85%)	Distance to services (71%)	Distance to services (81%)	Lack of integration (69%)	Lack of BH services specific to the population (73%)
5	Lack of providers with CMS credentials (85%)	Providers not accepting Medicare (65%)	Lack of in-home services (81%)	Distance to services (69%)	Lack of integration (67%)

Physical Infrastructure (Housing and Transportation)

When isolating physical infrastructure barriers that specifically asked about housing and transportation, after lack of affordable housing, the prevalence of Specialists who reported that a lack of transportation and distance to services were barriers flipped between 2017 and 2018. While lack of transportation was more often identified as a barrier than distance to services through the end of 2017, this inverted starting in 2018. Specialist rating of transportation (B = 0.00, p = .798) and housing (B = -0.01, p = .225) as a barrier did not change over time, however Specialists' rating of distance to services as a barrier indicated that this barrier has significantly improved (B = -0.04, p = <.001) from July 2016 to December 2020 (Table 2).

Table 2. Percentage of Specialists Reporting Infrastructure Barriers

Barrier	2016 Q3 %	2017 Q2 %	2018 Q2 %	2019 Q2 %	2020 Q3 %	Trend
Lack of affordable housing	92	94	100	97	85	n/s
Lack of transportation	88	77	69	62	58	n/s
Distance to services	73	71	81	69	55	-

Note. All quarters used in fixed-effects regression analysis but only one quarter each year presented in table.

Lack of Services and Programs

Specialists also identified barriers related to services and programs that were in need but unavailable. In the most recent quarter (i.e., Q3 2020), the most challenging service and program barrier was the lack of behavioral health services in long-term care settings such as nursing homes and assisted living residential settings (76%; see Table 3). Additional challenges reported by Specialists in the most recent quarter, in order of prevalence, were lack of behavioral health services specific to the population (73%), lack of in-home services (55%), other (not BH) needed services not available (48%), and lack of prevention or wellness services (42%). The least prevalent services and programs barrier was waitlists are full or would take too long, which 36% of Specialists identified in the third quarter of 2020. From July 2016 through September 2020, Specialist ratings of all barriers relating to services and programs, aside from lack of in-home services and lack of prevention or wellness services (which did not change), significantly decreased. This decrease in services and program barriers identified by Specialists suggests that this category of issues identified in the 2014 needs assessment have been mitigated across the last three years.

Table 3. Percentage of Specialists Reporting Service and Program Barriers

Barrier	2016 Q3 %	2017 Q2 %	2018 Q2 %	2019 Q2 %	2020 Q3 %	Trend
Lack of BH services in LTC			88	69	76	-
Lack of BH services specific to the population	85	61	66	52	73	-
Lack of in-home services	77	61	81	45	55	n/s
Other (not BH) needed services not available	77	55	34	31	48	-
Lack of prevention or wellness services			34	34	42	n/s

Waitlist is full or would take too long	54	48	44	41	36	-

Note. All quarters used in fixed-effects regression analysis but only one quarter each year presented in table. Items asking about the barriers of lack of BH services in LTC and lack of prevention or wellness services were not asked until October 2017.

Policy and Systems Issues

During the most recent quarter (2020 Q3), two of the top five barriers reported by Specialists were policy and systems issues (Table 4). Seventy-three percent of Specialists reported restrictive eligibility criteria and 67% of Specialists reported that a lack of integration among service agencies were barriers. A smaller percent of Specialists identified the barriers of providers not accepting Medicare (55%) and poor communication among agencies (39%). Across time, Specialists rating of all systems barriers aside from lack of integration (which did not significantly change; B = -0.01, p = .473) significantly improved from 2016 Q3 to 2020 Q3).

Table 4. Percentage of Specialists Reporting Policy and Systems Barriers

Barrier	2016 Q3 %	2017 Q2 %	2018 Q2 %	2019 Q2 %	2020 Q3 %	Trend
Restrictive eligibility criteria	77	71	88	83	73	-
Lack of integration	69	48	56	69	67	n/s
Providers not accepting Medicare	92	65	44	59	55	-
Poor communication among agencies	54	26	28	31	39	-

Note. All quarters used in fixed-effects regression analysis but only one quarter each year presented in this table.

Lack of Providers Barriers

While no barriers relating to providers were in the top five barriers reported by Specialists, issues within this category are important to recognize. Important improvements in Specialists reporting of barriers relating to a lack of providers were observed from 2016 Q3 to

2020 Q3. Specialist ratings of a lack of personnel with the required expertise to provide quality behavioral health services as a barrier in their communities declined from 77% in 2016 to 59% as of Q2 2019, a statistically significant improvement (*B* = -0.03, *p* = .002). Since the Centers for Medicare & Medicaid Services (CMS) policies for Medicare limit which types of providers can be reimbursed for services, many otherwise qualified providers cannot receive reimbursement. This limits access to services for those consumers who rely on Medicare for coverage, as these consumers often do not have the means to pay out of pocket for these services. In the most recent quarter, 61% of Specialists perceived a lack of providers with the CMS credentials required to get reimbursed for providing behavioral health services in their communities as a barrier. From Q3 2016 to Q3 2020, Specialist ratings of the lack of CMS credentialed providers as a barrier decreased from 85% to 61%, a significant improvement (*B* = -0.03, *p* = .013). Finally, the Specialist ratings of a lack of primary care providers knowledgeable about behavioral health as a barrier decreased from 69% to 42% between Q3 2016 and Q3 2020, a significant improvement (*B* = -0.03, *p* = .001) (Table 5).

Table 5. Percentage of Specialists Reporting Lack of Providers Barriers

Barrier	2016 Q3 %	2017 Q2 %	2018 Q2 %	2019 Q2 %	2020 Q3 %	Trend
Lack of providers with CMS credentials	85	58	47	59	61	-
Lack of qualified providers	77	45	38	59	45	-
Lack of PCPs knowledgeable about BH	69	52	75	52	42	-

Note. All quarters used in fixed-effects regression analysis but only one quarter per year shown in table.

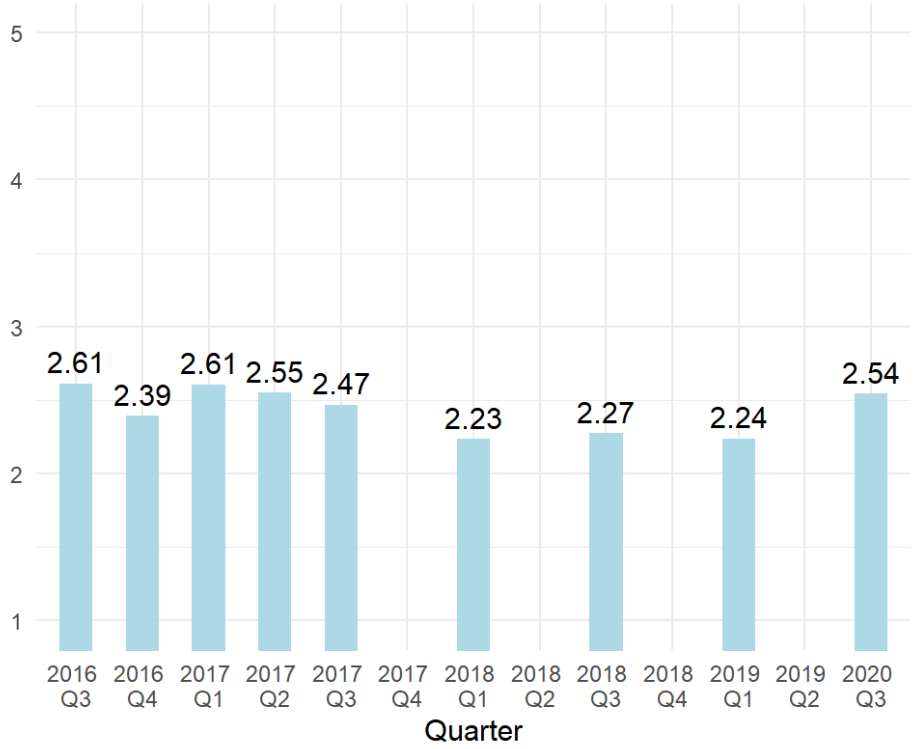
Multi-disciplinary team barriers

Multi-disciplinary teams (MDT) are a formalized group of stakeholders and community partners from diverse backgrounds to address the needs of older adults and people with disabilities with behavioral health needs in Oregon. These teams are an important part of the Initiative's work to increase collaboration and coordination among community partners and to address complex cases with multi-disciplinary stakeholders. Stakeholders and Specialists give positive ratings of the MDTs in which they participate. For instance, a majority of Specialists

(88%) and stakeholders (62%) report that MDTs conclude with agreement on a care plan either considerably or to a great degree. However, only 30% of stakeholders in our most recent stakeholder survey reported participating in one. Over the past five years, we have identified potential barriers to stakeholder participation in MDTs. These include a lack of referrals, stakeholder organizations that do not provide services to specific consumer populations, a lack of needed expertise, among others. From 2016 Q3 through 2020 Q3, Specialists' average rating of these barriers in the communities they served did not significantly change across time and remained in the lower half of the scale (i.e., below 3 out of 5) across time ($B = -0.01$, $p = .150$). However, when excluding the most recent quarter which overlapped with the COVID-19 pandemic that added substantial barriers in many communities, including those served by Specialists, there is a significant improvement in Specialist reported barriers to MDT participation from 2016 Q3 to 2019 Q2 ($B = -0.05$, $p < .001$). This suggests that, excluding the negative impacts of the pandemic, Specialists perceive barriers to MDT participation by stakeholders to be relatively low and to be decreasing across time. Looking specifically at the eight barriers (Figure 3), most barriers to MDT participation remained constant across time.

The exceptions were that Specialist ratings of a lack of MDT availability in their communities ($B = -0.02$, $p = .052$) and of meetings concluding without agreement on a care plan ($B = 0.03$, $p = .045$) increased since 2016 Q3, while their ratings of privacy requirements (e.g., HIPAA) limiting the info sharing necessary for MDTs decreased during that same time period ($B = -0.07$, $p < .001$). A greater understanding of the perceived need and barriers to MDT participation is necessary to understand whether there is a need for greater accessibility to MDTs in communities in Oregon and whether other existing barriers unaccounted for in this report are limiting stakeholders' ability to participate.

Figure 1. Specialists' ratings of multi-disciplinary team barriers



Strategies and Actions for Addressing Barriers

This report now summarizes the strategies and actions of the Specialists designed to address the barriers identified, including building community capacity through collaboration and coordination, training, and complex case consultation (CCC).

Collaboration and Coordination

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

As of September 2020, at least half of the Specialists identified involvement in their regions from the following community partners: aging and disability services (97%), behavioral

health services (85%), residential care (61%), advocacy organization, consumer, or family (58%), primary care clinics (55%), and area Coordinated Care Organizations (52%). With response categories ranging from 1 “not at all” to (4) “a great deal”, both aging and behavioral health services were perceived to be involved in coordination and collaboration somewhat (3) to a great deal (4). Area Coordinating Care Organizations, advocacy organizations, consumers, and family members, primary care clinics, Long-term care, hospital emergency departments, home care / home health care, and veteran services were seen as a little (2) to somewhat (3) involved. Other community partners were seen as having little (2) to no (1) involvement.

From 2016 Q3 to 2020 Q3, community partner involvement as perceived by Specialists remained mostly stable with the exception of four types of organizations (Table 6). A decrease in Specialist reported involvement was observed from Centers for Independent Living (B = -0.03, p = .002), hospitals / emergency departments (B = -0.03, p = .003), and elected government officials (B = -0.02, p = .043), and an increase in Specialist reported involvement was observed from advocacy organizations, consumers, and family members (B = 0.03, p = .002). While the involvement of stakeholders from aging services and older adult services remained high and consistent since 2016 Q3, more effort can be made to increase involvement of other stakeholder groups (e.g., faith communities and tribal organizations), in part by identifying the barriers to their knowledge of and understanding of the Initiative.

Table 6. Perceived Community Partner Involvement in Coordination and Collaboration Activities

Community Partner	2016 Q3 %	2017 Q2 %	2018 Q2 %	2019 Q2 %	2020 Q3 %	Trend
Aging services	85	87	81	100	97	n/s
Behavioral health services	81	90	84	79	85	n/s
Residential care	46	71	69	59	61	n/s
Advocacy organization / consumer / family	50	52	44	62	58	+

Primary care clinic	35	61	47	52	55	n/s
Area coordinating care organization	62	81	72	52	52	n/s
Hospital / emergency department	38	65	50	41	39	-
EMT or similar emergency responder	35	42	28	28	33	n/s
Home care / Home health care	23	42	38	55	33	n/s
Veterans services	38	32	41	21	27	n/s
Local law enforcement	31	35	28	28	15	n/s
Center for Independent Living	31	26	25	10	15	-
Faith community	23	26	16	28	9	n/s
Tribal organization	19	10	16	14	6	n/s
Elected government official	12	26	25	10	6	-

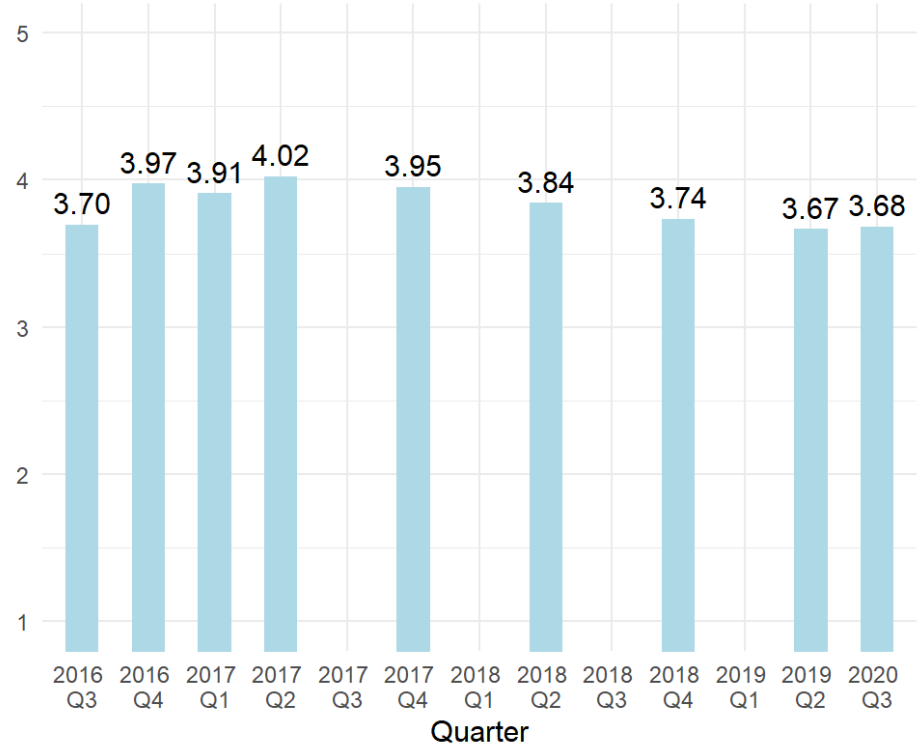
Note. While only one quarter of data for each year is presented in the table, data from all quarters (8) are used in fixed-effects regression analysis. Because percentage calculations are computed with cross-sectional data and regression, and analyses use longitudinal data, there may appear to be some disagreement between percentage trends and regression trends.

Stakeholder Engagement

In their quarterly reports, Specialists were asked to rate six statements (1 = strongly disagree to 5 = strongly agree) about the extent to which core stakeholders were engaged with the Initiative through such activities as expressing support, having direct involvement, having regular contact with the stakeholders, and agreement on gaps and priorities in behavioral

health services for older adults and people with disabilities, among others (see Figure 1 below). Additionally, two items that asked about barriers to engagement with stakeholders (i.e., "In spite of my efforts, core stakeholders are not involved" and "Many core stakeholders are too busy to participate in the Initiative.") were reverse coded so that for all stakeholder engagement items, higher scores mean greater engagement from stakeholders. The majority of Specialists agreed or strongly agreed with these statements. Core stakeholders' engagement in these activities as reported by Specialists did significantly decrease across time (B = -0.02, p = .004). However, after a significant increase in involvement scores was observed from 2016 Q3 to 2017 Q2 (B = 0.07, p = .034), followed by a significant decrease in involvement from the peak in 2017 Q2 to the most recent measurement period in 2020 Q3 (B = -0.04, p < .001), with the most recent two quarters of engagement score (i.e., 2019 Q2 and 2020 Q3) reverting back to 2016 Q3 levels. Variation in engagement scores may be attributed to turnover among Specialists and the length of gaps between hiring a new Specialist. Looking at the specific aspects of stakeholder engagement, there were significant negative trends for stakeholders not being involved despite significant Specialist efforts, Specialists having opportunities to discuss the Initiative with core stakeholders, and agreement on gaps in BH services for consumers.

Figure 2. Specialists' ratings of stakeholder engagement

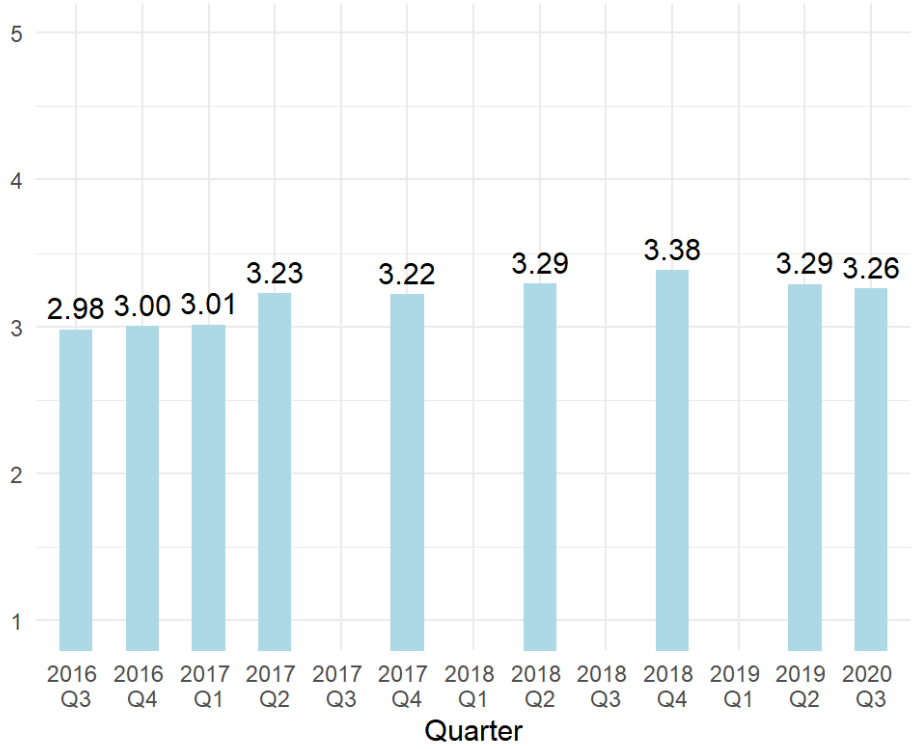


Note. These questions were not asked in 2017 Q3, 2018 Q1, 2018 Q3, and 2019 Q1

Community Capacity Building

Building and supporting community capacity is critically important to the success and sustainability of the Initiative. Specialists reported on 10 indicators of capacity in their communities. Examples of these indicators include: (1) forming a cohesive group to address gaps in services, (2) meeting often enough to make progress in reducing gaps in services, (3) putting formal agreements in place, and (4) ensuring "the right people" are participating in their meetings. A composite score of community capacity was created from the 10 indicators by averaging scores on a scale from 1 "strongly disagree" to 5 "strongly agree" with higher scores reflecting greater community capacity. This includes several reverse coded items that ask about barriers to increasing community capacity (e.g., "Turnover in community partner organizations interferes with momentum."). Since July 2016, Specialist reporting of community capacity in these activities has significantly increased ($B = 0.02$, $p < .001$) (see Figure 2 below). When looking at the ten specific items, the majority of the community capacity indicators significantly improved from 2016 Q3 to 2020 Q3. Specifically, only Specialists reports of community partners engaging in quality improvement ($B = 0.01$, $p = .594$), formal agreements among community partners (e.g., MOUs) are in place ($B = 0.02$, $p = .142$), turnover in community partner organizations interfering with momentum (reverse coded) ($B = 0.01$, $p = .364$), and of the right people who can make changes in agency programs or services are participating in our discussions or meetings ($B = 0$, $p = .643$) did *not* significantly improve across time. Specialist ratings of community capacity significantly improved in the areas of community partners forming cohesive groups, meeting often enough to make progress, moving past old resentments in order to make progress, including consumers at meetings and discussions, improving coordination, and breaking out of silos in order to collaborate.

Figure 3. Specialists' ratings of community capacity



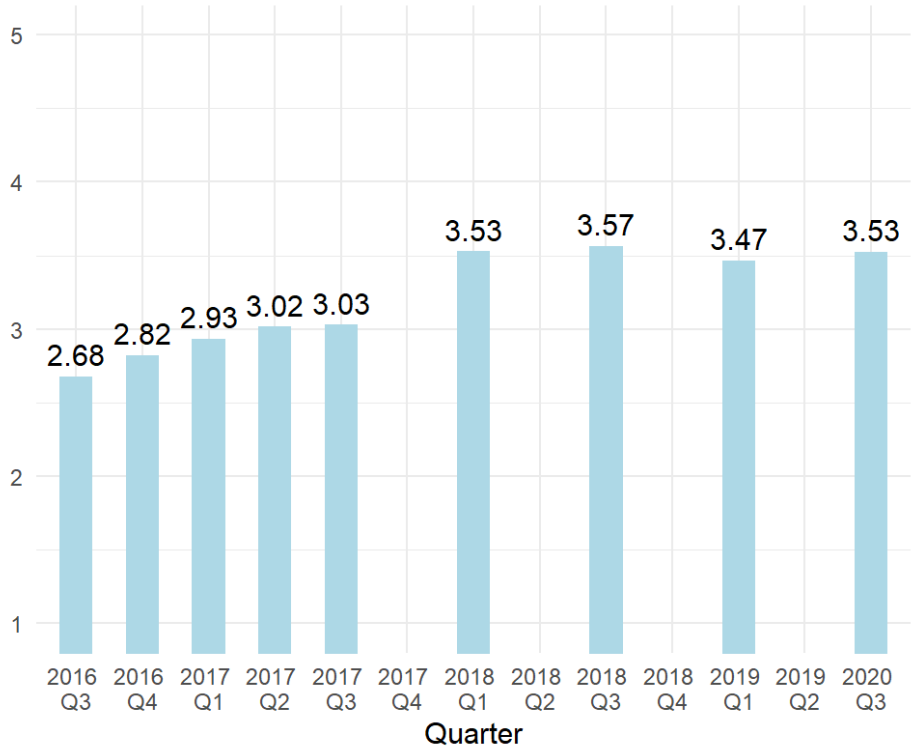
Note. These questions were not asked in 2017 Q3, 2018 Q1, 2018 Q3, and 2019 Q1.

Indicators of Success

Over the past five years, the Initiative has been tasked with improving access to behavioral health services for older adults and people living with disabilities with behavioral health needs, improving collaboration and coordination across stakeholder groups, increasing the knowledge base of service providers in aging services, and other agency types, and improving the collaboration among stakeholders working to address the needs of consumers with complex cases. We identified 13 outcomes that indicate the Initiative's success in achieving its goals. These success indicators include that community partners are more successful in resolving complex cases, credentialed providers are more willing to accept Medicare reimbursement, consumers and family members have greater access to needed services, and emergency department visits have declined, among others. Since 2016 Q3, Specialists average rating of these 13 indicators has significantly increased by almost a full point from a mean of 2.68 in 2016 Q3 to 3.53 in 2020 Q3 on the rating scale from 1 to 5 (Figure 4) ($B = 0.06$, $p < .001$). This indicates that overall, Specialists perceive the Initiative is making a significant and positive impact in communities across Oregon. When reviewing specific success indicators, improvements in five specific areas are found. Specifically, Specialists ratings of

improvements in the ease of making referrals (*B* = 0.03, *p* = .017), increases in credentialed providers willingness to accept Medicare for behavioral health issues (*B* = 0.04, *p* = .001), consumers and family members increases in access to needed services (*B* = 0.03, *p* = .004), a decline in inappropriate hospitalizations (*B* = 0.06, *p* = .006), and an increase in relevant service agencies knowledge about each other (*B* = 0.03, *p* = .007) significantly improved since 2016 Q3 based on fixed-effects models. Notably, no indicator of success significantly declined from 2016 Q3 through 2020 Q3.

Figure 4. Specialists' ratings of indicators of success



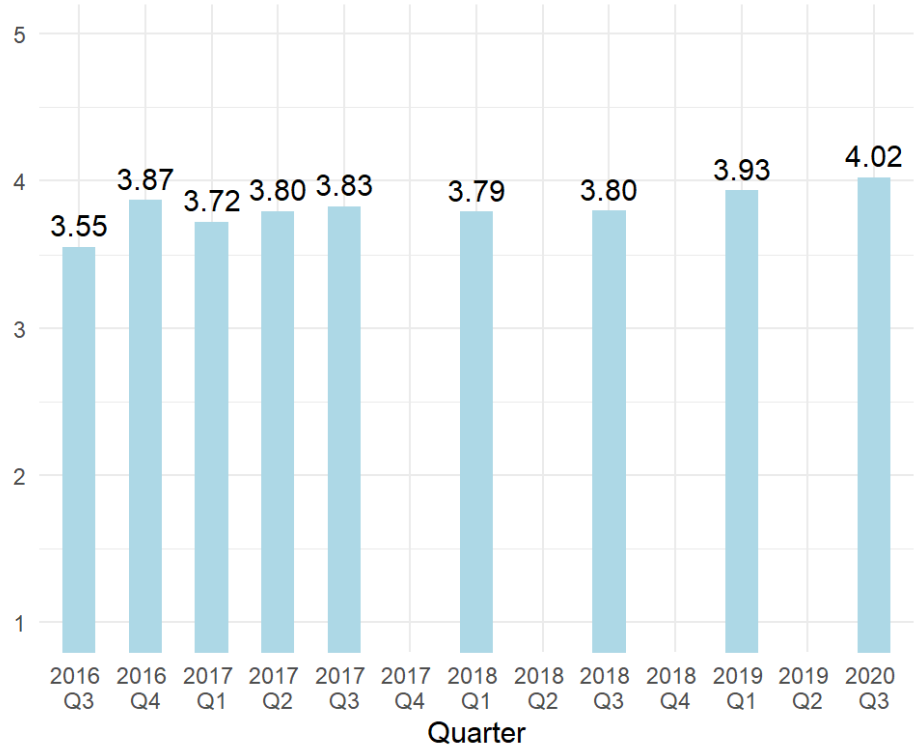
Note. These questions were not asked in 2017 Q3, 2018 Q1, 2018 Q3, and 2019 Q1.

Training

The PSU Evaluation Team asked Specialists about the type of support for workforce development and community education events they receive from stakeholders and community partners. Specifically, Specialists report on the degree to which they agree that stakeholders in their communities' co-sponsor training, provide release time for staff to attend, contribute space or other resources for training, and serve as trainers or content experts at training. Since 2016 Q3, Specialist reports of stakeholder support for training events significantly increased (*B*

= 0.02, *p* = .011). Specifically, two of the four forms of stakeholder support for training have significantly improved over time. This includes stakeholders providing support by co-sponsoring training (*B* = 0.02, *p* = .024) and through serving as a trainer or content expert at Specialist hosted training has significantly improved (*B* = 0.04, *p* = .003) (Figure 5).

Figure 5. Specialists' ratings of support for training from stakeholders



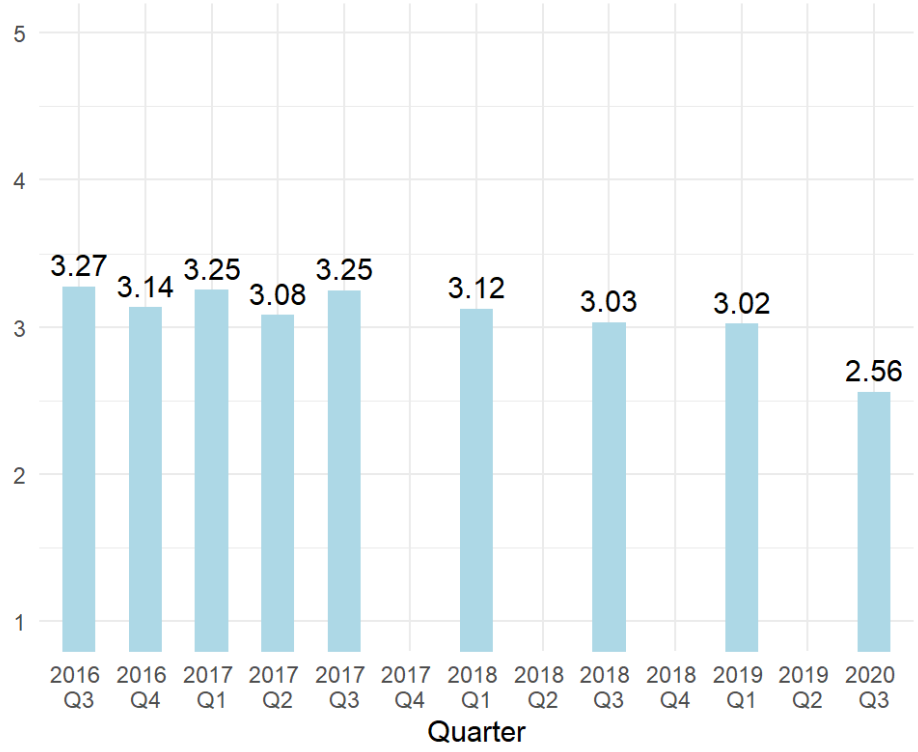
Note. These questions were not asked in 2017 Q4, 2018 Q2, 2018 Q4, and 2019 Q2.

Barriers to stakeholder involvement in training

While stakeholder participation in, support of, and ratings of workforce development and community education events remains strong, it is still important to identify potential barriers for some stakeholders to participate in Specialist hosted training events. We asked Specialists how much they agree with statements about seven possible barriers for stakeholders' participation. Overall, since 2016 Q3 (Figure 6), Specialists average ratings of stakeholder barriers to training participation have decreased (B = -0.04, p = 0). More specifically, five out of the seven potential barriers have improved. This includes improvements in resolving difficulty scheduling training, staff difficulty in getting time away from work to attend, prohibitive travel cost, needed expertise that is unavailable, and training materials that

do not meet community needs. The only barriers to training involvement that did not improve were last-minute emergencies that affected staff ability to attend training and a lack of stakeholder interest in the training topics offered. While last minute emergencies are unavoidable and outside of the Initiative's purview, it is important to identify potential training topics that are of greater interest to stakeholders.

Figure 6. Specialists' ratings of training barriers

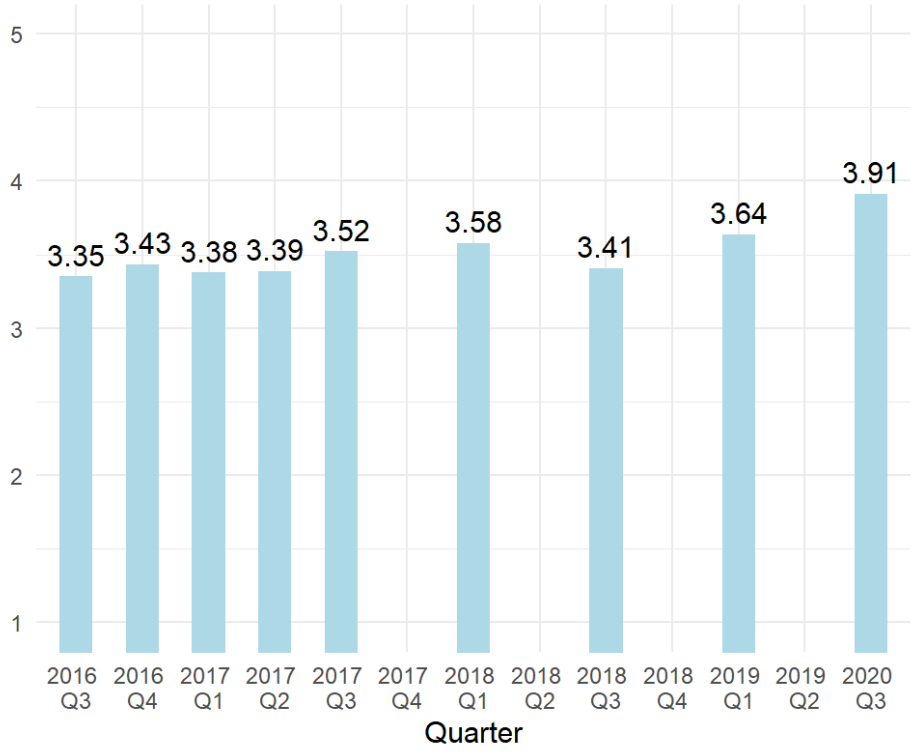


Note. These questions were not asked in 2017 Q4, 2018 Q2, 2018 Q4, and 2019 Q

We tracked Specialist ratings of the positive outcomes of workforce development and community education events along five areas. These include Specialist agreement on whether interest in training is increasing, attendance is reaching a "critical mass" needed to improve services, new training partners have been identified, services provided to consumers have increased as a result of training. and consumers are more likely to have their signs and symptoms recognized as a BH need rather than due to aging. On average, since 2016 Q3, Specialist ratings of training outcomes have significantly increased ($B = 0.03$, $p < .001$) (Figure 7). More specifically, all five positive training outcomes significantly increased across time. Overall, this indicates that training hosted by Specialists are achieving the intended outcomes and leading to an increase in community partner knowledge base with some indication that

services to consumers with BH needs are also improving (e.g., increase in likeliness of consumers signs and symptoms to be recognized as a BH need when that is the case).

Figure 7. Specialists' ratings of training outcomes



Note. These questions were not asked in 2017 Q4, 2018 Q2, 2018 Q4, and 2019 Q2.

Training: Workforce Development, Post-Training Evaluations

This section summarizes post-training evaluations for trainings that occurred during the reporting period, from July 2019 through December 2020. Where relevant, comparisons with the previous reporting period (October 2017 through June 2019) and across all quarters (October 2017 through December 2020) are presented. From July 2019 through December 2020, 311 workforce development training events were planned, conducted, or sponsored by the Specialists (fewer than during the previous reporting period due to having one less quarter

of measurement and due to training limitations from the COVID-19 pandemic; 507 trainings from October 2017 through June 2019), with an average of 52 events per quarter. A total of 3,188 training participants fully completed and 3,229 fully or partially completed the online evaluation of the training.

Response rates for specific events varied within and across periods. However, across all periods from October 2017 through December 2020, average response rates did not significantly change based on a bivariate regression model predicting response rates by quarter (p = .159). During the most recent reporting period (July 2019 through December 2020), response rates for specific events ranged from two percent to 39%. Four percent of event(s) received no response. Most events (76%) had response rates between 21 and 60 percent, which was a higher share than during the previous period (63%). Only two percent of events had response rates over 80%, which was the same as during the previous period.

Respondents were asked about their position. During the current reporting period (July 2019 through December 2020), 31% were direct service or primary care providers; 13% were middle managers, program managers, or clinical directors at their organization or agency; 11% were lay persons or advocates; and 4% were agency administrators or executive directors. The largest group of respondents (42%) selected the "Other" category, which included job titles such as ***case managers, police officers, behavior consultants, and eligibility specialists***. The distribution of these agency role categories has remained consistent between the two reporting periods (p = .074).

Table 7 (below) shows the types of organizations where respondents work. From July 2019 through December 2020, the largest group of respondents 29% reported working for a community partner other than the categories listed. When prompted, they provided a wide range of organization types ***including higher education, the Oregon Department of Human Services (ODHS), law enforcement, and housing***. Twenty-eight percent of respondents reported working for a behavioral health services organization, and 26% reported working at an aging and disability service agency. A smaller share reported working for health services (10%) or long-term services and supports (8%). The distribution of these categories has somewhat changed over time across periods, based on significant p-value for Pearson's chi-square test (p < .001). A slightly smaller share of training participants were from aging and disability services compared to last reporting period (26% vs. 30%). A slightly larger share of training participants were from behavioral health services (28% v. 24%) compared to the previous reporting period. The diversity and variation in respondents' occupations highlights the extent to which the Specialists are striving to create a knowledgeable workforce in their communities prepared to support older adults and people with disabilities who have behavioral health needs.

Table 7. Respondents' organization/agency

Type of agency	2017 Q4 - 2019 Q2 % (n)	2019 Q3 - 2020 Q4 % (n)	Total % (n)
Aging and Disability Services	30% (877)	26% (863)	28% (1,740)
Behavioral Health Services	24% (704)	28% (917)	26% (1,621)
Health Services	12% (362)	10% (326)	11% (688)
Long-Term Services and Supports	6% (183)	8% (251)	7% (434)
Other Community Partner	28% (811)	29% (969)	28% (1,780)
Total	100% (2,937)	100% (3,326)	100% (6,263)

Note. Percentages may not add up to 100 due to rounding. Total column includes counts and percentages for all periods from 2017 Q4 to 2020. Q1.

We asked participants to rate their level of knowledge about the training subject before they attended the training (Table 8 below). During the current reporting period (July 2019 through December 2020), almost all (98%) reported having at least a little knowledge before the training. However, only seven percent of training participants reported having a great deal of knowledge. Most respondents fell in the middle of response options with the largest group reporting a moderate amount of knowledge (40%). Participants reported knowledge prior to training showed a small significant increase between 2017 Q4 and 2020 Q4 ($B = 0.01$, $p < .001$). While this trend is statistically significant, it reflected a .01 point increase in ratings of previous knowledge per quarter, suggesting a very small real world effect that warrants some caution with interpretation. This effect is reflected in the slight increase from 72% having at least a moderate amount of knowledge during the previous reporting period compared with 75% this period as well as the slight decrease in the share of participants having little or no prior knowledge from the previous period (28%) to the current period (25%).

Table 8. Knowledge Rating Before Attending the Training

Knowledge before training	2017 Q4 - 2019 Q3 % (n)	2019 Q3 - 2020 Q4 % (n)	Total % (n)
Nothing at all	3% (96)	2% (76)	3% (172)
A little	25% (721)	23% (761)	24% (1,482)
A moderate amount	39% (1,147)	39% (1,313)	39% (2,460)
A good deal	27% (801)	29% (957)	28% (1,758)
A great deal	6% (172)	7% (219)	6% (391)
Total	100% (2,937)	100% (3,326)	100% (6,263)

Note: Percentages may not add up to 100 due to rounding. Total column includes counts and percentages for all periods from 2017 Q4 to 2020.

According to training participants, training events provide them with valuable information. During this measurement period from July 2019 through December 2020, when asked about how much they learned as a result of the training 69% reported having learned at least a good (46%) or great (23%) deal of knowledge, and another 22% reported they learned a moderate amount (see Table 9 below). Far fewer respondents (9%) reported having learned a little or nothing at all. Participants' positive ratings of how much training events have provided valuable information have stayed stable from 2017 Q4 to 2020 Q4 ($F(1, 6261) = 2.931$, $p = .087$).

Table 9. Knowledge after the training

Knowledge gained	2017 Q4 - 2019 Q3 % (n)	2019 Q3 - 2020 Q4 % (n)	Total % (n)
Nothing at all	1% (18)	1% (18)	1% (36)
A little	8% (242)	9% (284)	8% (526)
A moderate amount	20% (601)	22% (733)	21% (1,334)
A good deal	47% (1,371)	46% (1,536)	46% (2,907)
A great deal	24% (705)	23% (755)	23% (1,460)
Total	100% (2,937)	100% (3,326)	100% (6,263)

Note. Percentages may not add up to 100 due to rounding. Total column includes counts and percentages for all periods from 2017 Q4 to 2020 Q4.

An important workforce development objective is for training participants to be able to use their knowledge gains in their work (we ask training participants whether they were confident that they would be able to do so). Similar to previous periods, during the most recent measurement period from July 2019 through December 2020, a majority of respondents (80%) reported being pretty or extremely confident that they would be able to use the knowledge they gained in their work (Table 10 below). Only a small group of respondents (5%) reported being slightly or not confident at all. The average score of training participants' confidence to be able to use their knowledge gains in their work on a scale from 1 to 5 was 4.05, reflecting "pretty confident". Across all quarters from 2017 Q4 to 2020 Q4, participants' ratings of confidence to use knowledge gained from training remained stable ($F(1, 6{,}179) = 3.55$, $p = .060$). The consistently high average ratings found in both the current ($M = 4.05$, $SD = 0.85$) and previous reporting period ($M = 4.10$, $SD = 0.84$) suggests that participants continue to feel confident to use the knowledge gained from training.

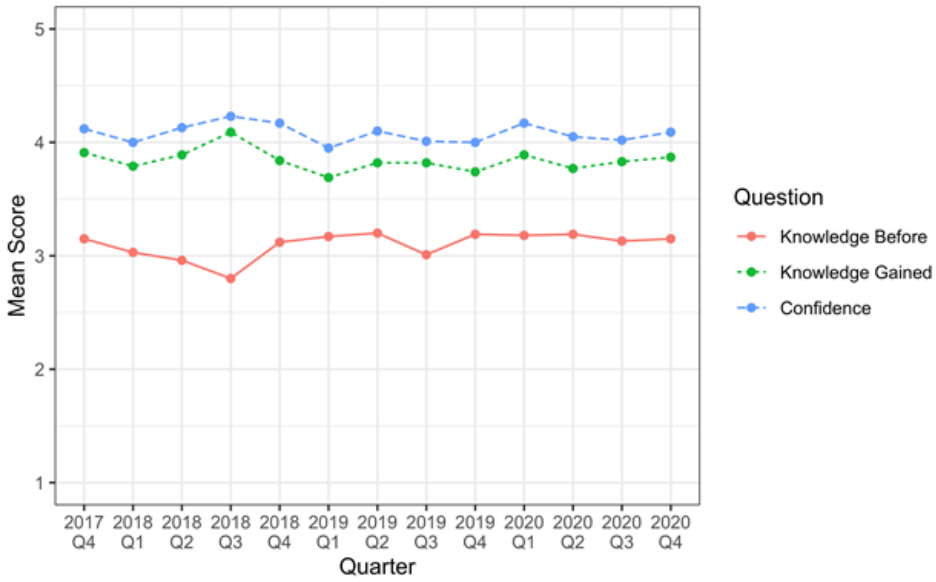
Table 10. Confidence to use knowledge gained in work

Confidence to use knowledge	2017 Q4 - 2019 Q3 % (n)	2019 Q3 - 2020 Q4 % (n)	Total % (n)
Not at all confident	1% (29)	1% (39)	1% (68)
Slightly confident	4% (124)	4% (129)	4% (253)
Moderately confident	12% (360)	15% (484)	14% (844)
Pretty confident	49% (1,416)	49% (1,609)	49% (3,025)
Extremely confident	34% (973)	31% (1,018)	32% (1,991)
Total	100% (2,902)	100% (3,279)	100% (6,181)

Note: Percentages may not add up to 100 due to rounding. Total column includes counts and percentages for all periods from 2017 Q4 to 2020 Q1.

Next, the PSU Evaluation Team examined changes in mean scores over time for reported knowledge prior to training, perceived knowledge gains as a result of training, and confidence in ability to use the knowledge gained from training (Figure 8 below). From 2017 Q4 through 2020 Q4, training participants' ratings of knowledge prior to trainings increased significantly, suggesting a gradual increase in the knowledge base of community members in Specialist communities. Average ratings of knowledge gained from training and participants' confidence to use this knowledge remained steadily around a 4 out of 5, suggesting that participants on average "slightly agree" with these training impact indicators.

Figure 8. Means of pre-training knowledge, knowledge gains attributed to training, and confidence items across periods



Training/workshop characteristics

During reporting periods, from July 2019 through December 2020, we asked training participants several questions about the training/workshop, the trainer(s), and the environment in which the training took place. Overall, participants were very positive regarding the contributions of the training to their work (Table 11 below). Most participants somewhat or strongly agreed that the training met their expectations (89%) and that training provided information that would be useful in their work (91%).

It is important to have the support of employers for workforce events since they can help address barriers to training through co-sponsoring, providing release time, and contributing space. Most participants (90%) perceived that the training topic was in an area supported by their employer. It is also important that the training topics are relevant to both older adults *and* people living with disabilities who have behavioral health needs as the Initiative focuses on both of these groups. A majority of training participants somewhat or strongly agreed that the training prepared them to work with or advocate for these two populations (87% and 82%, respectively).

Table 11. Participant perception of training/workshop characteristics

The training/workshop:	Strongly disagree % (n)	Somewhat disagree % (n)	Neither agree nor disagree % (n)	Somewhat agree % (n)	Strongly agree % (n)
Met my expectations	3% (97)	2% (74)	6% (190)	18% (600)	70% (2,294)
Presented information that will be useful in my work	3% (80)	1% (46)	5% (156)	21% (664)	70% (2,234)
Is an area supported by my employer	2% (69)	1% (27)	7% (212)	17% (512)	72% (2,129)
Prepared me to work with/advocate for older adults with BH needs	3% (80)	2% (59)	8% (257)	26% (822)	61% (1,916)
Prepared me to work with/advocate for people with disabilities with BH needs	3% (90)	2% (76)	12% (381)	29% (908)	53% (1,660)

Note. Percentages may not add up to 100 due to rounding.

From July 2019 through December 2020, most participants perceived the trainer(s) to be prepared, knowledgeable (94%), and responsive to their questions (Table 12 below). Almost all training participants somewhat or strongly agreed that trainers were well prepared (93%), that the trainer(s) gave clear explanations of the training topic (94%), and that the trainer(s) welcomed questions and responded to them appropriately (92%). Participant rating of trainers remained consistent across reporting periods.

Table 12. Participant perception of trainer(s): July 2019 through December 2020 data only

The trainer/workshop:	Strongly disagree % (n)	Somewhat disagree % (n)	Neither agree nor disagree % (n)	Somewhat agree % (n)	Strongly agree % (n)
Was/were well prepared	3% (88)	1% (32)	3% (109)	23% (746)	70% (2,304)
Gave clear explanations of the topic	3% (86)	1% (25)	3% (99)	23% (769)	70% (2,300)
Welcomed questions and responded to them appropriately	3% (92)	1% (27)	4% (142)	20% (669)	72% (2,349)

Training participants were mostly satisfied with the environment in which the training took place (Table 13 and Table 14 below). Similar to previous periods, during the current measurement period from July 2019 through December 2020, a majority of participants (84%) agreed or strongly agreed that the time allotted for the training was sufficient. Seventy percent reported that the meeting room and facilities were adequate and comfortable. Finally, 83% agreed or strongly agreed that the training took place at a location that worked well for them. Since 2020 Q2 most training events occurred virtually due to the COVID-19 pandemic so the meaning of agreement that the meeting room and facilities were adequate and comfortable and that the training was in a location that worked well for participants are somewhat ambiguous.

Table 13. Participant perception of training environment

The environment/workshop:	Strongly disagree % (n)	Somewhat disagree % (n)	Neither agree nor disagree % (n)	Somewhat agree % (n)	Strongly agree % (n)
The time allotted for the training was sufficient	3% (94)	6% (208)	7% (239)	32% (1,052)	51% (1,686)
The meeting room and facilities were adequate and comfortable	2% (75)	2% (60)	25% (809)	20% (655)	51% (1,680)
The training was in a location that worked well for me	2% (74)	1% (34)	14% (463)	18% (593)	65% (2,115)

Table 14. Means of post-training evaluation items over time

	2017 Q4 - 2019 Q2 M	2019 Q3 - 2020 Q4 M	Linear Trend
The training/workshop:			
Met my expectations	4.46	4.51	+
Presented information that will be useful in my work	4.53	4.55	n/s
Is an area supported by my employer	4.58	4.56	n/s
Prepared me to work with/advocate for older adults with BH needs	4.32	4.42	+
Prepared me to work with/ advocate for people with disabilities with BH needs	4.21	4.28	+
The trainer(s):			
Was/were well prepared	4.61	4.57	n/s
Gave clear explanations of the topic	4.58	4.58	n/s
Welcomed questions and responded to them appropriately	4.65	4.57	-
The environment/logistics:			
The time allotted was sufficient	4.23	4.23	+
The meeting room and facilities were adequate and comfortable	4.43	4.16	-
The training was in a location that worked well for me	4.59	4.42	-

Note. Only valid responses were included in calculation of means (i.e., excluding not applicable responses). All items range from 1 (strongly disagree) to 5 (strongly agree). The statistical significance for linear trend was tested using ordinary least squares (OLS) regression with period (from 2017 Q4 to 2020 Q4) entered as a continuous independent variable. In the "Linear Trend" column, "+" indicates significant positive linear trend, "-" indicates significant negative linear trend, and n/s indicates not statistically significant.

Other respondent characteristics

Respondents were asked their highest level of education. In the most recent reporting period July 2019 through December 2020, the largest share of participants held a master's degree (37%), and 69% of respondents had a four-year/Bachelor's degree or higher. No participants had less than high school, and only three percent were high school graduates. The distribution of training participant education varied between the previous and current reporting periods $c^2(6) = 22.6$, $p < .001$). Compared to the previous reporting period, a slightly smaller share of participants held a bachelor's degree or equivalent (35% vs. 30%), and a slightly larger share held a master's degree or higher (35% vs. 39%).

Respondents were also asked whether they had any of the credentials from a list provided (see Table 15 below). A greater share of participants reported having any number of credentials this period compared to the previous reporting period. During the current reporting period, 34% of respondents reported having one of these credentials (vs. 13% previously), 3% had two (vs. 1% previously), and less than 1% ($n = 9$) had three of these credentials (vs. 0% [$n = 9$] previously). Less often (5% previous; 6% current), stakeholders also reported the following credentials: PhD, ACSW, LPN/LVN, LMFT, NP, CADAC, MD/DO, and PA.

Table 15. Respondent credentials

Credentials	Previous % (n)	Current % (n)
None	66% (874)	61% (2,088)
MA/MS/MSW	12% (158)	15% (501)
LCSW	8% (102)	8% (283)
RN	5% (69)	5% (179)
LPC	2% (25)	3% (100)
CAN/CMA	3% (37)	3% (86)
Other	5% (63)	6% (201)
# of Respondents	100% (1,328)	100% (3,438)

Note. Percentages do not add up to 100 because 31 participants reported having multiple credentials in the previous reporting period and 98 did so currently. The "other" category includes credentials that were reported

less than 3% of the time which include PhD, Academy Certified Social Worker (ACSW), Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN), Licensed Marriage and Family Therapist (LMFT), Nurse Practitioner (NP), Certified Alcohol and Drug Counselor (CADC), Medical Doctor/Doctor of Osteopathy (MD/DO), and Physician's Assistant (PA).

Direct care service

Respondents were asked about the time of their job involved in direct care service to clients, consumers, or patients. During the current reporting period from July 2019 through December 2020, 77% of respondents reported providing at least some direct care service and 57% were providing direct care at least half of the time. However, only 36% reported providing care at least 75% of the time. During the current reporting period compared with the previous period, participants provided more direct care with a larger share providing at least some direct care (77% vs. 33%).

Demographics (gender, age, tenure at main job, and rural/urban)

For the most recent reporting period (from July 2019 through December 2020), 82% of respondents were female, 16% were male, and 1% were non-binary, questioning, transwomen, or transmen. There was no difference in the distribution of gender between the previous and current reporting periods. As expected, the majority of respondents were between the ages of 25 and 64 (87%). About 12% were 65 or older. Only one percent of respondents were 24 or younger. There were no differences in the age distribution between the previous and current periods.

Among respondents who reported how long they have been continuously working at their main job for their present employer during the current reporting period from July 2019 through December 2020 (*n* = 2921; 89% of all respondents), the median was 3 years and the average was 5.5 years. The response rate and median for the current reporting period were similar to the previous reporting period, though the mean tenure was almost 6months lower during the previous period (*M* = 5.1). Seventy-five percent of respondents had been working at their main job for their present employer for 7 years or more which was slightly greater than in the previous reporting period (75th percentile: 6.4years).

Finally, among respondents with non-missing and valid responses (*n* = 2,111; 63% of all respondents), 54% defined their work/service area as urban or mostly urban. The remaining 46% were working or providing services in areas perceived by respondents to be rural or mostly rural.

Training: Follow-Up Evaluation

The PSU Evaluation Team attempted reaching out for a two-month follow-up training evaluation to all 16,604 training participants who filled out their valid emails in rosters submitted by the Specialists. One thousand, two hundred and forty-seven emails failed to reach participant email servers (i.e., bounced back), resulting in 15,357 training participants that could have responded to the two-month follow-up evaluation survey. Participants had two weeks to complete the questionnaire. Non-respondents received a reminder email one week after the initial attempt. Overall, 3011 participants filled out the questionnaire for a response rate of 20.0 percent – similar to recent quarters (Table 16 below).

Table 16. Response patterns for all training participants with names on rosters by quarter

Response Category	2017 Q4 - 2019 Q2	2019 Q3 - 2020 Q4	Total
a. Number of Names on Rosters	7,797	8,858	16,655
(-) Names w/o Valid Email	25	13	38
(-) Duplicate Email	2	11	13
b. Total with Valid Email	7,770	8,834	16,604
(-) Bounced Emails	701	546	1,247
c. Emails Successfully Sent Out	7,069	8,288	15,357
d. Opted Out	175	369	544
e. Fully Completed	1,469	1,542	3,011
f. Response Rate (e/c)	21.0%	19.0%	20.0%

Note: Partial responses were not allowed for this evaluation considering the brief nature of the questionnaire. Open-ended questions did not count toward full responses.

There was large variation in response rates across training events from October 2017 through December 2020, ranging from 0 to 67 percent, with thirty-one events (13% percent) receiving no responses and thirty events having response rates higher than 40 percent. The median response rate across training events for both the most recent and the previous reporting periods was 17 percent. The distribution of response rates ($\chi^2(5) = 21.6$, $p < .001$) significantly differed between the previous and current reporting periods (though the average response rate did not; $T(603) = 0.363$, $p = .717$). Follow-up training from the previous quarter had a greater share of zero responses and a lower share of responses from 1 to 20% compared with the current reporting period.

Respondents were asked whether they agreed or disagreed with a set of ten statements related to their and their agency's use of knowledge gained from trainings that they attended. Respondents were given the option of selecting "don't know" or "not applicable" for each statement. The PSU Evaluation Team calculated the percent of respondents agreeing or strongly agreeing with these statements by excluding "don't know" and "not applicable" and summarized the results in a graph (see Figure 9 below).

During the current reporting period, a majority of participants agreed or strongly agreed with nine out of the ten items asking about their agencies' use of knowledge gained from trainings. Across all items, the percentage of participants who agreed or strongly agreed was similar between the current and previous reporting period.

Agency, Supervisor, and Co-Workers

During the current reporting period, most respondents (87 percent) agreed or strongly agreed that their supervisors were supportive of them using the knowledge and skills gained from trainings. A high share of respondents (78 percent) reported having shared information from the training with their co-workers. A majority of respondents (74 percent) agreed or strongly agreed that their agency has the staff and resources needed to apply the information presented in the training. Finally, a smaller proportion (31 percent) of respondents agreed or strongly agreed that their agency was using screening or assessment tools they learned about at the training.

Better Services to Older Adults and People with Disabilities

A majority of respondents reported that they were providing better services to older adults (62 percent) and people with disabilities (61 percent) as a result of the training.

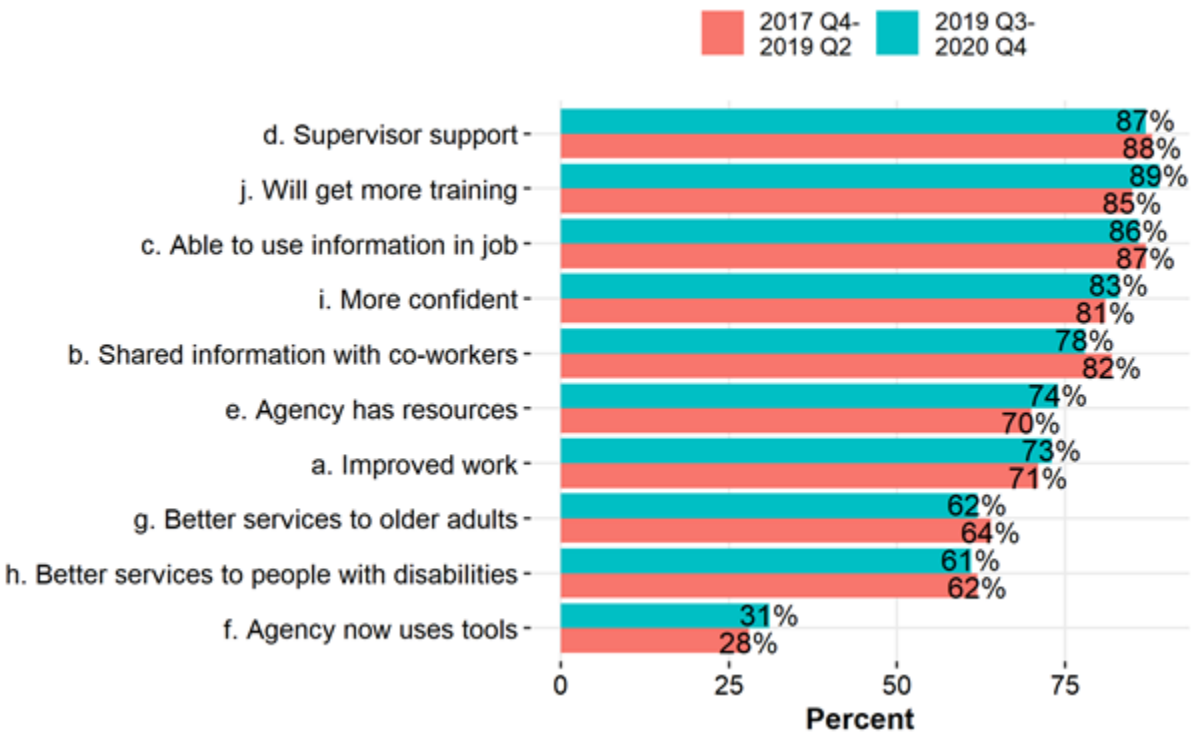
Use of Knowledge

Most respondents agreed or strongly agreed that they were able to use information from the training in their jobs (86 percent), and that the way they do their work improved as a result of the training (73 percent). Finally, 83 percent agreed or strongly agreed that the training gave them more confidence in their ability to meet the needs of older adults and people with disabilities with behavioral health needs.

Plans for Future Trainings

Overall, most respondents (89 percent) were planning to get additional training on behavioral health and older adults or behavioral health and people with disabilities in the future.

Figure 9. Respondents who agree or strongly agree with each statement by reporting period, excluding "don't know" and "not applicable" responses



Training: Community Education

Community education participants were asked the following questions in relation to the content of their training on a scale from 1 (strongly disagree) to 7 (strongly agree). Table 17 provides the questions asked about each community event. Table 18 below shows the mean scores for each item in the community education evaluation for participants who filled out the evaluation during the current reporting period from July 2019 to December 2020.

Table 17. Community Event Evaluation Questions

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

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

During the current reporting period, from July 2019 through December 2020, community education evaluation scores were similar to previous quarters. Participants somewhat agreed (5) to agreed (6) with statements about increased knowledge about the issue, increased well-being skills, greater awareness of warning signs, increased knowledge about where to get more information, and about recommending this presentation to others. Additionally, respondents agreed (6) or strongly agreed (7) that the location and time of community education events were convenient.

Table 18. Community Education Evaluations from July 2019 to December 2020

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

Complex Case Consultations (CCC)

Complex case consultation (CCC) is a core job function of the Specialists' work. CCCs promote a multi-disciplinary team and multi-morbidity approach to ensure older adults and people with disabilities receive the appropriate help at the right time and at the right level of care. Keeping detailed track of these CCCs is intended to inform the Initiative as well as key stakeholders of the types of consultations, reasons for consultations, and outcomes of consultation meetings in communities throughout Oregon. Consequently, this information is critical to informing policy about services and resources needed by this population.

Specialists across Oregon used a data entry tool to collect information about each CCC in which they participated between October 2017 and December 2020. From October 2017 through December 2020, Specialists reported participating in a total of 4,627 CCCs that took place in at least 30 counties. During the most recent reporting period from July 2019 through December 2020, Specialists reported participating in a total of 1,993 CCCs that took place in at least 28 counties. These CCCs constitute the primary sample for this report. Where relevant and available, comparisons between the current reporting period and the previous period, from October 2017 through June 2019 are provided. These comparisons are provided statistically where relevant (i.e., using chi-square analysis for categorical data and analysis of variance and regression for numeric data), and narratively where appropriate.

Complex Case Consultations: Demographic Data

During the current measurement period (from July 2019 through December 2020), focusing only on cases with non-missing information, consumers were slightly more likely to be female (52%; Table 19), similar to the gender distribution for the previous reporting period (52% female), and across all quarters (52% female) ($\chi^2(4) = 1.77$, $p = .78$).

Table 19. Gender of Consumers Involved in Consultations

Gender	'17Q4 - '19Q2 Valid % (n)	'19Q3 - '20Q4 Valid % (n)	All Valid % (n)
Female	52% (1,373)	52% (1,029)	52% (2,402)
Male	47% (1,240)	48% (953)	48% (2,193)
Transfeminine (Transwoman)	<1% (2)	<1% (2)	<1% (4)
Transmasculine (Transman	0% (0)	0% (0)	0% (0)
Questioning	<1% (1)	0% (0)	<1% (1)
Other	<1% (1)	<1% (1)	<1% (2)
Total	**100% (2,617)**	**100% (1,985)**	**100% (4,602)**

Notes. Percentages may not add up to 100 due to rounding.

During the current reporting period, focusing only on cases with non-missing information, the largest age group was 65-74 consisting of 35% of all CCCs, followed by consumers who were younger than 60 (26%). Only 4% of consumers were 85 years and older. The age distribution for the previous measurement period was similar, with the largest age group being between 65-74 (34%), followed by consumers who were younger than 60 (24%) and between 60-64 (18%, across all quarters: 19%). The age distribution of consumers was slightly but significantly younger between July 2019 through December 2020 than between October 2017 through June 2019 ($\chi^2(4) = 19.2$, $p < .001$).

During the current reporting period, focusing only on cases with non-missing information, specialists reported that only 7% of consumers were veterans and 93% were not (among cases with known veteran status). Specialists either reported that veteran status was

not known or had missing data for 23% of cases during the current reporting period and 24% of cases during the previous reporting period. A slightly, but significantly smaller share CCCs involved consumers who were veterans during the current reporting period compared to the previous period ($\chi^2(1) = 10.57$, $p = .001$).

From July 2019 through December 2020, in 45% of cases with non-missing data, consumers had a known physical disability, slightly but significantly higher than the share from the previous reporting period 41% ($\chi^2(1) = 1.55$, $p = .212$).

Finally, between July and December 2020, we collected information about the race/ethnicity of consumers involved in a complex case consultation (Table 20). Fifty-four percent of consumers were White, 3% were Hispanic or Latino, 3% were American Indian or Alaskan Native, and 2% of cases were Black or African American. For 38% of these cases, Specialists reported that they did not know the race of the consumer (37%), or the race of the consumer isn't included in the list (1%).

Table 20. Race/ethnicity (2020 Q3 & 2020 Q4 only)

Race/ethnicity	n	%	Valid %
White	294	54%	85%
Hispanic or Latino	17	3%	5%
American Indian or Alaskan Native	16	3%	5%
Black or African American	12	2%	3%
Not included in this list	5	1%	1%
Native Hawaiian or Other Pacific Islander	2	0%	1%
Asian or Asian American	0	0%	0%
Missing/non-standard/don't know	202	37%	-
Total	**548**	**100%**	**100%**

Notes. Data on consumer race/ethnicity were collected beginning in 2020 Q3. Missing or non-standard values were found for 24% (133) of cases and "don't know" values were found for 13% (69) of cases from 2020 Q3 through 2020 Q4. Percentages may not add up to 100 due to rounding.

Complex Case Consultations: Planning Status and Structure

During the current reporting period, in cases with non-missing information, Specialists reported having consulted on the consumer on a previous occasion in 40% of cases. This is significantly more than in the previous reporting period 35% ($\chi^2(1) = 11.66$, $p < .001$).

Focusing only on cases with valid responses, over half of all consultations were planned during the current reporting period (56%), a slight but significant increase compared to the previous reporting period (53%; $\chi^2(1) = 4.78$, p = .029).

Focusing only on cases with valid responses, during the current reporting period, 44% of cases involved staff from multiple departments, organizations or disciplines – in the form of people from multiple organizations/departments (14%) or multidisciplinary teams (30%) (Table 21). Compared to the previous reporting period, double share of CCCs were MDTs this period (30%) compared to last period (15%). The distribution of the structure of CCCs changed across reporting periods based on a significant chi-square test ($\chi^2(3) = 251.76$, $p < .001$).

Table 21. Structure of the complex case consultation

Structure of CCC	'17Q4 - '19Q2 Valid % (n)	'19Q3 - '20Q4 Valid % (n)	All Valid % (n)
Single Org. (Individual)	38% (998)	43% (668)	40% (1,666)
Single Org. (Team)	13% (350)	13% (205)	13% (555)
Multiple Org./Multiple Departments	33% (863)	14% (217)	26% (1,080)
Multidisciplinary Team	15% (398)	30% (476)	21% (874)
Total	**100% (2,609)**	**100% (1,566)**	**100% (4,175)**

Notes. Due to a change in the reporting tool that made this item optional to report starting in 2020 Q3, a larger share of cases during the current reporting period (21%, *n* = 427) included missing, non-standard, or "don't know" responses compared to the previous reporting period (1%, *n* = 25). Percentages may not add up to 100 due to rounding.

Complex Case Consultations: Referral Source, Residence and Residence Change

The PSU Evaluation Team asked about the referral sources of the CCCs at the beginning of the current measurement period starting in 2019 Q3 (Table 22). In cases with non-missing information, Specialists reported that most CCCs were referred by mental health/behavioral health/community mental health program (34%), by aging and people with disabilities (15%), or by area agency on aging (12%). Least frequently, referrals came from law enforcement or first responders (5%), adult protective services (5%), options counselors/ADRC (1%), or centers for independent living (<1%). No CCCs were referred from long-term or community-based care (e.g., assisted living, nursing facility, adult foster home) (0%).

Table 22. Referral Sources

Referral source?	'19Q3 - '20Q4 Valid % (n)
Mental health/behavioral health/community mental health program	34% (547)
Aging and People with Disabilities	15% (250)
Area Agency on Aging	12% (198)
Multidisciplinary Team	10% (169)
Health care setting (e.g., primary care, acute care)	10% (163)
Family member, guardian or other person responsible for consumers wellbeing	7% (118)
Law enforcement/first respondents	5% (82)
Adult Protective Services	5% (76)
Options Counselor/ADRC	1% (16)
Centers for Independent Living	<1% (1)
Long-term care or community based care (e.g., assisted living facility, residential care, nursing facility)	0% (0)
Other	0% (0)
Total	**100% (1,620)**

Notes. Data were missing, non-standard, or reported as "don't know" for 19% (*n* = 373) of cases this reporting period. Percentages may not add up to 100 due to rounding.

The PSU Evaluation Team asked Specialists about discussions on change in residence. The distribution of discussions about change in residence changed between 2018 Q3 through 2019 Q2 (the first quarters these data were uniformly collected) and the current reporting ($\chi^2(6) = 792.06$, $p < .001$). During the current reporting period, in 15% of cases no discussion of change in residence occurred, a substantially smaller share compared to last reporting period (44%). This change reflects an increase in important discussions about consumers' housing situations. A greater share of CCCs involved a discussion of residence change that did not lead to a recommendation this period (37%) compared to last (11%). In a slightly larger share of CCCs during the current period (23%) compared to the last period (19%), a change in residence was recommended but the option was not available. Additionally, in a slightly larger share of CCCs this period (10%) compared to last (6%), consumers refused the recommended change in residence even though it was or would soon be available. So, while housing was more often discussed in CCCs during the current reporting period, there also were a larger share of CCCs in which no housing recommendations were needed and consumers refused housing recommendation, as well as a smaller share in which housing recommendations were or soon will be made available. Given the larger context of the city, state, and national housing crisis, it is important for CCCs to continue to include discussions of housing for consumers, for researchers to track these trends, and for policy makers to use this information to fill the gaps in housing needs for older adults and people with disabilities who have behavioral health needs.

When the changes in residential setting were reported, 71% of CCCs involved changes to settings with a higher level of care, which was slightly higher than the share during the last reporting period (67%). The distribution of the residence level of care change recommendations was statistically similar between the current and previous reporting periods ($\chi^2(2) = 5.41$, $p = .067$).

Complex Case Consultations: Reasons for a Consultation

During the current reporting period, there were a total of 16,494 problems/issues reported related to these CCCs (excluding the "Other" categories), 1,880 of which were suspected/diagnosis pending across all quarters. While the total number of diagnosed or suspected problems/issues is smaller this reporting period compared to the last reporting period (n = 18,349), the average number of problems/issues per consumer was higher this period (M = 8.28) compared to last period (M = 6.97). Similarly, while the number of suspected problems/issues was similar between this and the previous reporting period, the average number of suspected diagnoses per consumer was higher this period (M = 0.94 vs. M = 0.70). Currently, 70% of cases had five or more reported issues (5-9 issues: 38%; 10+ issues: 33%)

which is a higher share compared to the previous reporting period (59%) (Table 23). Finally, most consumers during the current reporting period had at least one physical / medical (82%), neurological/cognitive (54%), psychiatric / mental health (88%), social / individual (83%), or systems level (70%) problem or issue (Table 24). The share of consumers with at least one issue was higher this reporting period compared to last reporting period for physical / medical (71%), neurological/cognitive (46%), psychiatric / mental health (77%), and social / individual (77%) categories of issues.

Table 23. Prevalence of diagnosed or suspected/diagnosis pending problems/issues reported per consumer (excluding "Other" categories)

# diagnosed or suspected problems/issues per consumer	'17Q4 - '19Q2 % (n)	'19Q3 - '20Q4 % (n)	All % (n)
0	2% (58)	1% (22)	2% (80)
1-2	14% (362)	7% (146)	11% (508)
3-4	25% (657)	20% (407)	23% (1,064)
5-9	32% (840)	38% (754)	34% (1,594)
10+	27% (717)	33% (664)	30% (1,381)
Total	**100% (2,634)**	**100% (1,993)**	**100% (4,627)**

Table 24. At least one diagnosed or suspected/diagnosis pending problems/issues reported by broad categories

Broad Categories	First % (n)	Second % (n)	Total % (n)
Physical / Medical	71% (1,862)	82% (1,627)	75% (3,489)
Neurological/Cognitive	46% (1,218)	54% (1,072)	49% (2,290)
Psychiatric / Mental Health	77% (2,041)	88% (1,748)	82% (3,789)
Social / Individual	77% (2,029)	83% (1,662)	80% (3,691)
Systems	74% (1,952)	70% (1,405)	73% (3,357)
Any	98% (2,576)	99% (1,971)	98% (4,547)

Note. Since multiple problems/issues for each consumer could be selected, the percentages need not add up to 100.

During the current reporting period from July 2019 through December 2020, *co-occurring medical conditions*, *Geriatric syndromes (e.g., frailty, falls, self-neglect)*, and *ADL and other functional limitations* were most likely to be diagnosed (56%, 39%, and 39% of all CCCs, respectively) within the **physical/medical category**, followed by *unresolved medical need*; 30%). *Polypharmacy* (6%) and *delirium* (2%) were the least cited reasons in this category. While the relative prevalence of these problems/issues were similar between the current reporting period and the previous reporting period, prevalence rates for each problem/condition in this category were higher from July 2019 through December 2020. For instance, 56% of CCCs this period compared to 45% last period were reported to include co-occurring medical conditions as a presenting problem/issue.

Under the **neurological/cognitive category**, during the current reporting period, *dementia* (18% diagnosed and 8% suspected) and *lack of capacity, competence for decision making* (17% diagnosed and 13% suspected) were the most frequently selected problems/issues. *Acquired or traumatic brain injury (e.g., stroke)*, *neurological disorder (e.g., seizures, Parkinson's)*, and *intellectual disability (added in 2018 Q2)* were less frequently selected (1%, < 1%, and 1% diagnosed, respectively). Of note, intellectual disability was not added as a presenting problem/issue until April 2018.

For the **psychiatric/mental health category**, during the current reporting period, *serious mental illness* (32% diagnosed and 9% suspected) and *mood disorders (e.g., depression, anxiety; discontinued in 2020 Q3)* (30% diagnosed and 14% suspected) were most likely to be selected, followed by *substance use disorders (excl. opioid use disorder)* (19% diagnosed and 4% suspected), and *depression (new in 2020 Q3)* (16% diagnosed and 13% suspected). Least likely to be reported as a presenting problem/issue for CCCs were *medication misuse* (5%), *opioid use disorder* (5%), *suicidality* (4%), *hoarding* (3%), and *personality disorders* (2%). Less than one percent of cases involved a consumer with a diagnosis of *animal hoarding*. The relative prevalence of psychiatric/mental health problems/issues was similar between the current reporting period and the previous reporting period, with the exception of suicidality (4%) and personality disorders (2%) which were relatively more prevalent in the previous period. Similar to problems/issues in the physical/medical category, prevalence levels were generally higher during the current reporting period compared to the previous period. For example, 32% of CCCs identified serious mental illness as a presenting problem/issue in the current reporting period compared with 4% during the last period. The greater share of cases in which a psychiatric/mental health issue was identified in the current reporting period compared to previously may reflect the increase in service providers' ability to identify behavioral health symptoms among older adults, a key goal of the Initiative.

During the current reporting period, *Lack of or poor family/natural supports* was the most frequently cited problem/issue (51% of all CCCs) in the **social/individual category**, followed by *isolation/loneliness (discontinued in 2020 Q3)* (34%), which was disambiguated as *isolation* (29%) and *loneliness* (27%) independently beginning in 2020 Q3. Additionally, over 25% of CCCs included *consumer refuses services* (26%) and *financial (e.g., cannot afford services, limited income)* (26%) as presenting problems. The least commonly selected problem/issue in this category was *law enforcement/criminal justice involvement* (9%). Prevalence rates and the prevalence order of social/individual problems/issues selected were similar between the previous and current reporting periods. However, the problem/issue of consumer refusing services was relatively more prevalent this reporting period (26%) than from October 2017 through June 2019 (21%).

The **system-related issues** category included the largest number of potential problems/issues that could be selected compared to other categories, in part because a key goal of the Initiative is to improve the wellbeing of older adults and people with disabilities who have behavioral health challenges through systems level improvements. During the most current reporting period, the most frequently involved system-related issues were *system navigation (difficult for consumer/family/supports)* (44%) and *understanding eligibility* (28%). These problems/issues were followed in prevalence by *can't afford services* (17%, which was

discontinued in 2020 Q3), *hard to determine root cause(s)* (*added in 2018 Q2;* 11%), *lack of BH services (new in 2020 Q3)* (11%), and *does not qualify for aging supports due to BH needs* (10%). Fewer than five percent of the time, *lack of or limited transportation* (4%), *lack of case managers (new in 2020 Q3)* (4%), *guardianship issues (new in 2020 q3)* (4%), could not agree on a care plan (4%), and *wait list is full or would take too long* (1%) were selected during the current reporting period. During the current reporting period, *system navigation (difficult for consumer/family/supports)* was slightly more likely to be reported (44%) than last reporting period (48%) as was the issue of *understanding eligibility* (28% vs. 34%). Problems issues that were more prevalent during the current reporting period compared to the previous reporting period were *can't afford services* (17% vs. 5%) and *hard to determine root cause(s)* (*added in 2018 Q2;* 11% vs. 7%).

Regardless of broad categories into which problems/issues were grouped, across all quarters, the most prevalent diagnosed issues during the current reporting period are *co-occurring medical conditions* (56%) and *lack of or poor family/natural supports* (51%). The most prevalent suspected/diagnosis pending issues regardless of broad category are *mood disorders (e.g., depression, anxiety)* (*discontinued in 2020 Q3*; 14%), *lack of capacity, competence for decision making* (13%), and *depression (new in 2020 Q3)* (13%). Similar to the last reporting period, these problems remain as the most prevalent issues presenting in CCCs.

The CCC form also includes an open-ended comment box for Specialists to describe "other reasons for a consultation." Most comments written in this section are a further description of the reasons for a consultation that are already included in the predetermined list of reasons in the CCC form. Examples of an additional reason for a consultation are need for connections to BH services, civil commitment, family member no longer able to care for individual, self-neglect, refuses to accept available housing options, older adult abuse, and mobility issues (see Table 25 below).

Table 25. Percent of issues/problems reported by the Specialists by Reporting Period

Broad Category	Problem/Issue	Diag '17Q4-'19Q2	Diag '19Q3-21Q4	Diag All	Susp '17Q4-'19Q2	Susp '19Q3-21Q4	Susp All
Physical Medical	Co-occurring medical conditions	45%	56%	50%	2%	4%	3%
	Geriatric syndromes (e.g., frailty, falls, self-neglect)	27%	39%	32%	3%	3%	3%

	ADL and other functional limitations	33%	39%	35%	5%	3%	4%
	Unresolved medical need	15%	30%	22%	2%	3%	2%
	High utilization of emergency department and/or 911	10%	16%	13%	2%	1%	1%
	Medical assistive device*	6%	13%	10%	< 1%	< 1%	1%
	Polypharmacy	5%	6%	5%	1%	2%	1%
	Delirium	1%	2%	1%	< 1%	< 1%	1%
Neurological Cognitive	Dementia	16%	18%	17%	9%	8%	9%
	Lack of capacity, competence for decision making	16%	17%	17%	11%	13%	11%
	Acquired or traumatic brain injury (e.g., stroke)	8%	7%	7%	1%	3%	2%
	Neurological disorder (e.g., seizures, Parkinson's)	3%	6%	4%	< 1%	< 1%	1%
	Intellectual disability*	3%	4%	4%	1%	3%	2%
Psychiatric Mental Health	Serious mental illness	24%	32%	27%	4%	9%	6%
	Mood disorders (e.g., depression, anxiety)*	25%	30%	27%	16%	14%	16%
	Substance Use Disorders (excl. Opioid Use Disorder)	14%	19%	16%	4%	4%	4%
	Depression (New in 2020 Q3)	-	16%	16%	-	13%	13%
	Disruptive behaviors	12%	15%	14%	3%	4%	4%
	Anxiety (New in 2020 Q3)	-	11%	11%	-	9%	9%
	Medication misuse	3%	5%	4%	2%	3%	3%
	Opioid Use Disorder	2%	5%	4%	< 1%	< 1%	1%

	Suicidality	6%	4%	5%	2%	2%	2%
	Hoarding	3%	3%	3%	1%	2%	2%
	Personality disorders	4%	2%	3%	3%	5%	4%
	Animal hoarding	< 1%	< 1%	< 1%	< 1%	< 1%	1%
Social Individual	Lack of or poor family/natural supports	47%	51%	48%			
	Isolation/loneliness (Discontinued in 2020 Q3)	34%	34%	34%			
	Isolation (New in 2020 Q3)	-	29%	29%			
	Loneliness (New in 2020 Q3)	-	27%	27%			
	Consumer refuses services	21%	26%	23%			
	Financial (e.g., cannot afford services, limited income)	26%	26%	26%			
	Housing	24%	20%	22%			
	Homelessness*	11%	13%	12%			
	Food insecurity	10%	12%	11%			
	Law enforcement/ criminal justice involvement	11%	9%	10%			
System	System navigation (difficult for consumer/ family/ supports)	48%	44%	46%			
	Understanding eligibility	34%	28%	31%			
	Can't afford services	5%	17%	10%			
	Hard to determine root cause(s)*	7%	11%	9%			

	Lack of BH services (New in 2020 Q3)	-	11%	11%			
	Does not qualify for aging supports due to BH needs	12%	10%	11%			
	Lack of communication between agencies	13%	9%	11%			
	Lack of services (Discontinued in 2020 Q3)*	11%	8%	10%			
	Medicare limitations (New in 2020 Q3)	-	8%	8%			
	Does not qualify for BH supports due to ADL needs	9%	8%	9%			
	Lack of aging services (New in 2020 Q3)	-	6%	6%			
	In home services needed, but not available	9%	6%	7%			
	Inadequate workforce (insufficient, lack of training)	3%	6%	4%			
	Health insurance limitations	6%	5%	5%			
	Legal issue (e.g., inappropriate evictions; guardianship issues)*	8%	5%	6%			
	Lack of or limited transportation	8%	4%	7%			
	Lack of case managers (New in 2020 Q3)	-	4%	4%			
	Guardianship issues (New in 2020 Q3)	-	4%	4%			

	Could not agree on a care plan*	6%	4%	5%			
	Wait list is full or would take too long	2%	1%	2%			

Note. Several problems/issues were either added later or discontinued at some point since October 2017. Medical assistive devices, intellectual disability, homelessness (previously combined into housing), hard to determine root cause, and legal issues were not added until April 2018, opioid use disorder was not added until January 2019, and depression, anxiety, isolation and loneliness independently (previously combined as isolation/loneliness), evictions, Medicare limitations, lack of bh and aging services independently (previously combined as service barriers), lack of guardians, and lack of case managers were added in July 2020. Additionally, the issues of could not agree on a care plan and hard to determine root cause were discontinued as of July 2020.

Complex Case Consultation: Specialist's actions and recommendations

Actions taken by Specialists during consultations included assisting with information/referrals to services required by the consumer (56% current; 62% previous), providing clinical information about the consumer's presenting problems (43% current; 34% previous), providing additional staff training/coaching (25% current; 29% previous), providing short-term help in accessing services (36% current; 28% previous), facilitating discussion among stakeholders (5%; new option starting in 2020 Q3), and other various activities (12% current; 15% previous) (Table 26). Most of the comments written in the "other Specialist actions" column further describe an item selected in the predetermined list.

Table 26. Specialist's actions during the consultation

Specialist actions taken	'17Q4 - '19Q2 Valid % (n)	'19Q3 - '20Q4 Valid % (n)	All Valid % (n)
Assisted with info/referrals to services required by the consumer	62% (976)	56% (1,126)	59% (2,102)
Provided the referral source with clinical info about consumer's presenting problem(s)	34% (541)	43% (865)	39% (1,406)
Provided the referral source with additional staff training/coaching	29% (453)	25% (493)	26% (946)
Provided consumer and/or surrogate with short-term help in accessing services	28% (443)	36% (714)	32% (1,157)
Facilitated discussion amongst stakeholders (New in 2020 Q3)	-	5% (28)	5% (28)
Other	15% (242)	12% (226)	14% (468)

Note. Specialist actions were collected starting in 2018 Q2 so the previous reporting period column includes data from 2018 Q2 -2019 Q2. A new item was added to our list of possible actions in 2020 Q3, capturing whether Specialists facilitated discussion among CCC participants. During the transition quarter from the old form to the newer form in 2018 Q2, missing values were entered in 257 cases. Since multiple actions can be selected for each consumer, the percentages need not add up to 100.

General recommendations for the consumer emerging from the case discussions included change in residence (35%), change in services and/or care plan (54%), review of current medications and possible adjustment (31%), admission to emergency department or hospital (6%), and other recommendations (26%) (Table 27). A larger share of CCCs during the current reporting than during the previous reporting period recommended a change in residence (27%), change in services or care plan (44%), and a review of current medications (17%). A majority of the comments written in the "other recommendations" column include actions taken, or follow-up tasks, and few comments describe specific recommendations for the consumer. Comments that describe specific recommendations mostly describe referrals and connections that should be made to connect the consumer with necessary services. Examples include discharge from inpatient psychiatric unit to home, seek out legal aid, further assessment, access medical assistive devices (e.g., audio device to enhance hearing), connect consumer with social activities (e.g., religious groups, family activities), focus on positive framing for consumer (focus on what individual has done to feel contented/satisfied and happy), and increase recreational activities (e.g., time outdoors, listen to books).

Also included in the form is a comment box for Specialists to describe follow-up tasks they will perform for this consultation. This box was included to assist the Specialists in keeping track of follow-up tasks for each of their case consultations. Most comments describe participating in a follow-up meeting with another team member or continuing to monitor the consumer and provide support to a family member. Examples of the variety of comments written by Specialists in this column include consult with MDT, review CCO database for medication management coverage, contact APD case manager for perspective on consumer behavior and care coordination, suggest care conference meeting, and contact community behavioral health contact to coordinate meeting.

Table 27. General recommendations for the consumer emerging from the case discussion

General Recommendations	'17Q4 - '19Q2 Valid % (n)	'19Q3 - '20Q4 Valid % (n)	All Valid % (n)
Change in residence	27% (424)	35% (700)	31% (1,124)
Change in services and/or care plan	44% (693)	54% (1,081)	50% (1,774)
Review of current medications	17% (274)	31% (608)	25% (882)
Admission to emergency department or hospital	6% (92)	6% (116)	6% (208)
Other	29% (453)	26% (509)	27% (962)

Note. Specialist recommendations were collected starting in 2018 Q2 so the previous reporting period column includes data from 2018 Q2 - 2019 Q2. During the transition quarter from the old form to the newer form in 2018 Q2, missing values were entered in 1change in residence, 257 cases. Because multiple actions can be selected for each consumer, the percentages need not add up to 100.

Complex Case Consultations: Community resources and follow-up time

In the most recent reporting period, in 57% of cases with information on community resources, the community had all the resources available to address the needs of the consumer. In 33% of cases, the community had some of the needed resources and in only 9% of cases did the community partners have none of the resources available to address the needs of the consumer. The availability of community resources to address the needs of consumers was similar between the previous reporting period and the current reporting period. The form includes an open-ended comment box for Specialists to describe community resources needed, but not available. Examples of comments written in this section include geropsychiatrists, long-term substance use focused residential programs, more options for affordable housing

(including specialized housing), housing for end of life. Similar to the previous reporting period, housing including specialized housing for older adults and people with disabilities who have behavioral health challenges continues to be a pressing community need.

During the current reporting period, projected follow-up time was none (24%) or minimal (less than an hour) (43%) for the majority of cases (67%) with information about follow-up time. Only a small portion of cases (8%) were reported to have a projected follow-up time of over five hours. A slightly greater share of cases required 3 or more hours of follow-up time during the current reporting period (17%) compared to the previous reporting period (12%). A large share of cases had missing or non-standard values for this item including 17% of cases during the current reporting period and 23% of cases during the last reporting, so these findings may not generalize to all CCCs.

Specialist Interviews

In the fall of 2019, each of the Specialists were interviewed about their most significant projects and their perspectives about the Initiative. The Specialists provided information on up to three projects that they considered to be the most significant to them. These were condensed and grouped into four main categories based on the focus of the projects: 1) Improving access to behavioral health care, 2) Increasing workforce knowledge and skills, 3) engaging community partners and 4) Working upstream on primary prevention. See Appendix 1 for project descriptions and Appendix 2 for a full list of projects.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Key Informant Interviews

In the spring of 2020, we implemented a new quantitative survey and qualitative interview instrument to gather open-ended data from directors and managers of key

stakeholder agencies working with the Initiative. These stakeholders (referred to as "key informants" here) were drawn from 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).

The final sample included 49 key informants out of a total recruited sample of 56. The we sought to interview an equal number of key informants for each stratum to collect equal amounts of information from each group however, 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) (see Table 28).

Table 28. Key Informant Sample

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

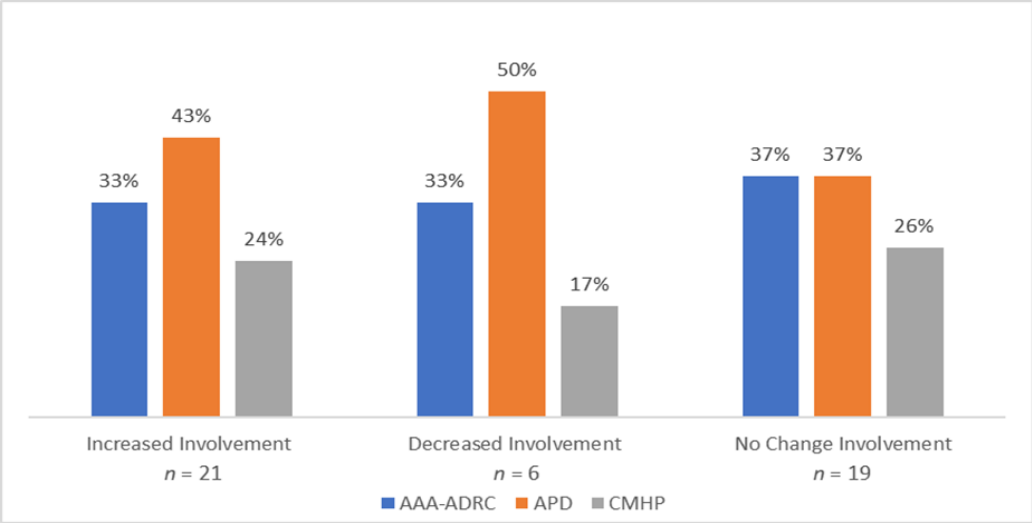
Agency Type		**APD**		**AAA-ADRC**		**CMHP**		
Involvement		**High**	**Med-Low**	**High**	**Med-Low**	**High**	**Med-Low**	**Area Subtotal**
Area	**Urban**	3	4	3	4	2	5	21
	Rural	5	5	4	4	4	6	28
Agency Type Subtotal		17		15		17		49

These interviews and surveys sought to assess perceptions of change since the Initiative began. Another goal is to determine how the Initiative can improve so that it can better support agencies that work to advance behavioral health locally. Lastly, this research intended to gauge the involvement of the Initiative's main partner organizations, aging services and behavioral health agencies. For the Initiative's work to be successful, the Specialists must collaborate and coordinate with local behavioral health and aging services agencies. As such, these stakeholder's perceptions of the Initiative, including its perceived effectiveness and the degree to which coordination is occurring is an important information source. Interviews were conducted with management level staff at AAA-ADRCs, APD offices, and CMHP offices to gauge how the Initiative is perceived by and has influenced the work of core community stakeholders.

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

To better understand involvement, we asked key informants if their agency's involvement with the Initiative had changed over time. Twenty-one key informants (42%) reported their agency's involvement with the Initiative had increased with time. Another six key informants (12%) indicated their agency's involvement with the Initiative had declined over time (see Figure 10). A little over one-third (*n* = 19, 38%) of key informants reported no change in their agency's involvement.

Figure 10. Self-reported change in Involvement across time by agency type



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

To assess key informant knowledge of the Initiative, the PSU Evaluation Team asked both quantitative and qualitative questions about their knowledge and communication about the Initiative. First, key informants were asked to respond to this statement on a scale of 1-10: Our staff is knowledgeable about the Initiative and its purpose. AAA-ADRC key informants responded with a mean score of 7.00 (*SD* = 2.45), while CMHPs had a score of 5.35 (*SD* = 2.74) and APD offices had a score of 4.94 (*SD* = 2.48). When compared by location, urban-based key

informants had a score of 6.05 and rural-based key informants had a mean score of 5.50 (*SD* = 2.87). 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.

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). 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.

Improved *Behavioral Health Services*

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

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

Collaboration and Coordination

Eighteen respondents (37%) reported improved collaboration between agencies due to 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.

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

Workforce Development

Twenty-four key informants (49%) reported that there is a more knowledgeable workforce due to workforce development training provided through the Initiative. This included reports of staff having more knowledge about consumers with behavioral health issues because of Specialist trainings, and staff attending more trainings hosted by the Initiative. An equal number of key informants from AAA-ADRCs and CMHPs (42%) noted that the workforce is more knowledgeable due to the Initiative, while 17% of respondents who noted that the workforce is more knowledgeable due to the Initiative worked in APD offices.

> "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)

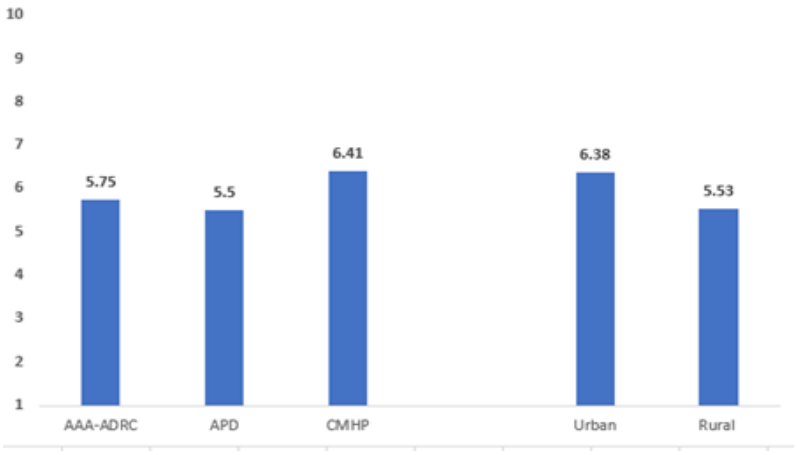
What role key informants' agencies may have played in facilitating those changes emerged from the interviews, including through providing resources (both directly and in-kind) to the Initiative, collaborating with other agencies, as well as directly collaborating with the Specialists.

Perception of Change

In order to assess the effectiveness of the Initiative at improving services for older adults and people living with disabilities who have behavioral health needs, participants were asked to provide a score on a scale of 1-10 to indicate their perception of the Initiative's overall effectiveness. AAA-ADRC key informants responded with a mean score of 5.75 (*SD* = 2.44),

while APD offices had a score of 5.50 (*SD* = 2.55) and CMHP offices a score of 6.41 (*SD* = 2.00). When compared by location, urban-based key informants had a score of 6.38 (*SD* = 2.01) and rural-based key informants had a mean score of 5.53 (*SD* = 2.50) (see Figure 11). All scores fell into the medium-low range in terms of involvement. This suggests there is still room for the Initiative to improve services for this population.

Figure 11. Overall Effectiveness of the Initiative



Providing resources

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

Fourteen respondents (29%) reported contributing resources that supported the changes they described. Examples of resources allocated include space for training events, space for specialists to work. 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. 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.

Collaborating with other agencies

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

Collaborating with the Specialists

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

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 [Initiative] came on board, we were just starting to struggle to serve these folks. So as the population we serve has changed over time, the Initiative has helped us to build those relationships and understand how aging and Mental health and all of the service systems are related and combined. Our role in this has been our willingness to engage and learn." (APD, Urban)

Improvements - Local Level

The findings also suggest a number of improvements that 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. Some of the systems-level findings include a need for **sustained resources to support behavioral health**, a need for **formal agreements between agencies (MOUs)** to more clearly define goals, and a need to **prioritize the Initiative at the state-level**.

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

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

Formal Agreements Between Agencies

Twelve key informants (24%) indicated that formal agreements between agencies (e.g., MOUs) would help improve behavioral health services for older adults and people living with disabilities. The formal agreements would include aligning purposes and policies between agencies (e.g., to prevent unnecessary client transfer) and establishing expectations for collaboration. Of these 12 key informants who noted that formal agreements between agencies would improve behavioral health services, 58% worked in APD offices, 25% worked in CMHPS, and 17% worked in AAA-ADRC offices.

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

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

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

Community-Level Recommendations

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

Keep the Momentum Going (Consistency)

Thirteen key informants (27%) suggested the Initiative could improve collaboration and coordination in their communities by ensuring consistency in existing efforts. In other words, the Initiative should focus on keeping the momentum going. Some examples offered include agencies maintaining consistent collaboration (e.g., keeping regularly scheduled meetings with Specialists), continuing to contribute to collaborative efforts that are already underway, and retaining Specialists. One key informant stated:

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

Promote Involvement from Other Agencies

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

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

Marketing

Seven respondents (14%) reported the Initiative could improve collaboration and coordination through marketing the services and needs of other agencies. In other words, the Initiative can help advertise and share information about the services and needs of agencies in their community to improve coordination and collaboration. Examples of these types of improvement included advertising what services are available, what services are needed,

agency roles, and agency billing abilities in terms of Medicare and insurance coverage. According to one key informant,

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

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

Stakeholder & Specialist Survey Findings

We distributed a survey to stakeholders and Specialists in March 2021. Both surveys were intended to assess the impact of the Initiative, as well as what is working well and how it might improve. Different questions were displayed to the stakeholders and Specialists depending on their position, and stakeholders were asked certain sets of questions depending on their engagement in specific Initiative activities. Although Specialists and stakeholders answered different questions, the surveys were intended to be comparable. Stakeholder Surveys in 2017, 2018, and 2019 to assess the impact of the Initiative, how it might improve, and the greatest community successes and barriers. The 2021 Stakeholder Survey administered online via Qualtrics in Spring 2021 differs significantly from the previous questionnaires. It assessed stakeholders' opinions about what is working well and where there is room for potential improvement in the Initiative. In addition, the survey provided information about how stakeholders work with the Specialists on Initiative activities. Stakeholders also provided general perspectives about the state of behavioral health services for older adults and people living with disabilities in Oregon. The findings contribute to a better understanding of how the OHA, Specialists, and Initiative stakeholders can best address the behavioral needs of older adults and people with physical disabilities in Oregon and collaborate with professionals from community partner organizations.

We collected 910 email addresses from the Specialists of stakeholders who have had some level of involvement with the Initiative over the last six years. Sixteen percent (*n* = 147) of surveys were unable to reach their intended recipient because their email was not a valid format (i.e., email failed), the destination server rejected the email (i.e., email bounced), or the email was a duplicate. A total of 763 unique emails were successful, and of those valid cases, 18% (*n* = 137) either partially or fully completed the stakeholder survey. This response rate was lower than in previous years. The COVID-19 pandemic likely impacted survey response rates. We also emailed questionnaires to all 21 Behavioral Health Initiative Specialists. Thirteen of the 21 Specialists (62%) partially (5%, *n* = 1) or fully completed (57%, *n* = 12) the optional survey (see Table 29 below).

Table 29. Stakeholder survey response status

Response Status	n	Valid %
Email Sent - No Responses	8	38%
Finished Survey	12	57%
Partially Completed Survey	1	5%
Total	21	100%

Stakeholders: Organization Types and Locations

We asked stakeholders to identify which counties they work in (Table 30). Of the stakeholders with valid data (*n* = 132), the largest share (32%) selected more than one county and (3%) reported working statewide. The largest share of stakeholders who identified only one county worked in Multnomah (10%), Lane (9%), and Douglas (8%) counties. A smaller share of stakeholders worked in Washington (5%), Coos (5%), Yamhill (4%), and Clackamas (3%) counties.

Table 30. Stakeholders' Work Region

Region of Oregon	n	%
Multiple Counties	**42**	**32%**
Statewide	**4**	**3%**
Portland Metro	**24**	**18%**
Willamette / North Coast	**26**	**20%**
Southern Oregon / South Coast	**22**	**17%**
Eastern Oregon	**14**	**11%**
Total	**132**	**100%**

Note. Five cases had missing data for these items and are not included in this table. Regions of Oregon are based on the following county designations: Portland Metro includes Clackamas, Columbia, Multnomah, Washington; Willamette Valley / North Coast includes Benton, Clatsop, Lane, Lincoln, Linn, Marion, Polk, Tillamook, Yamhill; Southern Oregon / South Coast

includes Coos, Curry, Douglas, Jackson, Josephine; East of the Cascades includes Baker, Crook, Deschutes, Gilliam, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, Wheeler.

Of the 137 stakeholders who responded to the survey and selected an agency type, most reported working for an older adult services agency including AAA/ADRCs (23%) and APD/APS (10%), or a behavioral health agency including community mental health programs (CMHP) (9%) and other BH providers (9%). In 2017, 2018 and 2019, aging and disability service providers (ODHS/APD/APS, AAA/ADRC) and behavioral health service providers (CMHP and other behavioral health providers) also made up the highest percentage of survey respondents. A smaller share of stakeholders surveyed in 2021 came from advocacy organizations (5%), primary care clinics (4%), or coordinated care organizations (CCO; 4%). About a fifth of stakeholders (22%) said they worked for a different type of organization than those presented. Examples of other organizations include advisory council members, public fiduciaries, and university faculty.

Participation in Initiative Activities

Stakeholders were asked about their participation in Specialist organized activities across their region. Stakeholders with valid data (n = 127) most often reported participating in workforce development training or community education events (80%) organized by the Specialist. About half of stakeholders (51%) participated in a stakeholder or community partner group, 43% collaborated on a project or program, and 42% participated in a complex case consultation organized by a Specialist. In 2017, 2018, and 2019, a similar share of stakeholders reported participating in complex case consultations, but a slightly smaller share reported participating in training or community education events. This year, stakeholders less often reported participating in a multidisciplinary team (MDT; 30%) or other types of activity organized by the Specialist (16%). Other types of activities include monthly meetings (outside of MDTs), and establishing a workgroup.

Stakeholder Length of Involvement

Starting in 2015, the Specialists began working to improve timely access to care from qualified providers who work together to provide coordinated quality and culturally responsive behavioral health and wellness services to older adults and people living with physical disabilities. We asked stakeholders to report the year they first became involved with the Initiative to obtain a sense of their tenure with the Initiative. The largest share of stakeholders began their involvement with the Initiative in 2015 or 2016 (40%), followed by those who began involvement with Initiative in 2017 or 2018 (31%), and those who became involved with the

initiative in 2019 or 2020 (28%). The smallest share of stakeholders has been involved with the Initiative for less than a year (2%). Since we asked the Specialists to provide contact information for stakeholders who have been involved with the Initiative and can reflect on the impacts of the Initiative's work, it is unsurprising the largest group of stakeholders had been involved with the Initiative since its inception. The perspective of these long-tenured stakeholders is helpful for understanding how the Initiative has impacted Oregon's older adults and adults living with physical disabilities.

Comparing stakeholders' tenure with the Initiative by their organization type provides information about trends in engagement (Table 31). The group with the largest share of stakeholders who have been involved with the Initiative since the beginning (i.e., 2015 - 2016) was AAA/ADRC (60%). Most stakeholders from AAA/ADRC (80%), BH agencies (75%), and APD/APS (72%) have been involved since at least 2018. Stakeholders from other agency types have more recently become involved with the Initiative with 38% from 2017-2018 and 38% from 2019-2020.

Table 31. Stakeholder Initial Year of Involvement with the Initiative by Organization Type

First year of BHI Involvement	AAA/ADRC % (n)	BH (incl. CMHPs) % (n)	APD/APS % (n)	Other % (n)
2015-2016	60% (18)	46% (11)	45% (5)	21% (7)
2017-2018	20% (6)	29% (7)	27% (3)	38% (13)
2019-2020	20% (6)	21% (5)	27% (3)	38% (13)
2021	0% (0)	4% (1)	0% (0)	3% (1)
Total	100% (30)	100% (24)	100% (11)	100% (34)

Note. Thirty-eight cases had missing data for either organization type or BHI participation and are not included in this table. Reading or discussing reports and/or factsheets by the Initiative did not statistically differ by stakeholder organization type, chi-square(9) = 12.00, p = .213.

Stakeholders were asked if their involvement with the Initiative has changed over time (Table 32). Most stakeholders (57%) reported that their involvement with the Initiative has remained relatively consistent, while 24% of stakeholders are now less involved, and 20% are more involved with the Initiative.

Table 32. Stakeholder Change in Involvement Over Time

Change in BHI Involvement	n	%	Valid %
I am more involved now	25	18%	20%
My involvement has remained relatively consistent	72	53%	57%
I am less involved now	30	22%	24%
Missing	10	7%	-
Total	137	100%	100%

Comparing stakeholders' changes in involvement with the Initiative over time by stakeholders' organization type helps to identify any involvement trends specific to agency type (see Table 33). The majority of stakeholders from AAA/ADRC (60%) and BH agencies (67%) and the vast majority from APD/APS (91%) reported that their involvement with the Initiative has stayed relatively consistent. A larger share of BH agency stakeholders reported that they are more involved now (21%), compared to those that say they are less involved now (12%). No stakeholders from APD/APS reported being less involved now. Other types of agency stakeholders (32%) reported being less involved now more than for any other organization type.

Table 33. Change in BHI Involvement by Stakeholder Organization Type

Change in BHI Involvement	AAA/ADRC % (n)	BH (incl. CMHPs) % (n)	APD/APS % (n)	Other % (n)
I am more involved now	20% (6)	21% (5)	9% (1)	21% (7)
My involvement has remained relatively consistent	60% (18)	67% (16)	91% (10)	47% (16)
I am less involved now	20% (6)	12% (3)	0% (0)	32% (11)
Total	100% (30)	100% (24)	100% (11)	100% (34)

All thirteen Specialists who responded to the survey also provided ratings of AAA, APD, and CMHP agency involvement in each of the 22 counties in which they work. Across agency types, Specialists rated community partners involvement an average of 3.93 out of 5 and 50% (i.e., median score) rated agency involvement as at least a 4 out or 5. Specialists rated APD stakeholders' involvement in trainings they organized highest (*M* = 4.55, 95% CI: 4.26, 4.83) compared with stakeholders in AAAs (*M* = 3.42, 95% CI: 2.81, 4.03) and CMHPs (*M* = 3.88, 95% CI: 3.45, 4.31).

Barriers to Participation in Training Events

Stakeholders have multiple priorities and barriers that may make attending training events organized by the Specialists difficult. We gave stakeholders a list of potential barriers to attending training events and asked them to identify those that impacted their participation. Of the five potential barriers, no stakeholders reported that difficulty for staff to take time away from work or an over-saturation of training are barriers to attendance. The most often reported barriers were related to conflicts in scheduling between work and BHI training. Specifically, last-minute emergencies make staff unable to attend training (43%) and that training is difficult to schedule (29%). Thirteen percent of stakeholders also reported that the topics were not a priority for them. In 2019, 44% of stakeholder respondents agreed there is insufficient time in their schedule to attend training events, compared to 29% of 2021 survey respondents who reported that training is difficult to schedule. It is possible that some stakeholders working remotely due to the COVID-19 pandemic have had more availability to attend virtual training events. A smaller share of respondents in 2021 (13%) than in 2019 (24%) and 2018 (30%) said

that training topics are not relevant to their work, suggesting that training topics are now more relevant to stakeholders' work (see Table 34).

Table 34. Stakeholders' Barriers to Attending Training Events Organized by the Specialists

Barriers to involvement in BHI trainings and education events	Yes % (n)	No % (n)	Total % (n)
Training is difficult to schedule	29% (22)	71% (53)	100% (75)
It's difficult for staff to take time away from work	0% (0)	100% (75)	100% (75)
Last-minute emergencies affect staff attendance	43% (32)	57% (43)	100% (75)
Topics do not seem to be a priority for the target audience	13% (10)	87% (65)	100% (75)
Over-saturation of training offering	0% (0)	100% (75)	100% (75)
None of the above	0% (0)	100% (75)	100% (75)

Note. Of the 102 stakeholders who reported attending a BHI training, twenty-seven cases had missing values for these items and are not included in the table.

Specialists' Perceptions of Training Involvement and Barriers to Participation

We asked Specialists about the involvement of stakeholders from AAAs, APDs, and CMHPs in training and education events that they organize. Involvement an include requesting training from the BH Specialist on specific topics for staff, planning training needs with the BH Specialist, co-sponsoring training (i.e., marketing, promoting, or planning a training event with the BH Specialist), serving as a trainer or content expert, providing in-kind donations (e.g., physical space, food or beverages), allowing release time to staff to attend training, and encouraging staff who attend training to share knowledge and resources with others in their organization.

Specialist ratings of involvement in training significantly differed by agency type based on a significant analysis of variance test ($F(2, 68) = 5.22$, $p = .008$). Looking at the distribution of ratings of involvement (Table 35), the majority of Specialists rated agency involvement in training at least 4 out of 5 (72%). Eighty-six percent of Specialists rated APD, 72% rated CMHP, and 58% rated AAA stakeholder involvement in training as at least 4 out of 5.

Table 35. Average training involvement of AAA, APD, and CMHP stakeholders

Agency Type	N	Mean	95% CI	25%ile	Median	75%ile
AAA	24	3.42	[2.79, 4.04]	2	4	5
APD	22	4.55	[4.24, 4.85]	4	5	5
CMHP	25	3.88	[3.45, 4.31]	3	4	5
Total	71	3.93	[3.64, 4.22]	3	4	5

Note. Each Specialist (*N* = 13) was asked to rate the training involvement of the AAA, APD, and CMHP stakeholders for each county (*N* = 22) in which they worked. Total number of cases (N = 75) refers to number of agencies rated which is equal to ratings for each of AAA, APD, and CMHP in 22 counties with three counties receiving ratings from two Specialists (i.e., 3 agencies x 22 counties + 3 counties with a second Specialist* 3 = 75.

Workforce development and community events hosted by Specialists are highly attended and rated aspects of the Initiative. Given the importance of workforce development and community education to the Initiative's goals of improving the provision of behavioral health and aging services to older adults, it is useful to understand any barriers in conducting these events. In addition to asking stakeholders about the barriers they experience attending events, we also asked Specialists about the barriers that they experienced organizing training. Specialists only reported three of five possible barriers to organizing training and community events. Forty-five percent of Specialists (*n* = 5) reported that last-minute emergencies affect staff attendance and that topics don't seem to be a priority for the target audience as potential barriers to organizing training. While stakeholders also identified last-minute emergencies as a barrier to training attendance (*report percentage from stakeholder report here*), the salience of training topics was rarely identified as a barrier. Just over a third of Specialists reported that scheduling training events was a barrier to organizing these events (36%, *n* = 4) (see Table 36).

Table 36. Specialist Perceptions of Barriers to Training Events

Training barriers	Yes % (*n*)	No % (*n*)
Last-minute emergencies affect staff attendance	45% (5)	55% (6)
Topics do not seem to be a priority for the target audience	45% (5)	55% (6)
Training is difficult to schedule	36% (4)	64% (7)
None of the above	0% (0)	100% (11)
Over-saturation of training offering	0% (0)	100% (11)
It's difficult for staff to take time away from work	0% (0)	100% (11)

Stakeholders identified populations that are underserved or marginalized in the behavioral health system and experience high unmet needs in their communities. The most often identified populations experiencing high unmet needs were home-bound older adults (76%), followed by people experiencing houselessness (75%), long-term care residents (56%), and Black, Indigenous, and other people of color (51%). Populations identified as experiencing high unmet needs by less than half of stakeholders include LGBTQ+ populations (42%), veterans (33%), and other populations (15%) including *older adults living in poverty*, *women*, and *family caregivers* (see Table 37 below).

Table 37. Stakeholders' Perceptions of Populations with High Unmet Needs

Populations experiencing high unmet needs	Yes % (*n*)	No % (*n*)	Total % (*n*)
Home-bound older adults	76% (89)	24% (28)	100% (117)
People experiencing houselessness	75% (88)	25% (29)	100% (117)
Long-term care residents	56% (65)	44% (52)	100% (117)
Black, Indigenous, and People of Color	51% (60)	49% (57)	100% (117)
LGBTQ+ populations	42% (49)	58% (68)	100% (117)
Veterans	33% (39)	67% (78)	100% (117)
Other populations	15% (17)	85% (100)	100% (117)

Note. Twenty cases had missing values for these items and are not included in the table. Long-term care residents include residents who live in adult foster/care homes, nursing homes, assisted living, or memory care facilities. One of the reasons we modified the framing of this question was due to a high proportion of "Don't know" responses to this question in previous surveys.

Specialists were asked to identify whether or not more outreach is needed to reach any groups or agencies currently underrepresented in their stakeholder or community partner groups (e.g., faith communities, primary care). The vast majority of Specialists responded "Yes" to this question (92%). When asked about the kinds of support or buy-in needed for greater success in outreach to underrepresented agencies, their responses included greater support from upper management, consumers themselves, hospital systems (including primary care), law enforcement, behavioral health, places of faith, and tribal groups. It was also proposed that buy-in would increase if messaging from ODHS or CMHPs more strongly encouraged participation from agencies, if stakeholders have a clear idea how the goals of the Initiative

could enhance the goals of their organization, and if systems are regulated and funded at the community level in ways that promote collaboration and coordination.

Collaboration and Coordination

A core job function of the Specialists is to facilitate collaboration and coordination across relevant community partners. Across Oregon, Specialists have developed and maintained stakeholder and community partner groups. We asked stakeholders who reported being involved in one of these groups the degree to which several outcomes related to coordination and collaboration have been achieved. When stakeholders respond with either "Considerably" or "A great deal" to items about the stakeholder group, it is considered as an endorsement of the item. Less than half of stakeholders reported that stakeholder groups meet often enough to make progress in reducing gaps in services (43%), that advocates, consumers and their families are represented (19%), that the group engaged in a quality improvement program (36%), formal agreements, such as MOUs, are in place (22%). About half of stakeholders reported that the right people who can make changes are participating in these groups (49%) and coordination among community partners has improved (50%). Nearly one-third (31%) felt that turnover in community partner organizations interferes with momentum. While the majority (56%) of stakeholders reported that historical barriers to progress between agencies get in the way of progress only "Slightly" or "Moderately," 41% reported this issue persists considerably (28%) or a great deal (13%).

The PSU Evaluation Team compared the share of stakeholders who rate these items as "considerably" or "a great deal" based on their urban, mixed, or rural area. A larger share of rural stakeholders reported that their stakeholder groups meet often enough to make progress in reducing gaps in services (50%). A larger share of stakeholders who serve in both rural and urban counties (i.e., mixed) report that historical barriers between agencies gets in the way of progress (50%), that advocates consumers and family members are well represented in meetings (34%), that coordination among community partners has improved (71%), and that turnover in community partner organizations interferes with momentum (37%).

The PSU Evaluation Team asked stakeholders about their perceptions about MDTs organized by a Specialist in their communities. The majority of stakeholders reported that MDTs are functioning as they should be by reporting that positive characteristics were occurring either considerably or a great deal in their communities. For instance, 70% reported that relevant people or organizations are represented, 63% reported that meetings conclude with agreement on a care plan, 74% reported that a formal agreement (e.g., an MOU) among stakeholders is in place, and 72% reported that evidence-based practices and screening tools are recommended to address consumers' needs in MDTs. A smaller share of stakeholders

reported that needed services are available (35%) or that complex cases are referred to appropriate agencies (50%) either considerably or a great deal in their communities.

A majority of Specialists report that these MDT characteristics are present at least to a moderate degree (Table 38). This includes relevant people or organizations are represented (100%), needed services are available to meet consumers' needs (71%), complex cases are referred to appropriate agencies/resources (100%), meetings conclude with agreement on a care plan (100%), and that evidence-based practices and screening tools are recommended to address consumer needs (82%). However, only 41% of Specialists reported that MOUs or formal agreements to share client information and/or to overcome HIPAA privacy requirements are occurring to at least a moderate degree. The MDT characteristic that was rated most highly on a scale from 1 to 5 were that meetings concluded with agreement on a care plan (*M* = 4.35, 95% CI[4.02, 4.69]), that relevant people or organizations are represented (*M* = 4.06, 95% CI[3.63, 4.49]), and that complex cases are referred to the appropriate agencies or resources (*M* = 4.00, 95% CI[3.66, 4.34]) (Table 39).

Table 38. Stakeholders' Perceptions of MDTs organized by a Specialist

MDTs	Not at all % (*n*)	Slightly % (*n*)	Moderately % (*n*)	Considerably % (*n*)	A great deal % (*n*)	Total % (*n*)
Relevant people or organizations are represented (needed expertise is available)	0% (0)	0% (0)	30% (8)	37% (10)	33% (9)	100% (27)
Needed services are available to meet the consumer's needs.	0% (0)	28% (8)	28% (8)	28% (8)	17% (5)	100% (29)
Complex cases are referred to the appropriate agencies or resources.	0% (0)	4% (1)	46% (12)	27% (7)	23% (6)	100% (26)
Meetings conclude with agreement on the care plan.	0% (0)	8% (2)	29% (7)	33% (8)	29% (7)	100% (24)
We have an MOU or formal agreement to share client information and/or to overcome HIPAA privacy requirements.	0% (0)	5% (1)	21% (4)	37% (7)	37% (7)	100% (19)
Evidence-based practices and screening tools are recommended to address the consumer's needs.	0% (0)	12% (3)	16% (4)	40% (10)	32% (8)	100% (25)

Note. Based on 38 stakeholders who reported having attended an MDT with a Specialist.

Most stakeholders who reported having participated in an MDT (*n* = 38) reported that their involvement with MDTs has remained relatively consistent over time (51%). A little over one-quarter reported increasing involvement in MDTs (26%) and slightly fewer reported reduced involvement in MDTs (23%).

Table 39. Specialist ratings of MDTs

	N	*M*	95% CI
Relevant people or organizations are represented (needed expertise is available.	17	4.06	[3.63, 4.49]
Needed services are available to meet the consumer's needs.	17	2.82	[2.52, 3.13]
Complex cases are referred to the appropriate agencies or resources.	17	4.00	[3.66, 4.34]
Meetings conclude with agreement on the care plan.	17	4.35	[4.02, 4.69]
We have an MOU or formal agreement to share client information and/or to overcome HIPAA privacy requirements.	17	2.71	[1.80, 3.61]
Evidence-based practices and screening tools are recommended to address the consumer's needs.	17	3.65	[3.14, 4.15]

Specialists' Perceptions of Other (non-MDT) Community Partner/Stakeholder Groups

In addition to questions about MDTs, Specialists were asked about the characteristics of the community partner / stakeholder groups in their communities. Of the six questions that asked about positive characteristics of these groups, a majority of Specialists reported that most to all or almost all of their community partners have formed a cohesive group committed to addressing gaps in services (64%) and that they meet often enough to make progress toward

the goals of the group (70%). Additionally, 36% of Specialists reported that the right people are participating in discussions or meetings, 30% reported that community partners are engaged in a quality improvement project, and 22% reported that community partners have formal agreements in place for at least most stakeholders in their communities. When asked about the degree to which advocates, consumers, or family members are well represented in discussions or meetings, zero Specialists reported this was occurring for at least half of community partners, and 45% reported that this was occurring for very few or none of their community partners. Two items asked about barriers to community partner / stakeholder group progress. The majority of Specialists reported that these barriers are either occurring for very few or none or some community partners. Seventy-two Specialists reported that turnover in community partner organizations interferes with momentum, and 91% reported that historical barriers between agencies get in the way of progress for either very few or none or some community partners (see Table 40).

Table 40. Distribution of community partner / stakeholder group ratings

	Very few or none % (*n*)	**Some % (*n*)**	**About half % (*n*)**	**Most % (*n*)**	**All or almost all % (*n*)**	**Total % (*n*)**
Community partners have formed a cohesive group committed to addressing gaps in services.	9% (1)	27% (3)	0% (0)	18% (2)	45% (5)	100% (11)
Community partners meet often enough to make progress toward the goals of the group.	10% (1)	10% (1)	10% (1)	30% (3)	40% (4)	100% (10)
Advocates, consumers, or family members are well represented in our discussions or meetings.	45% (5)	18% (2)	36% (4)	0% (0)	0% (0)	100% (11)

Community partners are engaged in a defined quality improvement project.	20% (2)	20% (2)	30% (3)	10% (1)	20% (2)	100% (10)
Community partners have formal agreements in place.	33% (3)	33% (3)	11% (1)	0% (0)	22% (2)	100% (9)
The right people who can make changes in agency programs or services are participating in our discussions or meetings.	18% (2)	27% (3)	18% (2)	27% (3)	9% (1)	100% (11)
Turnover in community partner organizations interferes with momentum.	27% (3)	45% (5)	9% (1)	18% (2)	0% (0)	100% (11)
Historical barriers between agencies get in the way of progress.	45% (5)	36% (4)	9% (1)	9% (1)	0% (0)	100% (11)

Note. Four Specialists had non-valid data for at least one of these items which included 8 (8%) missing responses and 12 (12%) "don't know" responses.

COVID-19 Pandemic Impacts

The COVID-19 pandemic has impacted the work of the Initiative, the work of the Initiative's stakeholders, and the ways stakeholders interact with the Initiative. We queried stakeholders on how the COVID-19 pandemic might have impacted their involvement with the Initiative. Eighty-four respondents commented on the pandemic's impact on their involvement. Approximately 46% of the respondents indicated less involvement with the Initiative since the pandemic started. Some respondents specifically mentioned they were less available to

participate in online training events due to “staff shortages” and “time conflicts”. One respondent stated,

> “COVID-19 has increased my clients’ needs for certain support services from me that have impacted my time to devote to attending video [virtual] meetings. They are very beneficial, but it is a challenge to be present”.

An additional 17% of respondents stated that the pandemic increased their involvement with the Initiative. One respondent stated, “increased staff trainings, increased staff awareness of [Specialists] available for consultation and assistance”. Another respondent stated that they experienced an increase in complex case consultation referrals. Another 10% of survey respondents mentioned vague comments about technology. For example, there were comments such as “everything is virtual”, “lots of Zoom time”, and “all virtual meeting and training events.”

About five comments described the unique quality of the ‘new normal”. For example, one respondent stated, “Virtual meetings/trainings leave a lot to be desired and also have been crucial this past year. Welcome [to] the new normal”. Another respondent described their complex experience working with some older adults throughout the past year. This person shared, “[We have received] more referrals from people who [we] would never have known they would need help in their lives, and are hesitant to ask for it or to accept it. [We are finding] that most new referrals are scared and lonely, they do not know what to do, they get more confused, and the COVID problems with getting appointments for vaccines...just basic things they took for granted every day...These are not usually people with documented behavioral issues - they are just people caught, sometimes alone, in a situation where their ‘normal’ life routines will never return...”. Lastly, four respondents made comments that were not specifically related to their involvement with the Initiative.

Specialists also provided comments about how the COVID-19 pandemic has affected their work. Comments from the Specialists were highly variable as some Specialists noted that some activities have decreased while there has been an increase in other activities, like training events. One Specialist noted that some positive outcomes from working remotely are an increase in availability to research more information about topics of interest, less driving around, and the ability to attend more meetings. Another Specialist shared, “I have been substantially more busy since COVID-19 pandemic. Case consultations, system navigation needs have increased across the community. There are so many new meetings and projects, attempting to keep communities connected and transitioning support to virtual format.”

One Specialist shared negative outcomes of remote work, noting, "[There is] more time spent on phone and virtual platforms trying to keep connections and relationships strong which loses its impact somewhat. Networking abilities are severely hampered. Many competing meetings and meeting-fatigued people. Many previously standing groups disbanded or switched focus due to COVID response demands. It is difficult to make long-term plans and the focus for most continues to be COVID-driven."

Impact of the Initiative

The Initiative is intended to improve the provision of behavioral health services to older adults and adults with disabilities by enhancing the knowledge base of community agency staff, facilitating collaboration and coordination across agencies, and consulting on complex consumer cases. We asked both stakeholders and Specialists five questions that asked about the degree to which these goals of the Initiative have been reached. We asked whether there was increased awareness of the BH needs of older adults and adults living with disabilities, a reduction in barriers between aging services and behavioral health agencies, increased integration between BH services and primary care, increased access to BH services, increased access to long-term services and supports, and improvement in consumers ability to navigate eligibility and reimbursement criteria. Specialists and stakeholders provided similar ratings of these items.

Overall, few stakeholders reported that these goals were not achieved at all (range 3% to 12%). Stakeholders most often reported that the Initiative has led to increased awareness of the behavioral health needs of older adults and adults with disabilities (64% rated as considerably or a great deal). Specialists also most often reported that the Initiative has led to increased awareness of the behavioral health needs of older adults and adults with disabilities (73%). A majority of stakeholders said that the Initiative has at least moderately led to reduced silos between aging and BH agencies (70%), compared to 63 percent of Specialists (considerably or to a great deal). Only thirty-six percent of stakeholders and 27% of Specialists reported increased integration between BH and primary care services (considerably or to a great deal). Stakeholders and Specialists reported increased access to BH services (68%, 56% respectively), increased access to long-term services (68%, 70% respectively), and helped consumers navigate systems (64%, 73% respectively) (see Table 41 and 42).

Table 41. Stakeholder Perceptions of the Impact of the Initiative

BHI impacts	Not at all % (n)	Slightly % (n)	Moderately % (n)	Considerably % (n)	A great deal % (n)	Total % (n)
Increased awareness of the behavioral health needs of older adults and people with disabilities.	3% (3)	12% (12)	21% (22)	41% (43)	23% (24)	100% (104)
Reduced siloes between aging services and behavioral health agencies.	9% (9)	21% (20)	33% (32)	25% (24)	11% (11)	100% (96)
Increased integration between behavioral health services and primary care.	10% (8)	23% (18)	31% (24)	26% (20)	10% (8)	100% (78)
Increased consumers' access to behavioral health services.	7% (6)	24% (20)	38% (31)	15% (12)	16% (13)	100% (82)
Increased consumers' access to long-term services and supports.	11% (9)	20% (16)	33% (26)	23% (18)	13% (10)	100% (79)
Helped consumers navigate restrictive eligibility or reimbursement criteria (e.g., Medicaid, APD).	12% (9)	24% (19)	31% (24)	19% (15)	14% (11)	100% (78)

Note. Of the 137 stakeholders who reported partially or completely responded to the survey, 32, 42 cases had missing values and are not included in this table

Table 42. Specialist Perceptions of the Impact of the Initiative

BHI impacts	Not at all % (n)	Slightly % (n)	Moderately % (n)	Considerably % (n)	A great deal % (n)	Total % (n)

Increased awareness of the behavioral health needs of older adults and people with disabilities.	0% (0)	0% (0)	27% (3)	18% (2)	55% (6)	100% (11)
Reduced siloes between aging services and behavioral health agencies.	0% (0)	27% (3)	9% (1)	36% (4)	27% (3)	100% (11)
Increased integration between behavioral health services and primary care.	18% (2)	18% (2)	36% (4)	18% (2)	9% (1)	100% (11)
Increased consumers' access to behavioral health services.	11% (1)	33% (3)	22% (2)	22% (2)	11% (1)	100% (9)
Increased consumers' access to long-term services and supports.	0% (0)	30% (3)	30% (3)	30% (3)	10% (1)	100% (10)
Helped consumers navigate restrictive eligibility or reimbursement criteria (e.g., Medicaid, APD).	0% (0)	27% (3)	27% (3)	27% (3)	18% (2)	100% (11)

Note. Of the 13 stakeholders who reported partially or completely responded to the survey, four cases had missing (n = 1) or "don't know" values (n = 3) and are not included in this table.

We also wanted to obtain a sense of stakeholders' global perceptions of how effective the Initiative has been at improving services for older adults and adults with disabilities who have BH needs. Across all agency types, stakeholders rated the Initiative a six out of ten on effectiveness. While stakeholder's organization type was not significantly associated with ratings of effectiveness, stakeholders from behavioral health agencies (M = 6.86) and from agencies other than BH or aging services (M = 6.44) rated the Initiative's effectiveness higher than those from AAA/ADRCs (M = 5.42) and APD/APS (M = 5.62) (See statistical tests in Table 43

below). However, there was wider variation in scores of effectiveness among stakeholders from both AAA/ADRCs and APD/APS (as well as more uncertainty due to the small number of APD/APS stakeholders in our sample) reflected in the relatively wide confidence intervals.

Table 43. Stakeholders' Rating of the Overall Effectiveness

Organization Type	N	Mean [95% CI]
AAA/ADRC	26	5.42 [4.47,6.37]
Behavioral Health (incl. CMHPs)	22	6.86 [6.20,7.52]
ODHS/APD/APS	8	5.62 [3.53,7.71]
Other	32	6.44 [5.77,7.11]
Missing	28	6.29 [5.54,7.04]
All	116	6.20 [5.81,6.59]

Note. Twenty-one cases had missing data on this question and are not included in the table.

We also wanted to get a sense of Specialists global perceptions of how effective the BH Initiative has been at improving services for older adults and adults with disabilities who have BH needs. Specialists rated the Initiative 6.58 out of ten on effectiveness, slightly higher than stakeholders (6.20) and key informants (5.88) (see Table 44).

Table 44. Specialists' Rating of the Overall Effectiveness

	N	Mean [95% CI]
Initiative's effectiveness (out of 10)	12	6.58 [5.80, 7.36]

Note. One case had missing data on this question and is not included in the table.

The survey results indicate that increased outreach to several specific groups and populations may be necessary to address unmet needs. Further, the results identify different forms of outreach that could be most beneficial in reaching these communities. Some examples of groups identified by stakeholders were consumer populations such as older adults living with behavioral health needs who need but may often reject help, communities of color, and individuals experiencing houselessness. Faith communities and behavioral health agencies were also identified as in need of additional outreach. Respondents went on to identify several other groups that would benefit from further outreach including LGBTQ+ organizations, hospice social workers, and staff working in long-term care facilities.

Recommendations: Initiative and Systems-Level Change

Several recommendations on how to better serve the behavioral health needs of older adults and people living with disabilities emerged from the evaluation findings. These recommendations are intended to build on the successes achieved over the past several years of the Initiative and suggest areas where improvements can be made at the Initiative-level as well as at systems-level through policy change.

Initiative-Level Recommendations: Stakeholders

Sustained Investment

- Sustained investment to support this population is essential. Investment also means improving the ways that funding streams operate.

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.

- Some additional ways that collaboration with partners could be advanced:
    - Invite groups to attend community partner meetings
    - Obtain buy-in from key players in the community or within agencies
    - Hold additional in-person meetings once staff return to in-person work

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 ongoing workforce development is needed, and that the Specialists are well-positioned to provide this within their local communities.

Address Gaps in Services

- Share resources and increase MDT staffing to create clearer pathways and reduce barriers for consumers to obtain support and services.
- Increase capacity to expand collaborative partnerships.
- Provide assistance with referrals and access to care.
- Provide more timely delivery of services.
- Leverage partnerships with entities such as APS, fire departments, and law enforcement to connect older adults who have BH needs with behavioral supports and services, not only physical care.
- Recruit more mental health and substance use providers to serve this population.

Advertise and Raise Awareness of the Initiative

- Convey the benefits of coordination to partners and the community
- Coordinate efforts to inform the public of available resources including funding

Initiative-Level Recommendations: Specialists

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

- Provide the Specialists the opportunity to offer additional assistance with referrals and navigating access to care, for example during CCCs.

- Increase capacity of the Specialists to expand collaborative partnerships with entities such as APS, fire departments, and law enforcement to connect older adults who have BH needs with behavioral supports and services, not only physical care.
- Promote the influence of Specialists so they are able to reach primary care providers and APD foster homes.
- Elevate the voice of the Specialists as subject matter experts on how to address gaps in services with senior leaders and department directors of ODHS and OHA.
- Improve funding streams within local agencies so that resources are properly targeted to support the BH needs of this population.

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

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

Increase the role Flexibility of the Specialists

- Allow Specialists to provide direct services including mental health assessments at complex case consultations. This would be especially beneficial in Oregon's rural communities that are experiencing provider shortages.

Advertise the Initiative

- Conduct targeted statewide marketing about the Initiative and what Specialists provide so the Initiative becomes more widely known.

Stakeholder Engagement

- Messaging from ODHS or CMHPs to more strongly encourage participation from potential partner agencies.
- Improve marketing efforts so stakeholders have a clear idea of how the goals of the Initiative could enhance the goals of their own organization.
- Regulate and fund systems at the community-level in ways that promote collaboration and coordination.

Systems-Level Recommendations: Stakeholders

Funding

- Prioritize resources and funding for additional behavioral health services across Oregon. This extends beyond funding to include the way the financing systems operate including a new Medicaid Waiver to more adequately support behavioral health. The multiple mental health impacts of the COVID-19 pandemic make this an even more salient need.

Coordination and Collaboration

- Implement formal agreements between agencies such as memorandums of understanding (MOUs). These formal agreements will help to align purposes and policies between agencies and establish clear expectations for collaboration across agencies.
- Continue to focus on breaking down the silos between service agencies, most specifically aging and behavioral health.

Address Gaps in Services

- Increase the number of specialized long-term care facilities that can support people living with behavioral health needs. The lack of facilities is particularly acute in many rural and frontier areas of Oregon.
- The direct care workforce would also benefit from additional training to obtain the tools they need to support this population.
- Provide additional resources to older adults to address issues such as substance use, depression, and anxiety, which have all increased during the COVID-19 pandemic.

Workforce Development

- Recruit and train more mental health professionals who are able to directly work with people not yet in the system so they can obtain the necessary services that support their behavioral health.

Awareness of Behavioral Health

- Focus on reducing the stigma that surrounds mental health disorders and focus on ensuring greater inclusion within the community.

Systems-Level Recommendations: Specialists

Support Operation of Medicare and Medicaid

- Promote access to behavioral health services through Medicare by supporting enrollment of providers who will provide billable Medicare services. Specialists can help address the shortage by working to recruit more professionals to enroll in Medicare and as well as by expanding their outreach beyond agencies that only serve Medicaid clients.
- Address billing-related issues and support greater Medicare accessibility by offering technical assistance to providers.
- Reduce existing barriers to Medicaid coverage of mental health services in Oregon, specifically for consumers residing in licensed long-term care settings.

Funding for the Initiative

- Provide funding for workforce development events to decrease knowledge gaps.
- Direct additional financial support to Specialists in order to implement and maintain projects and programming within their local communities.
- Increase funding to hire additional full-time Specialists, especially in Eastern Oregon where only two Specialists and one part-time provide coverage for multiple counties.

Establish Formal Agreements Between Agencies

- Establish MOUs between aging and behavioral health systems to promote information sharing and prevent clients from falling through the cracks in the system.
- Implement state-level MOUs between the Oregon Department of Human Services and Oregon Health Authority's Behavioral Health Division.
- Use braided funding to better address consumer issues through reduced administrative burdens.
    - An exemplar model might be Wraparound, a program that uses designated funds to ensure cases escalate 'up the chain' to the appropriate entities as part of the goal of providing comprehensive, holistic behavioral health supports.

Address Gaps in Services

- Sustain funding for AAA-ADRC mental health programs to provide a safety net for people who live alone and lack natural supports.
- Address the lack of medical support for mental health as there is a need to provide consumers with medical care so they can live successfully in licensed care settings.

- Support affordable housing options for older adults and people living with disabilities with behavioral health needs. Increase access to Enhanced Care Services provided by Oregon's licensed long-term care settings.

Prioritize Older Adults

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

Policy Options to Address Gaps and Needs

Investing in the Behavioral Health System

❖ Sustained investment in behavioral health services is foundational to achieving better outcomes for older adults and people living with disabilities who have behavioral health needs. Ensure that programs and services are fully funded to meet the challenges facing the behavioral health system.

Addressing Gaps in Service Delivery

❖ Far too many gaps remain in the services available to Oregonians who are older or are living with disabilities. Service gaps could be addressed in part through the use of 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.

Supporting Further Coordination and Collaboration

❖ The use of formal agreements between agencies, specifically memorandums of understanding (MOUs), have been identified as a clear need. The binding nature of these agreements ensures collaboration and coordination will take place between multiple agencies. The OHA and ODHS must seek to institute these agreements between agencies. Consider providing funding incentives to agencies that through collaborative efforts are able to achieve goals of better outcomes.

Developing the Behavioral Health Workforce

- One of the greatest strengths of the Initiative is the focus on workforce development across behavioral health and aging services. Yet, significant gaps remain in Oregon's behavioral health workforce. This population must have a workforce that is able to provide necessary and essential services.

Policy Options to Address Gaps and Needs

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

Table 45. Micro-level interventions to support behavioral health for older adults and people with disabilities: Specialists' approaches

Program name	Resident Services Navigator Pilot
Population served	Older adults in need of care coordination services
Scope	Interns from local colleges and universities provide one-on-one health navigation, as well as training to HUD communities. The interns receive supervision from Cascade Behavioral Health and Senior and Disability Services. The Specialists provide training to the interns focused on navigating the behavioral health system and the healthcare system in general.

Intent	The project provides direct health navigation services through Homes for Good to the residents of two Department of Housing & Urban Development (HUD) communities.
Recommendation addressed by this intervention	Address Gaps in Services

Table 46. Micro-level interventions to support behavioral health for older adults and people with disabilities: Interventions in other states/countries

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

Program name	BEAT-IT
Population served	Older adults and adults with intellectual disabilities
Scope	Adapted manual of behavioral activation therapy for adults with intellectual disabilities, based out of Scotland.
Intent	Behavioral activation is used to engage adults and older adults with an intellectual disability in meaningful activities and positive reinforcers.
Recommendation addressed by this intervention	Provide additional resources to older adults to address issues such as substance use, depression, and anxiety, which have all increased during the COVID-19 pandemic.

Table 47. Macro-level interventions to support behavioral health for older adults and people with disabilities: Specialists' approach

Program name	Expansion of Mental Health First Aid (MHFA) programming
Population served	Older adults experiencing a mental health condition

Scope	Two, eight-hour trainings provided at no cost to staff and/or volunteer
Intent	To train staff and volunteers in the Older Adult curriculum provided in MHFA training. This training aims to provide staff with knowledge to effectively respond to older adults who may be experiencing a mental health condition. Specialists in Polk, Lane, Linn-Benton, Klamath, Washington, Marion, Yamhill and Multnomah counties are certified to deliver MHFA.
Recommendation addressed by this intervention	To Better Serve Older Adults and People Living with Disabilities with Behavioral Health Needs

Table 48. Macro-level interventions to support behavioral health for older adults and people with disabilities: Specialists' approach Interventions in other states/countries

Program name	EZ Fix Program
Population served	Older adults and adults with disabilities currently residing in their own homes
Scope	Volunteer-based program

Intent	This program helps older adults and adults with disabilities remain safely in their homes by providing minor home repair and housekeeping services in rural eastern Maine.
Recommendation addressed by this intervention	To better serve older adults and people living with disabilities with behavioral health needs

Table 49. Meso-level interventions to support behavioral health for older adults and people with disabilities: Specialists' approaches

Program name	Public Guardianship and Conservator Development Project
Population served	Older adults in need to guardians and conservators
Scope	Group of agencies and community partners held a regional summit in November, helped produce a report early this year, and is currently working to transform the project into its own non-profit organization.
Intent	The project aims to increase the number of public guardians and conservators in Central Oregon. The project brings together relevant agencies and community partners to establish its own nonprofit guardianship organization.

Recommendation addressed by this intervention	Implement formal agreements between agencies such as memorandums of understanding (MOUs).

Table 50. Meso-level interventions to support behavioral health for older adults and people with disabilities: Interventions in other states/countries

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

Recommendation addressed by this intervention	Implement formal agreements between agencies such as memorandums of understanding (MOUs).

Table 51. Meso-level interventions to support behavioral health for older adults and people with disabilities: Interventions in other states/countries

Program name	Telehealth Intervention Program for Older Adults (TIP-OA)
Population served	Isolated older adults with mental health/cognitive issues and/or their caregivers
Scope	Volunteer-based program based in Quebec provides weekly calls from trained volunteers to older adults and/or their caregivers with mental health/cognitive issues. Volunteers check in on the OA/caregiver and to see if they need any support (e.g., food delivery, medication from their pharmacy), provide information about any needed community supports (e.g., grocery delivery) and COVID-19. Volunteers also provide company to form a sense of connection.
Intent	This program aims to ensure that this population's needs are being met, have necessary information about the COVID-19 pandemic, and provides a sense of connection for older adults who are experiencing loneliness due to the pandemic.

Recommendation addressed by this intervention	Provide additional resources to older adults to address issues such as substance use, depression, and anxiety, which have all increased during the COVID-19 pandemic.

Table 52. Meso-level interventions to support behavioral health for older adults and people with disabilities: Interventions in other states/countries

Program name	Certified Older Adult Peer Specialist Programs (COAPS)
Population served	Older adults with behavioral health issues
Scope	This program, based out of Pennsylvania, utilizes a Certified Peer Specialist (CPS) who is 50+ and in recovery for mental health and/or substance use disorder and has completed the PA 2-week (75 hours) CPS training and COAPS-specific training (18 hours).
Intent	COAPS supports older adults with behavioral health issues in a variety of ways including crisis support, development of community roles and natural supports, individual advocacy, self-help, and self-improvement.
Recommendation addressed by this intervention	Provide additional resources to older adults to address issues such as substance use, depression, and anxiety, which have all increased during the COVID-19 pandemic.

Summary and Conclusion

There are several achievements the Initiative and the Specialties can point to in their work to improve the behavioral health of older adults and people living with disabilities in Oregon. Across our multiple data sources, it is clear tremendous overlap exists in how stakeholders and Specialists view the barriers to success as well as in their view of the potential opportunities to address these barriers.

This report provides several recommendations based on the findings of the data collection efforts for ways the Specialists could build on their successes. Several examples from other states and localities that may be applicable to the Oregon context are provided where new programs and interventions could be implemented. These are offered in terms of local level and systems level options. At the local level, programs and interventions that could be implemented by the Specialists' within their communities are provided. Examples are also offered that could be implemented as a county-level as well as at the state-level. This multi-level approach is needed to help facilitate continued improvement in the behavioral health for Oregon's older adults and people living with disabilities.

References

Cucinotta, D., & Vanelli, M. (2020). WHO Declares COVID-19 a Pandemic. *Acta bio-medica : Atenei Parmensis*, 91(1), 157–160. https://doi.org/10.23750/abm.v91i1.9397

Koma W., True, S., Biniek, J.F., Cubanksi, J., Orgera, K., & Garfield, R. (2020). "One in Four Older Adults Report Anxiety or Depression Amid the COVID-19 Pandemic." October 9. 2020. Washington, DC: Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/one-in-four-older-adults-report-anxiety-or-depression-amid-the-covid-19-pandemic/