Evaluation of the Older Adult Behavioral Health Initiative

2022-2023 Key Informant Interviews

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List of acronyms

AAA: Area Agency on Aging

ADRC: Aging and Disability Resource Center

APD: Aging & People with Disabilities

BH: Behavioral Health

CMHP: Community Mental Health Program

OABHI: Older Adult Behavioral Health Initiative

I. Background of the Initiative

The Older Adult Behavioral Health Initiative (referred to as "OABHI" in this report) was formed in 2015 and is comprised of 24 Behavioral Health Specialists (referred to as "Specialists" in this report) who work in every county across the state of Oregon and engage with stakeholders and other community-based partners to reduce siloes, increase the knowledge and skills of the behavioral health workforce and the community, and consult on complex care cases (CCCs) involving older adults and people with physical disabilities who have behavioral health needs[1]. The overall goal of the OABHI is to better meet the needs of older adults and people with disabilities by improving timely access to care from qualified providers who work together to provide coordinated, quality and culturally responsive behavioral health and wellness services. Specialists work with other stakeholders to address issues unique to their local communities.

The Oregon Health Authority (OHA) funds the OABHI and contracts with a team of researchers from the Institute on Aging (IOA) at Portland State University (PSU) to evaluate the work of the OABHI by collecting data from the Specialists and stakeholders. The PSU Evaluation Team has evaluated the OABHI since 2016. Key stakeholders (referred to as "key informants" in this report) are considered primary partners of the Initiative and work within Aging and People with Disabilities (APD) offices, Area Agencies on Aging-Aging and Disability Resource Centers (AAA-ADRCs), and Community Mental Health Programs (CMHPs). In 2020, the PSU Evaluation Team developed and administered a survey and qualitative interview instrument with managers from these key informant agencies in both rural and urban areas.

The PSU evaluation team conducted a second round of Key Informant Interviews from October 2022 through January 2023. Similar to those administered in 2020, the evaluation included both a survey and open-ended qualitative questions, although the items in these instruments were updated in 2022. Because the items are significantly different, we are not comparing 2022 data to those data collected in 2020. In addition, we included a mix of both frontline staff and managers in the 2022 sample. The 2022 instruments include more survey and interview items and took about 30-45 minutes to administer.

The primary objectives of the Key Informant survey and interview instruments are to assess the perceptions of the Initiative's impact, including what components are working well, and where improvements can be made to best support older adults and people with physical disabilities who have behavioral health needs. Second, the evaluation aims to improve coordination with the Initiative and Key Informant agencies.

II. Methods

The PSU Evaluation Team worked closely with the OABHI Project Director to develop an instrument to:

1. assess key informants' perceptions of what is different now as a result of the Initiative;
2. determine how the Initiative can be improved; and
3. identify opportunities to improve coordination with partner agencies.

A mixed-methods approach was used, drawing on both quantitative survey items and qualitative interview questions. We aimed to understand if these three areas differed based on whether the Key Informants worked in rural or urban areas, the type of agency in which they worked, and whether the Key Informants primarily worked in a management or direct service position.

Sample and participants

The PSU Evaluation Team focused our sample on managers and frontline staff from local AAA-ADRCs, APD offices, and CMHPs. First, we identified the population of managers from AAA-ADRC and APD offices using the February 2022 publication of "DHS Aging and People with Disabilities (APD) Branch Contact Information for APD and AAA Field Offices". Managers at CMHPs were identified through contact information provided by the Specialists in 2020, outreach to the current Specialist when contact information was outdated, and Google searches for names and contact information of managers. This resulted in a sampling frame of 36 total managers, of which we made contact with 29. To reach frontline staff, we asked half of the managers we contacted to refer us to someone at their agency who was familiar with the Initiative and worked directly with consumers. We asked the other half of the managers' contacts to participate directly in an interview. Next, we used stratified random sampling based on three grouping variables to construct our sample. Grouping variables were agency type (i.e., AAA-ADRCs, APDs, and CMHPs), whether the agency was based in an urban or rural county (counties with a metropolitan area were grouped as urban), and whether the Key Informant primarily worked directly with consumers (referred to as "frontline staff" in this report, this group consisted of case managers, options counselors, I&R Specialists, and eligibility case managers) or were primarily in a management role (referred to as "managers" in this report).

When we were unable to recruit a randomly selected respondent after at least three contact attempts, we replaced them in the sample with the next respondent within the same strata based on random ordering. Additionally, when certain strata included fewer than the desired number of three key informants, we oversampled from the most similar strata (i.e., same

urban/rural status and same agency type) to support a balanced sample. Participant recruitment began in October 2022 and ended in January 2023. Our final sample included 29 key informants out of a total recruited sample of 36, with a total response rate of 81%. We aimed to interview an equal number of key informants for each stratum with the goal of collecting equal amounts of information from each group. The sample groups varied slightly based on the number of respondents from each group (see Table 1). There were 10 Key Informants in both AAA-ADRC and APD groups, and 11 Key Informants from the CMHP group. There were slightly more managers (*n* = 16) than frontline staff (*n* = 13) in our sample and our sample was more rural (*n* = 15) than urban (*n* = 14).

Table 1: Stratified random sampling of key informants by agency type, position, and area.

Agency Type		APD		AAA-ADRC		CMHP*		Area subtotal
Position		Frontline	Manager	Frontline	Manager	Frontline	Manager	
Area	Urban	2	3	2	2	3	2	14
	Rural	1	3	3	3	2	3	15
Agency Type Subtotal		9		10		10		29

*6 of the 10 CMHP participants worked in CCBHCs (Certified Community Behavioral Health Clinics)

Data collection tools

Quantitative survey. The PSU Evaluation Team developed an online survey in Qualtrics. The survey link was sent to all 29 participants in advance of the interview and most participants ($n = 17$) completed the survey in advance of the interview, and the rest answered the survey questions at the start of the interview ($n = 14$). This survey included five questions on a scale from 1 to 5 (see the Appendix). The quantitative items asked about frequency of contact with the Specialist(s) in their area, and the types of engagement activities. Depending on item wording, the scale from 1 to 5 either measured frequency of contact (from "Never" to "Always") or (from "We haven't started yet" to "We do this all the time"), and degree of effectiveness (from "Not at all effective" to "Extremely effective").

Qualitative interview guide. The PSU Evaluation Team developed and conducted semi-structured, video conferencing-based interviews with key informants (see the Appendix) using the Zoom application. We piloted interview questions with a manager from a CMHP who has worked with the Initiative for several years and made additional revisions based on their responses and feedback about the questions. The interview script for frontline staff included 18 open-ended questions, with several sub-questions and probes. The interview script for managers included 17 open-ended questions, with several sub-questions and probes. The questions asked of the managers and frontline staff were the same, except for one additional question asked of frontline staff (*What support would you need from your agency's leaders to better serve older adults and people with disabilities in your area?*) Interviews were transcribed

using Zoom's transcription service. Transcripts were reviewed after interviews to correct any transcription errors.

Analysis

Quantitative Analysis. Quantitative data cleaning, management, and analysis were conducted using the R statistical software environment[2] and the RStudio integrated development environment[3]. Data cleaning was primarily conducted with the Tidyverse suite of function packages. Contingency tables were created using the gtsummary package[4], and chi-square and Fisher's exact tests of independence were conducted using the 'chisq.test' and 'fisher.test' functions from base R.

Descriptive statistics were computed for five pre-interview screening questions. We calculated a total involvement score for each key informant based on the average response to a battery of screening questions that asked each respondent to assess their organization's current involvement with the Initiative. Key informants were designated as having 'low to medium' involvement if their mean score on the five pre-screening items was less than three and were designated as having 'medium to high involvement' if their mean score was greater than three. Group differences, including urban and rural settings, agency type, and respondent role. We compared group means in Initiative involvement for each of the categories. Respondents were divided into two groups based upon county of employment: Urban (Benton, Clackamas, Columbia, Deschutes, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Washington, and Yamhill Counties) and Rural (Baker, Clatsop, Coos, Crook, Curry, Douglas, Gilliam, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Lincoln, Malheur, Morrow, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, and Wheeler Counties). Respondents were also grouped according to broad agency categories: AAA-ADRC, APD, and CMHP.

Qualitative Analysis. Qualitative data cleaning, management, and analysis were conducted using qualitative analytical software applications to identify and describe emergent themes relating to key informants' experiences with the Initiative. Qualitative coding was conducted by a team of six researchers and followed a three-phase process of 1) open, collaborative coding, 2) iterative code review, and 3) code distillation. During the open, collaborative coding phase, three teams of two researchers each read through several questions for the first half of the sample and identified meaningful themes through the creation of preliminary thematic codes. Once this phase was completed, the teams of researchers were assigned a different set of questions for the second half of the sample. The resulting codes were discussed and distilled in order to isolate the pertinent emergent themes.

The most prevalent themes for each interview question were identified, thematically analyzed, and grouped for meaningful and representative examples. Group comparisons were also conducted to identify whether theme endorsement differed by key informant location in rural or urban communities, work in APD, AAA-ADRC or CMHPS, or level of involvement with the Initiative. Themes rather than prevalence rates are reported since key informants responded to

questions based on roles within their agency, interpretation of the question, and experience with the initiative. Responses have been de-identified to maintain participant anonymity and may have been edited for spelling, grammar, and conciseness.

III. Key Findings

Involvement with the OABHI

The Key Informant sample consisted of 12 frontline and 17 managerial respondents. Frontline workers reported higher overall levels of involvement with the Initiative than managers (means of 3.9 and 3.6 respectively) (see Figure 1). Respondents were divided into quartiles based upon their self-reported tenure in their current position. This assignment may not reflect the respondents' overall experience in the field of Behavioral Health). Key Informants reporting less than two years in their job scored the lowest with regard to interaction with the OABHI (mean of 3.3 on the screening questions), while those with between two and five years in their positions reported the highest average involvement score (mean of 4.1 on the screening questions).

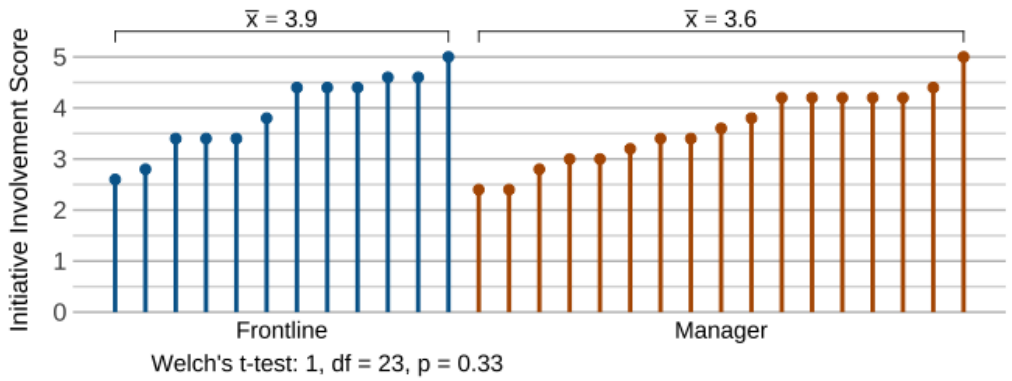


Figure 1: Key Informant Role and Initiative Involvement Score

Figure Two describes participants' tenure in their current position, and their involvement with the initiative. We separated the sample into rough quartiles based upon the years each key informant reported that they had been in their current position (see Figure 2). The 'newest' key informants (0-2 years' experience) had the lowest Initiative involvement scores ($\overline{x} = 3.3$), followed by those reporting between 5 and 7 ½ years in their current position ($\overline{x} = 3.6$). Key

informants with more than 7 ½ years in their current position averaged 3.9 with regard to Initiative involvement, with those with between 2 and 5 years scoring the highest ($\overline{x} = 4.1$).

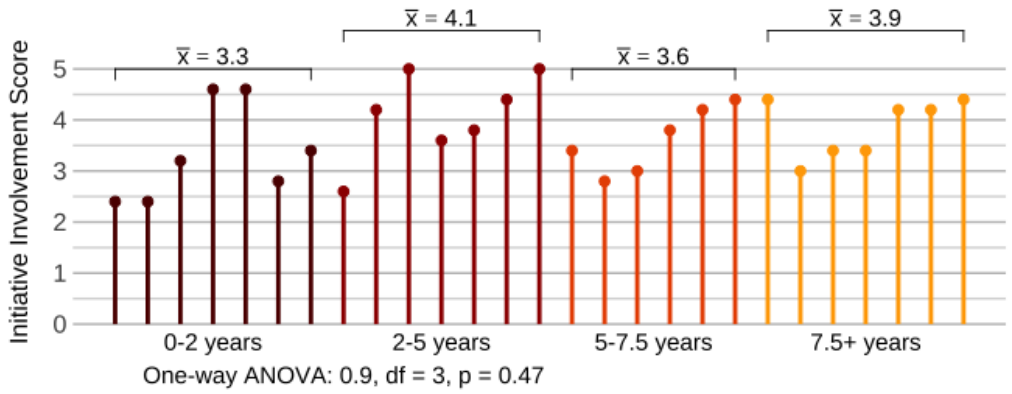


Figure 2: Key Informant Tenure and Initiative Involvement Score

Over half of respondents (n= 17) were identified as working in rural counties, and 12 from urban counties (see Figure 3). Overall, the rural respondents indicated similar levels of involvement with the Older Adult Behavioral Health Initiative (a mean of 3.73 to 3.73 respectively), a statistically insignificant difference.

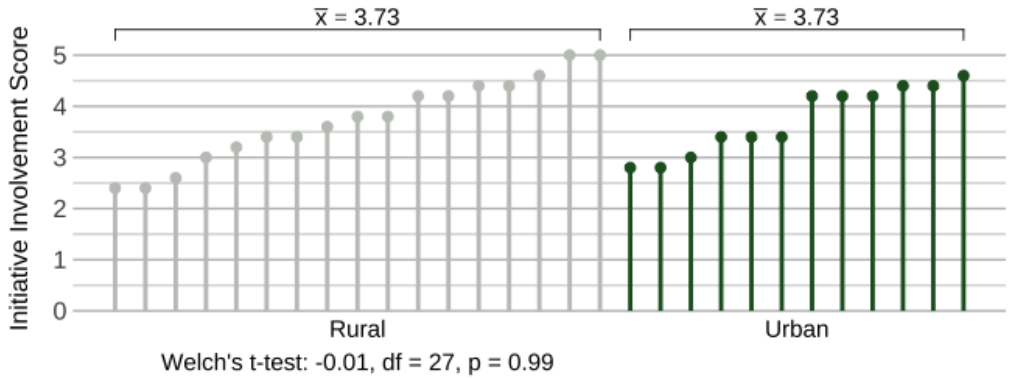


Figure 3: Key Informant Geographical Location and Initiative Involvement Score

Ten respondents worked for AAA-ADRCs, eight for APDs, and 11 for CMHPs (see Figure 4). Overall, respondents who worked in APDs indicated higher levels of involvement with the

Initiative than respondents who worked for either CMHPs or AAA-ADRCs (mean of 3.85 to 3.76 and 3.6 respectively), but those differences were indistinguishable from those that might be attributed to random chance.

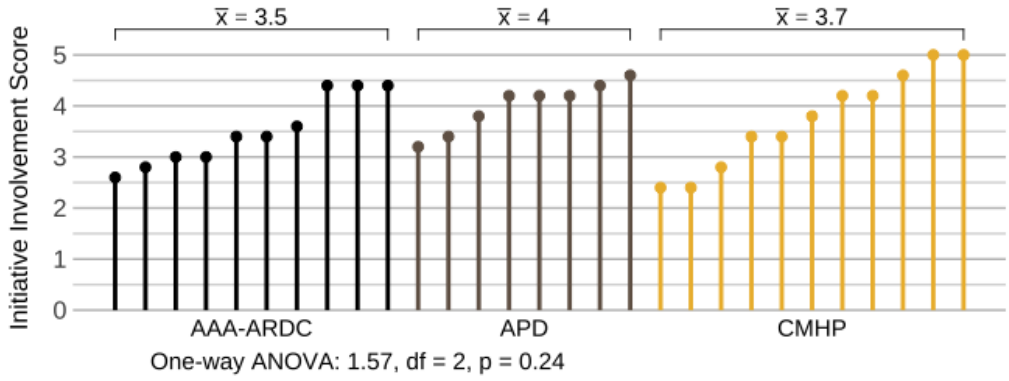


Figure 4: Key Informant Agency Affiliation and Initiative Involvement Score

Participants completed a pre-interview survey about their involvement with the Initiative. Figure five below describes key informants' responses on a scale of one to five. The first question asked how often the respondent was in contact with their specialist (one being never and five being always). Questions two to five responses ranged from one to five with one being "We haven't started yet," to five being "We do this all the time. The first question asked about Specialist participation in agency staff meetings (survey question 1 (SQ1), Specialist participation in complex care consultations (CCC) (SQ2), inter-agency collaboration (SQ3), whether the respondent's agency refers CCCs to a Specialist (SQ4), and whether the respondent's agency allocates time for them to attend training sessions done by Specialists (SQ5) (see Figure 5). Responses were broadly skewed towards the favorable end of the scale (4-5) across all respondents. Key informants indicated that they had frequent contact with their Specialists (SQ1 $\overline{x} = 3.72$), that they often met with Specialists in order to address complex cases (SQ2 $\overline{x} = 3.69$), that they regularly hosted or attended planned meetings with CMHPs and aging services agencies (SQ3 $\overline{x} = 3.45$), that they often referred complex cases to Specialists (SQ4 $\overline{x} = 3.48$), and that their respective agencies allowed them to use time to attend training events organized by the BHS (SQ5 $\overline{x} = 4.31$). These responses were used to construct a measure of Initiative Involvement for each key informant ($\overline{x} = 3.73$, $sd = 0.76$).

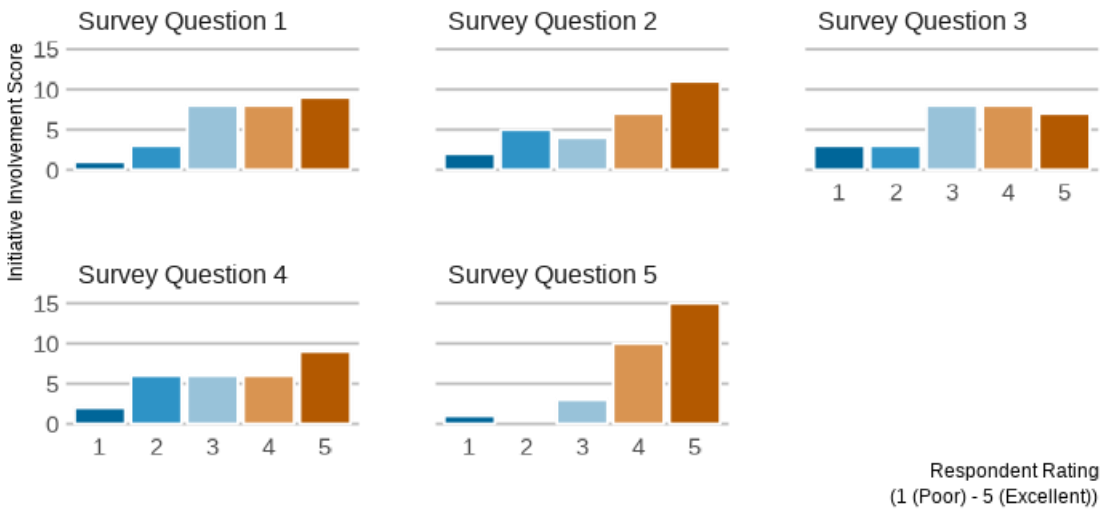


Figure 5: Key Informant Responses to Pre-Interview Questions (Involvement)

In their interviews, respondents identified three primary interactions with the Initiative: CCCs, Collaboration, and Education. Key Informants were quick to suggest that a primary interaction was contacting their Specialist for complex care consultations.

> *"[Our Specialist] periodically attends unit meetings to announce what [they] can offer. I attend two community collaborative meetings that Specialists attend to build interagency bridges."* (Manager, Urban, AAA-ADRC)

Including the Specialist in discussions of complex cases was overwhelmingly seen as not just helpful, but as a normal part of addressing consumer behavioral health needs.

> *"We have a weekly meeting where we go over our older adult consumers The Specialist is involved."* (Frontline, Rural, CMHP)

Specialists were a resource in accessing a broad range of supports, contacts, and funding sources than might be available to a case manager or front-line worker. Additionally, Key Informants highlighted the importance of having a Specialist to help navigate bureaucratic systems and resolve consumer cases.

> *"If there is crossover between the mental health system and the disability or aging system our Specialist will help connect us to key people to navigate those waters."* (Manager, Urban, CMHP)

Workforce curriculum development and community education were identified as the second primary avenue of agency involvement and as crucial pathways for engagement between agencies and the Initiative. Specialist trainings on anxiety, substance use disorder, hoarding, boundaries, moral distress, and presentations on the Initiative itself were all described as examples of useful workforce development topics. Further, Key Informants valued Specialists' assistance with developing curriculum for their workforce to use in addressing hoarding and loneliness, and in providing training to community health partners.

> *"The Specialist has come to all staff meetings to provide trainings. Recently they came and did a training on boundaries and moral distress. They've just put out like a whole winter series of free educational events, which is really cool."* (Frontline, Urban, AAA-ADRC)

Finally, respondents identified Specialists' collaboration with agencies about the Initiative. Respondents identified ad hoc and scheduled meetings, special projects, work groups, Specialists' presence at their agency, and resource sharing as ways agencies worked with the Initiative to serve older adults. Specialists were broadly portrayed as connecting forces, bridging various agencies and behavioral health systems and resource pools.

Barriers to involvement. Respondents identified potential barriers which prevent them from being more involved with the Initiative. These include a lack of resources (e.g., insufficient coverage, a lack of in-person presence, a lack of personnel), and Initiative-specific barriers (e.g., lack of responsiveness, a new Specialist in their community), and respondent-related barriers (e.g., a lack of training, a lack of utilization, a lack of awareness of the Initiative and what it can offer). Time, a lack of bandwidth, and workload presented barriers to greater Initiative involvement.

> *"There's inconsistency among staff awareness of resources, how much they're familiar with our point person, and how much they take advantage of the Initiative's support." (*Manager, Urban, AAA-ADRC)

Respondents with the lowest tenure working with the Initiative identified more barriers than those with longer tenure. This may be due in part to a lack of familiarity with the Initiative, which suggests that with greater collaboration over time greater involvement may be seen.

Learning about Initiative activities.
Email, newsletters, and flyers were the top ways respondents learned about Initiative activities. Additionally, respondents cited meetings as a way they learned about activities. Other ways include hearing directly from the Specialists in conversation, from the Initiative's leadership or their managers, through training events, and in staff meetings. One AAA-ADRC respondent summed up how hearing about Initiative events commonly takes place in scheduled meetings.

> *"If things are happening, we learn about it from the Specialist at monthly meetings."* (Manager, Urban, AAA-ADRC).

COVID-19 impact on involvement. Unsurprisingly, respondents often indicated that the COVID-19 pandemic impacted their involvement with the Initiative in some capacity and that the pandemic-induced effects could take many forms. For example, workforce related impacts included increased staff turnover, labor shortages, and decreased workforce connections. Specific changes to Initiative involvement, decreased Specialist connection, and a decrease in Specialist responsiveness were described. One respondent noted ways in which COVID-19 made their work more complex and challenging.

> *"We see more people in crisis related to COVID, and poor access to care is difficult. Families are going to ERs when loved one has changes in behavioral health and shows signs of dementia."* (Manager, Urban, CMHP)

Some respondents reported minimal pandemic-related impact on Initiative. Others talked of a 'new normal' that underpins work and their involvement with the Initiative. Some 'new normal' changes are negative such as feeling isolated from colleagues and consumers. Others point to unintended benefits such as the wide use of virtual meetings which allows for more participation than pre-pandemic.

Other positive impacts were noted.
The unintended, positive benefits suggest a high level of resilience and adaptability by the Specialists and the Initiative during and post-pandemic to better support the BH needs of older adults and people living with physical disabilities.

> *[COVID] impacted a bunch. Specialist spent Fridays at a dining site with older adults and became a friendly face. Really wonderful. It was a great way to meet someone from the mental health field without [engaging] mental health services. It helps to reduce stigma* (Manager, Rural, AAA-ADRC).

Training and education needs

Training Topics. Frontline staff and managers identified training topics related to mental health, neurological/cognitive, physical/medical, social/individual and systems issues when working with older adults and consumers with disabilities Suggested topics and specific focus areas are described below each subsection.

Behavioral Health Training Topics

- De-escalation: identifying triggers, recognizing behaviors which may trigger reactions, ways to de-escalate triggering situations
- Hoarding
- Substance use: unique needs and barriers related to addiction and severe and persistent mental illness, how to engage with individuals to accept help, substance use and addiction among younger adults with a physical disability
- Trauma informed care
- Chronic mental illness: schizophrenia, bipolar disorder
- Depression: paranoia and depression, understanding depression and grief

Physical/Medical Training Topics

- Co-occurring conditions: The most frequently cited topics that agency staff need to learn about were related to co-occurring conditions, particularly ways to support a consumer with a cognitive impairment and mental health diagnosis.
    - specific topics: understanding that depression and MH issues are not a natural part of aging, supporting people who have physical and behavioral health needs, conditions that present similarly to dementia (e.g., UTIs, medication side effects); MH and cognitive issues confounded with aging, making a differential diagnosis, traumatic brain injuries and dementia, mental health and developmental disability
- Hospice and end of life care: Supporting a consumer who is thinking about going on hospice
- HIV

Neurological/Cognitive Training Topics

- Traumatic brain injury
- Making a dual diagnosis (see co-occurring
- conditions above)
- Dementia

Social/Individual Training Topics

- Caregiving: How to support unpaid family caregivers

- Cultural competencies: improving culturally and linguistically responsive behavioral health services
- Engaging with homelessness
- Grief
- Isolation
- Loneliness
- Normal signs of aging

Systems Training Topics

- System navigation was one of the most frequently cited topics that would be helpful to agency staff.
    - *Specific topics*: resources and placement options for people in crisis, access to services, removing barriers to system navigation, building collaborative plans with other agencies, navigating the APD system, how to reach out to assisted living facilities and more non-traditional services, learn about what other key agencies provide
- Guardianship: power of attorney and guardianship
- Caregiver burnout: secondary trauma from high death rates at LTC facilities during COVID
- Transitioning to a different level of care: tips for motivating someone to transition to a different level of care

Participants' suggestions did not vary by area or position, though there were some training topic suggestions unique to agency types. APD staff cited de-escalation techniques as a priority area, while CMHP respondents more often cited cognitive assessments and system navigation as top training needs. The topic of caregiving was unique to AAA-ADRC staff. Both CMHP and AAA-ADRC participants specifically cited the need to learn how to navigate the APD system. Several more APD and CMHP staff reported training topics under "systems issues", including "system navigation" than AAA-ADRC staff.

> *"As a clinician who works crisis at times, it would be good for more staff to know about resources and placement options, power of attorney and guardianships – these are hard topics and crisis workers don't have a lot of experience with this. Family members always have questions about guardianship."* (Frontline, Rural, CMHP).

Training Format. Participants were asked which training format would be most helpful for them. There was a wide range of suggestions provided.

Location. Participants were split on their preferred training format: virtual or in-person. Most preferred in-person events, particularly for longer trainings, as there is more engagement. Many preferred virtual formats for shorter events. Many requested on-site training. BH staffing shortages and increased workloads were commonly cited reasons why travel to training events was inconvenient. Due to staffing time constraints, several respondents requested asynchronous recorded training modules that staff can do in their own time.

"Have shorter trainings such as a 'lunch and learn' rather than two-day long events is better for staff attendance and interest. Have day long events that offer networking opportunities. Anything longer than two hours is difficult. My preference is for in-person training, but with COVID and travel costs we don't often send people. Remote options work well." (Manager, Rural, CMHP).

"The challenge is bandwidth and time. [The Specialist] offered trauma-informed care training that we haven't figured out when to implement. [Provide] short trainings in a unit meeting, little bits here and there over the year versus long trainings or intensive work groups that pull staff away from more workload than we have time for." (Manager, Urban, AAA-ADRC)

Training type. Several participants were not familiar with alternative training formats, like study groups, learning collaboratives, or workshops, but were enthusiastic about the idea. Another common preference among participants is for trainings to include real case examples and practical steps to address issues often encountered by agency staff.

"We're talking about the work that we're doing on a daily basis. A Academic training is easy to check out. It's applicable to work that we do day to day, where we're bringing tangible cases to the table. It's a lot easier to stay engaged, opposed to just following a PowerPoint, and being talked at as opposed to engaging." (Manager, Rural, APD)

Other. In addition to comments about the training format and type, respondents expressed the importance of providing as much notice as possible for training events, in part because of staffing shortage and the need to prepare to attend training events further in advance. Perhaps unsurprisingly, most of the staff who preferred the opportunity to attend training events remotely were Community Mental Health Program staff, who have seen significant staffing shortages since the COVID-19 pandemic (Zhu et al., 2022; US Government Accountability Office, 2022; Saunders, Guth and Eckhart, 2023). More rural respondents requested virtual training events over in-person training events.

"It would be helpful to have more advanced notice when it comes to training events. Six months would be great." (Manager, Rural, CMHP)

Agency support

Participants who work directly with older adults and people with physical disabilities were asked about the support they would need from their agency's leaders to better serve older adults and people with disabilities in their area.

Training. Responses related to the need for more training centered around increasing the BH knowledge of agency staff, and facilitating cross-training to reduce siloes: Examples of training-related suggestions include training among both APD and BH staff, which could lead to more accountability and open communication among both agencies.

> *"It would be really helpful to work more closely with APD – they have so many new staff and don't seem to know the importance of working with us and the Initiative. There are older adults falling through the cracks because the ecosystem is not working together." (Frontline, Rural, CMHP)*

Resources. Most frontline staff cited a growing need for resources, ranging from hiring more staff and increasing salaries to address agency-wide staffing shortages.

> *"We have mental health workers, homeless outreach workers on the streets making very low salaries and they do the hardest work. We need more [workers] going into nursing facilities. I need a commitment to funding, more staff who are literally doing the work. We have crises so I want to make sure that they're aligning our values, which are very clear and highlighted during the pandemic, about who was the front line and who are the most important. You can see what happens when you pay them like nothing." (Frontline, Urban, AAA-ADRC).*

Other management support. A few participants noted the need for accountability among the Older Adult Behavioral Health Specialists and their supervisors. One participant had never heard from their local Specialist and were not sure if they have one. A few other respondents expressed concern over lack of responsiveness and follow-through with their local Specialist.

> *"In regard to the initiative specifically, people who fulfill the specific roles need to have accountability. It's frustrating when no accountability ends up leading to more work for case managers."(Frontline, Rural, APD)*

There was little variability among the region and agency of the frontline staff who responded to this question, though most of the respondents who cited the need for more resources, namely increased salaries, and more staffing, worked in AAA-ADRCs.

Interacting with BHS

Complex Care Consultation: Benefits. Most respondents stated that they were likely to reach out to their Specialist for a consultation.

> *"If I say, 'I need help with this person' [the Specialists] say, I'll take it.' They reach out any way they can. She is one of my favorite people."* (Frontline, Rural, AAA-ADRC).

Supporting caseloads: Many respondents described a benefit and reason to reach out to Specialists for consultation is to help support behavioral health staff manage complex cases and often large caseloads with limited capacity. Respondents were also more likely to reach out if the Specialist was generally responsive to requests.

Positive prior experience: Several respondents noted that they are very likely to reach out to their Specialist because they already meet to staff cases with them on a regular basis and have found prior consultations to be beneficial.

> *"I think of [them] immediately as a resource when I hear of staff managing complex cases and need more help or support. I loop our behavioral health specialist in pretty quickly to see if a consultation can happen." (Manager, Urban, AAA-ADRC)*

Expertise: Several respondents shared that they benefit from the Specialists special expertise about older adults and familiarity with local resources for this population, which was often cited as lacking in their own agencies.

Barriers to reaching out to a Specialist for consultation. A small portion of participants stated reasons why they were *unlikely* to reach out for a consultation.

Lack of awareness: Several respondents noted that they were unaware that consultation with a Specialist was an available resource. Several respondents noted that they did not know who their local Specialist was and whether or not the position was staffed in their area.

> *"I have in the past, but now I go to my direct supervisor because the Specialist is less likely to have background knowledge of a particular resident who is having difficulties." (Frontline, Urban, CMHP).*

Lack of relationships: A few respondents also stated that they prefer to staff cases internally because the Specialist doesn't have the same level of background knowledge on cases.

AAA-ADRC staff noted that they were most likely to reach out to their local Specialist for a consultation, while a large portion of CMHP participants noted that they were unlikely to reach out to their local Specialist for a consultation. Several frontline staff are unaware that this is an available resource and tend to learn about the resource ad hoc through staffing with their

supervisors.

Only a small portion of respondents had not participated in a consultation with a Behavioral Health Specialist. Of those who had, most noted that the follow-up by the Specialist was immediate, followed by a few days. Only one respondent shared that the consultation was not timely.

Most participants stated that there was resolution to the consultations with Specialists. For those who stated there was no resolution, many clarified that it was due to the nature of the case and available resources, not the consultation itself.

Managers were more likely than frontline staff to report they had *not* participated in a consultation with a Specialist. AAA-ADRC staff more often reported that the Specialist provided immediate consultation.

Dedicated Time at Community Partner Agencies. A majority of respondents reported that their local Specialist has dedicated time either virtually or physically at their agency, although this varied by agency type and geographic location. The direct contact between agency staff and the Specialist was cited as most beneficial. For example, one respondent stated that the type of interaction with the Specialist that is most helpful:

Managers were more likely to report knowing about dedicated time than frontline staff. Rural-based respondents were twice as likely than their urban counterparts to report dedicated time by Specialists at their agency. In terms of agency type, CMHPs more frequently reported dedicated time at their agency compared to AAA-ADRCs or APD offices, with APD offices reporting this at the lowest rate of all three agency types.

> *"Their presence could help by doing case consultations, providing staff training and education, helping us with understanding systemic barriers and how to get around those. That would be great – we are very open to that." (Manger, Rural, CMHP)*

Some of the ways that the presence of a Specialist at respondents' agencies could be most beneficial included providing additional trainings and attending more regularly scheduled staff meetings. In response to how the Specialists could be of most beneficial to their agency, one respondent stated:

> *"Yes, very timely. [They] are very easy to get ahold of. The advice the Specialist provides is always good – the meetings never feel like a waste of time." (Frontline, Rural, CMHP)*

Promoting Collaboration. Respondents reported that their local Specialists promote collaboration with other agencies in a variety of ways and broadly within their community. Collaborating agencies include primary care providers, aging service providers, other behavioral health agencies, and other stakeholders who may provide services or support to this population. Another collaboration facilitated by Specialists with other stakeholders in their communities and coordinated care organizations (CCOs). Rural respondents were more likely to provide examples of collaboration carried out by their Specialists compared to their urban counterparts.

> *"The Specialists meet with us at least monthly and are in our quarterly IDT meeting. We talk about consumers that fall through the gaps between systems. We have a system gaps analysis referral form that line managers can bubble up to us so that we can look at it and say, 'is there any way we could get community partners involved with this?'"(Manager, Rural, APD)*

Addressing OABHI Goals

Key informants were asked to assess the impact of the Initiative with regard to three primary metrics: timely access to care for older adults and people with disabilities (Q13), the quality of behavioral health and related services (Q14), and the development and support of culturally and linguistically responsive behavioral health services (Q15).

OABHI's efforts to address the issue of timely access to care. In response to the prompt "How well does the Initiative address the issue of timely access to care in your experience?" frontline workers rated the Initiative an average of 4 out of 5 ($\bar{x} = 3.5$), while managers were more neutral - rating the Initiative's efforts an average of 3 out of 5 ($\bar{x} = 2.7$). Employees of AAA-ADRCS rated the Initiative's work on timely access to care 3.5 out of 5 ($\bar{x} = 3.5$), employees of CMHPs 3 out of 5 ($\bar{x} = 2.9$), and employees of APDs a 3 out of 5 ($\bar{x} = 2.7$). Respondents from both rural and urban spaces ranked the Initiative's effectiveness on improving timely access to care an average of 3 out of 5 (Rural: $\bar{x} = 2.9$, Urban: ($\bar{x} = 3.3$)), but the rural respondents had a much wider standard deviation on the qualitative aspect of this question (see Figure 6).

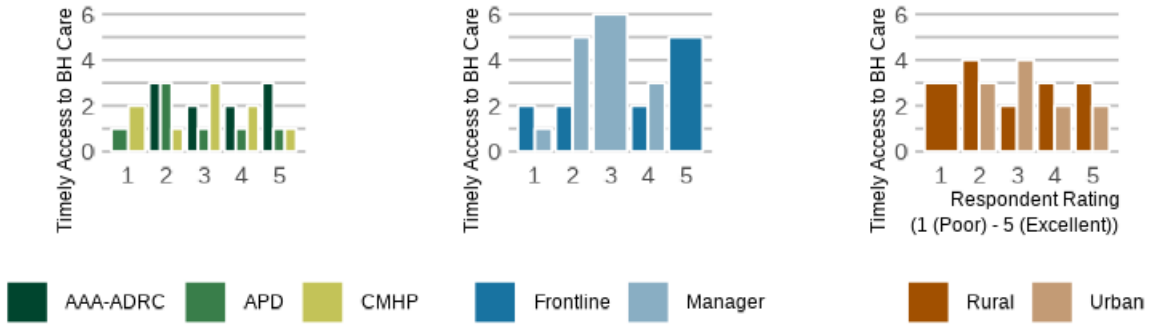


Figure 6: Respondent Rankings of OABHI's Impact on Timely Access to Care

Key informants in urban spaces and those associated with AAA-ADRC and CMHPs were more likely to rate Initiative efforts to improve timely access to care more positively. Themes that emerged were of advocacy, connectivity, and of resource sharing. Respondents noted that Specialists facilitated the movement of clients between services effectively, that Specialists excelled at linking agencies and people together, and that Specialists could be relied upon to leverage resources in order to speed up problem resolution.

"I see an excellent job being done with sharing resources and community building relationships." (Frontline, Urban, AAA-ADRC).

"Everybody has input, has a resource, is willing to help. With one consumer, [our Specialist], managers, and complex case team are involved. Everybody says, 'What do you need? We have resources for this and for that.' Everything just flows with everybody collaborating and doing their part ."(Frontline, Urban, CMHP)

Key informants from rural areas were more likely than those from urban areas to identify positive themes regarding the Initiative's improvement of BH and related services. Respondents identified training provided by Specialists on evidence-based

"Our [Specialist] does as much as is possible and is well aware of the systemic issues that cause breakdowns and lack of certain timely service for behavioral health needs, and helps us navigate those as best we can but there's a real gap in our larger system and structures. There are many clients who slip through the cracks so we're always trying to problem solve creatively on what to do. It's a bigger system problem, not reflective of the work of the Initiative." (Manager, Urban, AAA-ADRC)

"Barriers are inherently built into the system. There aren't enough access points in the community. We can have all the right people in the right place at the right time, and the right consumer trying to get care or placement but if there's no placements to get them into and no providers willing to help, that's what slows down the system and the Initiative. I've seen a huge desire to help but there's a lack of care providers and there's not enough access for us to provide the support to a lot of the consumers we're trying to help." (Manager, Rural, APD)

practices as particularly effective and Specialists' capacity for making appropriate referrals in a timely fashion.

Quality of BH and related services.

In response to the prompt "How well does the Initiative address the quality of BH and related services in your experience?" frontline workers rated the Initiative an average of 4 out of 5 ($\bar{x} = 3.6$), while managers were more neutral - rating the Initiative's efforts an average of 3 out of 5 ($\bar{x} = 3.1$). Employees of AAA-ADRCs, APDs, and CMHPs rated the Initiative's work on the quality of BH 3 out of 5 (AAA-ADRC; $\bar{x} = 3.4$, APD: $\bar{x} = 3.1$, CMHP: $\bar{x} = 3.9$) Respondents from rural spaces as well as those from Urban spaces ranked the Initiative's effectiveness on improving timely access to care an average of 3 out of 5 (Rural: $\bar{x} = 3.2$, Urban: $\bar{x} = 3.4$) (see Figure 7).

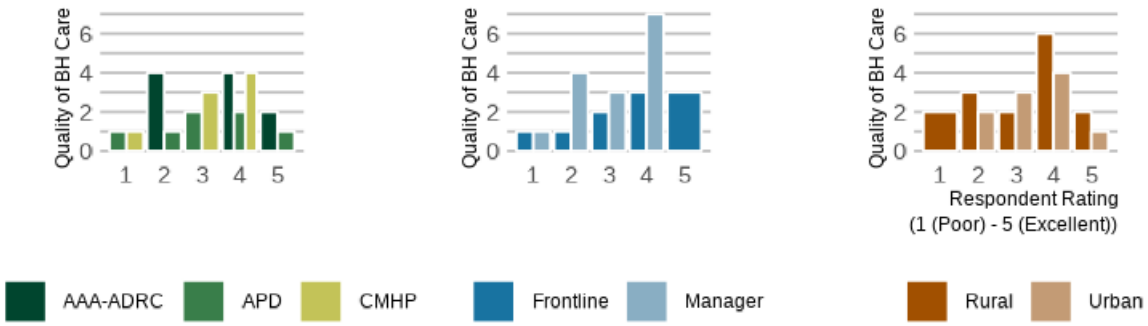


Figure 7: Respondent Rankings of OABHI's Impact on Quality of BH and Related Services

Key informants from rural spaces were more likely than those from urban spaces to identify positive themes regarding the Initiative's improvement of BH and related services. Respondents identified training provided by Specialists on evidence-based practices as being particularly effective, as well as Specialists' capacity for making appropriate referrals in a timely fashion.

> *"OABHI brought in people who wrote the book to train people here to provide evidence based educational series. They have done that numerous times. Now we have the evidence-based program here for folks to go to." (Frontline, Rural, AAA-ADRC)*

Opportunity areas identified by key informants included systemic barriers, lack of resources, and lack of support. Respondents noted difficulty in reaching their designated Specialist, the difficulty presented by complex cases, and the challenges presented by the necessity of meeting or being trained in a virtual format.

> *"We have individuals come to us that should be able to get care through behavioral health or are on their state plan. They come through us because they can't get a personal service worker provider and we have to deny them because they're on services already through adult behavioral health. Or they don't want to go through adult behavioral health and prefer to go through us and we have to deny them It's a mental health diagnosis that's driving their care needs, and what we struggle with is what to do with those individuals, because there's still a need but we don't have easy access into their system." (Frontline, Rural, APD)*

Culturally and Linguistically Responsive BH Services.

In response to the prompt "How effective is the Initiative in supporting culturally and linguistically responsive BH services?" Both managers and frontline workers rated the Initiative an average of 3 out of 5 (Frontline: $\bar{x} = 3.0$, Manager: $\bar{x} = 2.9$). Employees of AAA-ADRCS rated the Initiative's work on supporting culturally and linguistically responsive BH services a 3 out of 5 ($\bar{x} = 2.9$), employees of CMHPs 3 out of 5 ($\bar{x} = 3.3$), and employees of APDs a 3 out of 5 ($\bar{x} = 2.8$). Respondents from both urban and rural spaces ranked the Initiative's effectiveness on improving timely access to care an average of 3 out of 5 (Rural: $\bar{x} = 3.0$, Urban: $\bar{x} = 2.8$) (see Figure 8).

> *"We don't have a lot of evidence-based programs and in-person EBPs have not been offered. Virtual EBPs don't meet the needs of their community as many don't use the necessary technology for them." (Manager, Urban, AAA-ADRC)*

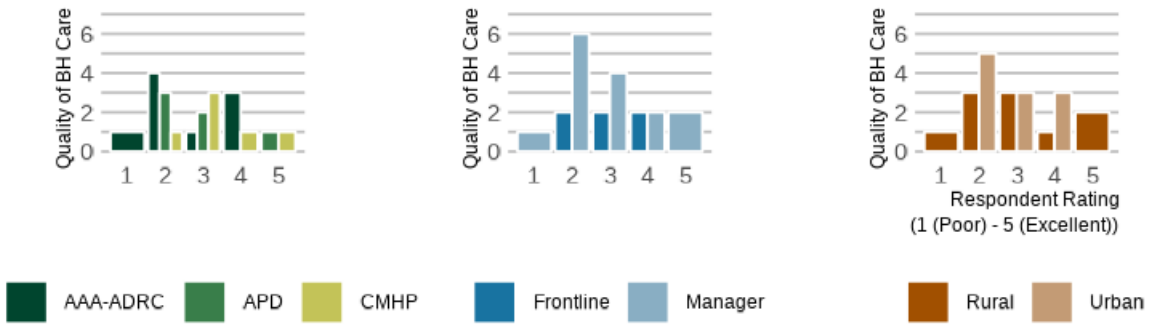


Figure 8: Respondent Rankings of OABHI's Impact on Culturally and Linguistically Responsive BH Services

On the whole, respondents found Initiative efforts to support culturally and linguistically responsive BH services to be lacking. Key informants cited a lack of diversity among care providers, lack of capacity, the unique needs of various minority groups, the overall lack of culturally specific services, and a general lack of interest as areas needing attention.

> *"This is a tricky and it goes back to what resources are available. If the Initiative is supporting evidence-base programs, a majority are not culturally relevant. Because of that we're trying to take them, put them in, and make them available for different cultures. But it's not meeting their needs because it's not fully encompassing how they actually live life so when we're trying to fit this evidence-based program in, it's just not working. So much work needs to be done and it needs to be made a priority." (Frontline, Urban, APD)*

Overall perceptions of OABHI program impact

Key Informants were asked to describe what, if anything, is different now for older adults and people with disabilities who have behavioral needs in their communities as a result of working with a local behavioral health specialist and being involved with OABHI. Both managers and frontline staff discussed examples of how working with BHS has increased knowledge, support, and communications, as well as improved interventions for older adults and people with physical disabilities.

Bringing older adults to the forefront. Participants described how working with the Initiative and BHS has resulted in more training opportunities for service providers and case managers as well as a nuanced understanding of older adults with behavioral health needs as a "special population" with unique needs and considerations. Involvement with the OABHI has resulted in multilevel impacts, ranging from individual success stories to system-wide changes.

"Staff aren't always trained well on older adult issues and barriers – I have seen an improvement with staff knowledge of older adult issues." (Manager, Rural, CMHP)

"Some clients lives have been positively impacted because of case consultation and research support because they would not have enrollment and services otherwise. I can think of cases that have been positively impacted, individual lives are changed for the better, and on a systemic level because the Initiative has helped us know what resources are available in the community in an area we are not at all expert. Now our case managers and staff think of resources in the community, or know who to call, or who to reach out to for things they might not have previously. So there's a wider impact." (Manager, Urban, AAA-ADRC)

Building a bridge for services. One of the goals of working with BHS is to promote collaboration and reduce silos across the spectrum of services providers and community agencies who can meet the behavioral health needs of older adults and people with physical disabilities. Key Informants talked about how working with their local BHS has facilitated relationships and communications across different types of service providers and advocacy agencies.

It's that connection piece of knowing the different partners in a particular area. Let's get everybody at the table and let's talk over some of these issues facing not only the individual, but the community. I think that's changed and we're able to connect at least with some of the people that we serve. We're able to connect them with resources or at least know what's available better than we once were (Manager, Rural, APD).

Improving access and timing of interventions. Participants discussed specific examples of how working directly with their local BHS kept consumers in housing, connected to appropriate services, and broadened awareness for available resources in the community, "we can prevent evictions due to behaviors and mental health crises (Frontline, Rural, AAA-ADRC)." By working together, Specialists and case managers are able to meet individuals where they are and get the supports they need.

Both managers and frontline staff indicated improvements and increases as a result of their involvement with the Initiative and working with Specialists. Three respondents (all managers) did indicate they did not know or could not describe any changes as a result of the OABHI. A larger share of managers described increases in knowledge, communication, and support compared to frontline staff, while a larger share of frontline staff described improvements in interventions for consumers. More participants in rural communities reported increased support and improved interventions, while a larger share of participants in urban communities reported increased knowledge and interventions.

> *"With behavioral support specialists in place, and when referrals are made it definitely helped some consumers. They have not been evicted. They are able to stay in their adult foster home. It's helped caregivers manage care and redirect a consumer when they're having their behaviors. It's definitely helping the consumer and their caregivers in a positive way." (Manager, Rural, CMHP)*

Compared to AAA-ADRC and CHMP staff, respondents affiliated with APD were the largest share to report increased support and improved interventions. The majority of respondents to report increased knowledge were affiliated with CHMPs and the majority of respondents who reported increased communication were from AAA-ADRCs.

IV. Policy Interventions to Address Top Challenges

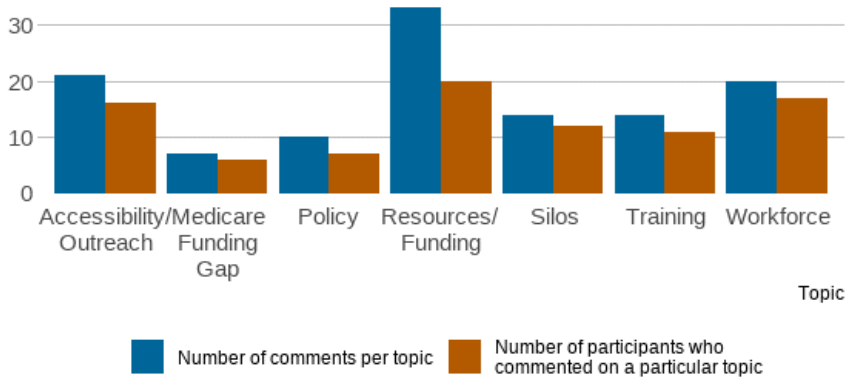
Twenty-nine (29) participants from APD, CHMP, and AAA-ADRC agencies offered suggestions on what needs to be done to address the top challenges related to the behavioral health of older adults and people with physical disabilities within their area. Twelve frontline staff and 17 managers from these three agencies provided responses on eight topics. Table 2 describes topics, comments related to a particular topic, and whether they relate to systemic issues that affect the Initiative's success or topics that Specialists can identify and address.

Table 2: Topics related to challenges addressing older adults' behavioral health needs.

Topic	Number of comments per topic	Number of participants who commented on a particular topic	Systemic-related comments	Initiative-related comments	Systemic/ Initiative-related comments
Accessibility/ Outreach	21	16	3	18	-
Medicare Coverage Gap	7	6	7	x	-
Policy	10	7	9	1	-
Resources/ Funding	33	20	28	5	-
Silos	14	12	-	-	14
Training	14	11	13	-	1
Workforce	20	17	20	-	
Total Suggestions	119	89	80	24	15

Figure 9 displays the frequency of comments made by Key Informants about the top challenges in their community related to older adults and people with physical disabilities who have BH need, as well as the number of participants who commented on each type of challenge

Figure 9: Frequency of Comments About Needed Resources to Address Top Issues



Systems-Level Suggestions

Accessibility and Outreach. One goal of the OABH Initiative is that it seeks to improve access to available resources. Respondents' suggestions included increasing Specialists' outreach efforts to inform agency and community service providers about available resources and how to access services that best meet consumer needs, while facilitating collaboration among agencies. The following comments help to highlight the importance of this topic.

"Meetings, annual conference, or annual work group. A joint legislative task force needs to be advocated for. All of that comes together and would be helpful, because at the end of all of it we are creating a service for a human, not for one specific need." (AAA/ADRC manager)

"We need resource and model shifts, more low barrier resources, and more effort to accessibility and outreach, and proactive help versus reactive, trying to just stop the bleeding. Sometimes we're in emergency mode all the time." (Manager, Urban, AAA/ADRC)

Medicare Coverage Gap. We refer to the Medicare coverage gap as limited funded services and service providers for Medicare recipients. These individuals do not qualify for Medicaid services but are unable to pay out-of-pocket for mental health-related care. The following comment describes challenges agencies and Medicare recipients experience in obtaining support.

"The top challenges for us are getting mental health services to older adults on Medicare, both with the number of providers and the cost. I can find a provider but often the folks I see can't afford a $40 copay and the same thing with psychiatric care." (Frontline worker, Urban, AAA-ADRC)

"Federal policy and Medicare could provide mental health [services]. But if you don't have the providers and you can't afford the copay you're not gonna get mental health. "(Frontline worker, Urban, AAA-ADRC)

While the Initiative and state and local policymakers may not be able to directly address the gaps in Medicare coverage (due to federal policy arrangements), there is much that can be done to mitigate the impact of these gaps and to better support the individuals who fall into the gaps between the coverage provided by the Medicare program.

Policy. Policy-related topics discussed by respondents included the need for State Legislators to prioritize and increase funding for resources that address mental health needs, including substance use disorders, for a growing number of older adults and people living with disabilities. Respondents described the challenges surrounding mental illness stigma and ageism, which influence policymakers' focus on the populations served by the Initiative. Comments describe the need to review and revise the Oregon Administrative Rules (OARs), programs, and policies.

"Create that kind of umbrella and that comes from policy making, that comes from all the way up to Oregon Administrative Rules, development, and anything in between. So, I think that, you know, legislation needs to be reviewed and changed down to policy. Development needs to be reviewed and changed. Funding sources need to be reviewed." (Manager, Urban, AAA/ADRC).

"I think that older adults can get lost in the priorities, especially if there's not a key advocate at the legislative level and at the state level." (Frontline, Urban, APD)

Resources and Funding. The need to increase funding for mental health programs, services and supports was the most discussed challenge. Many respondents described the need for wrap-around services in both residential and community settings, low-barrier programs to address older adults' mental health and substance use needs, more housing and housing placement support, and additional programs that support aging in place.

"We need a whole lot more different kinds of models because you can't make a consumer choose where they're at, and they're not willing to move forward or able to move forward with the resources there are. We need some other resources to meet their needs. They just won't be met." (Manager, Urban, AAA-ADRC)

"It's housing and the way it relates to older adults. It's more than treatment facilities, adult foster homes, assisted or supportive living, all those different levels of support. There's just not enough of them to go around, and the competition for those placements or support programs means that only the most extremely severe people ever have a chance of getting into them. There are a lot of people that go without a level of care they would benefit from, whether it's in their own home with the family trying to piece it together, or whether it's when we put them in a home with support for their mental health needs, but the physical health is still on an outpatient basis." (Manager, Urban, CMHP)

Agency staff in rural areas emphasized rural support needs including transportation and programs that address isolation.

Silos. Respondents suggested aligning resources, services, and practices among state agencies to maximize services and supports for older adults and people living with disabilities who have behavioral health needs. Suggestions included the need to share resources, facilitate collaboration, and develop interagency agreements concerning shared goals and how best to achieve those goals.

"Our systems are so siloed. The specialist is trying to help bridge services that are not connected or agencies that are not connected." (Manger, Urban, AAA/ADRC)

"Service agencies need to work together to share and learn more about available resources." (CMHP manager)

Initiative-level suggestions

"[I] would like to see more interagency agreements between CMHPs, AAA, APD offices or service level agreement. Let's put in writing exactly what we expect from one another – our overarching visions and goals. There is currently varied accountability across the state." (Manager, Urban, APD)

Training. Cross training of the workforce was offered as a way to address behavioral health workforce challenges as well as for breaking down silos between systems, for instance, by funding and supporting the provision of behavioral health training to staff in long-term service and support facilities (e.g., assisted living, adult foster homes). While this type of training is included in the Initiative and the Specialists' work, there is a perceived need to provide additional – and more specific – workforce development training to address the systemic behavioral health workforce deficits across Oregon. Respondents' suggestions included the need to increase training, educate local communities, agency staff, and assisted living, residential care, memory care staff about older adult behavioral health issues and needs, and for Specialists to increase participation in agency staff meetings and MDTs.

"It's important to train people and have them understand people who have these needs. This issue isn't because this guy is doing drugs. It has to do with the cumulative set of disadvantages and the compounding effects of having to try to survive with those." (Frontline, Urban, AAA/ADRC)

"There is a stigma for older adults with mental health challenges and with substance use issues. We need more accessibility to trainings for CNA's. I think too often older adults with these challenges are written off." (Frontline, Urban, CHMP).

Workforce. Addressing workforce challenges related to behavioral health was a frequently cited systems-level priority. The multiple effects of the COVID-19 pandemic exacerbated many already existing behavioral health workforce challenges, especially in rural and frontier regions of Oregon (Zhu et al., 2022)**.** According to respondents, workforce-related issues include the need for more mental health providers to address consumers' mental health and substance use disorders, providing more community support, managing complex cases, addressing housing needs, and reducing the number of consumers evicted from their living spaces.

> *I have clients say, 'It took me forever to get in to see you! Your waiting list is too long!' So I think that kind of speaks to the number of mental health providers for older adults (Frontline, Urban, CMHP).*

Recommendations to Support Behavioral Health for Older Adults and People with Physical Disabilities in Oregon

Systems-level recommendations

Policy - The multitude of challenges facing older adults and people living with disabilities who also experience behavioral health issues requires bold action.

- Establish a joint legislative task force to explore policy and legislative opportunities to address the needs of this population.

Building up the behavioral health workforce. The multiple workforce challenges confronting our state require a systems-level approach to ensure that Oregon has the workforce to address the behavioral health needs of older adults and people living with disabilities.

- Focus on how to recruit, train, retain, and support more mental health providers who can address consumers' mental health and substance use needs.
- Provide community support to help manage complex cases outside of clinical settings.
- Ensure behavioral health agencies across the state are aware of the Initiative and services the Specialists can provide to help support behavioral health agency staff.
- Address housing needs including a focus on reducing the number of consumers evicted from their living spaces.

Addressing systems gaps. The multiple gaps between systems that provide services and support to older adults and people living with physical disabilities is a longstanding issue. Continued effort is required to fill these gaps.

- Use memorandums of understanding (MOUs) to codify new and existing partnerships between agencies.
- Cross train the workforce by funding and supporting behavioral health training to staff who work in long-term service and support facilities.

Adequate Resourcing of Programs. The programs that support older adults and people living with physical disabilities must have adequate resources to achieve their intended goals related to behavioral health. Additional resources – appropriately targeted – can help achieve those behavioral health-focused goals.

- Increase funding for mental health programs, services, and supports.
- Support the use of wrap-around services in both residential and community settings.
- Invest in low-barrier programs that are able to address both older adults' mental health and substance use disorder-related needs.
- Provide additional housing along with more housing placement supports across Oregon.
- Fund transportation and programs that address isolation, especially in rural and frontier communities of the state.

Initiative-level recommendations

Accessibility and Outreach.

A multitude of existing resources are available across Oregon's many communities that can be leveraged to support this population. However, often these resources may be unknown to local community partners.

- Focus on outreach efforts to inform agencies, service providers, and other community partners about available resources and how to access those resources including specific services for consumers.
- Facilitate greater collaboration between and among agencies across the aging and behavioral health systems.
- Identify strategies to inform community partners when there is turnover, and ensure that a list of established community partnerships is passed on to the next Specialist when there is turnover.
- Reach out to both managers and frontline staff about OABHI-sponsored and facilitated activities and determine how the Initiative can best support these agencies.
- Ensure that direct supervisors are knowledgeable about Initiative activities and are made aware of the variety of job activities to support Specialists in meeting the needs of community partners.

Breaking Down Silos.

The siloed nature of many programs and services across the aging and behavioral health systems continues to be a barrier to better behavioral health for older adults and people living with physical disabilities. While the Initiative, through the direct work of the Specialists, has made tremendous strides in reducing these barriers, a continued focus on reducing these silos is needed to achieve better behavioral health support in Oregon.

- Share resources between agencies, which will allow far greater flexibility in the ability to provide the right supports for this population.
- Facilitate increased collaboration across communities and agencies by hosting joint meetings between aging and behavioral health services agencies.
- Continue to identify and reach out to new community partners and new agency staff.
- Develop interagency agreements concerning shared goals and how best to achieve those goals related to improving behavioral health services and supports.

Workforce Development.

In addition to the systems-level opportunities to enhance Oregon's behavioral health workforce, there are also several Initiative-level options to build on the existing work of the Initiative and the Specialists, which can help to mitigate the current workforce challenges. Support the provision of targeted behavioral health training to staff in long-term services and supports facilities including assisted living, adult foster homes, and residential care as well as nursing facilities.

- Educate local communities, agency staff, and service providers including assisted living, residential care, and memory care, about older adult behavioral health issues and the unique needs of this population.
- Identify which training topics are most useful to community partners.
- Provide trainings in alternative formats such as prerecorded modules and brief, regularly scheduled trainings at all-staff meetings for community partner agencies, especially those with staffing shortages and high caseloads, to make training more accessible.

V. Summary and Conclusions

This report presents findings from the PSU Team's Evaluation of several stakeholders' perceptions – called key informants (KI) – whose work to support older adults and people living with physical disabilities intersect with the Initiative. This report intends to describe impacts of

the Initiative, including components that are perceived to be working well within local communities, and where improvements can be made to better support the behavioral health needs of this population.

This report also seeks to provide insight into the coordination and collaboration that is taking place between the Initiative and KI agencies. Since the initial Key Informant interviews were conducted in 2020, the impacts of the COVID-19 pandemic on Oregon's behavioral health system and populations have become increasingly clear and brought to the forefront a number of new issues. The findings presented in this report inform a number of Initiative-level and systems-level recommendations which, if pursued, could help to better support older adults and people living with physical disabilities who also have behavioral health needs across Oregon.

The recommendations provided within this report focus on building Oregon's behavioral health workforce, continuing to address the existing gaps between systems and programs, and ensuring that adequate mental health, substance use disorder, and housing-related needs are offered to older adults and people living with physical disabilities. Recommendations offer the Initiative ways to help achieve these goals and include continued focus on accessibility and outreach, breaking down longstanding silos between agencies and systems, and workforce development. This multilevel approach is needed to achieve improved behavioral health for this population.

APPENDIX

Quantitative survey items

#	Items
Q1	How often are you in contact with your local Behavioral Health Specialist? This can include activities such as communicating by email or attending a virtual training hosted by a Specialist.
Q2	Our staff participate in meetings with BHS who provide consultation to determine an appropriate course of action with consumers who present with complex care needs.
Q3	I host or attend a planned meeting between community mental health and aging services agencies.
Q4	We refer complex cases to our local BHS for consultation.
Q5	Our agency allows us to use time to attend training events that are organized by the BHS.

Qualitative interview guide

#	Interview Question
1.	What is your job title? And how long have you been in your current position?
1a.	How long have you been in your current position?
1b.	While you may do both, would you say your current role is primarily providing direct services or management?
2.	How is your agency currently involved with the initiative?
3.	What, if any, barriers may prevent you from being more involved with the initiative?
4.	How do you learn about the activities of the Initiative (i.e. newsletter, flyers, etc.)?
5.	How has COVID impacted your involvement with the Initiative?
6.	[Frontline staff] What would be more helpful to learn more about when working with

	older adult clients? Consumers with disabilities? [Management] What would be helpful for your agency to learn more about when working with older adult consumers? Consumers with physical disabilities?
7.	What training format would be most helpful for you?
8.	[Frontline only] What support would you need from your agency's leaders to better serve older adults and people with disabilities in your area?
9.	How likely are you to reach out to your local Specialist for a complex care consultation? *Probe: Why or why not?*
10.	Have you participated in a meeting where a behavioral health specialist provided consultation about an older adult or person with physical disabilities who have behavioral health needs? How timely was the consult? How helpful was the resolution?
11.	To your knowledge, does your local Specialist have dedicated time either virtually or physically at your agency? *Probe: [if yes] What activities are most beneficial to your agency? Are there other activities that your agency might benefit from?* *[if no] How could the presence of a Specialist be most beneficial to your agency?*
12.	In your opinion, how does your local Specialist help promote collaborations among other agencies such as behavioral health, aging, or primary care? Can you please provide some examples?
13.	One goal of the initiative is to improve timely access to care. This may be done by building relationships or sharing resources. On a scale of 1 to 5, with 1 being 'Very Poor' and 5 being 'Excellent', how well does the Initiative address the issue of timely access to care in your experience? Please provide a reason for your ranking.
14.	Another primary goal of the Initiative is to address the quality of behavioral health and related services. This may be done by making referrals to appropriate services or enrolling consumers in evidence-based programs. On a scale of 1 to 5, with 1 being 'Very Poor' and 5 being 'Excellent', how well does the Initiative address the quality of BH and related services in your experience? Please provide a reason for your ranking.
15.	The Initiative also aims to support culturally and linguistically response behavioral health services. This may be done by going to culturally specific sites or training on underserved population groups. On a scale of 1 to 5, with 1 being 'Very Poor' and 5 being 'Excellent', how effective is the Initiative in supporting culturally and linguistically responsive BH services in your experience? Please provide a reason for your ranking.

16.	What, if anything, is different now for older adults and people with disabilities who have behavioral health needs in your community as a result of working with your local behavioral health specialist?
17.	In thinking about programs, policies, or inter-agency agreements either at the county or state level, what needs to be done to address the top challenges related to the behavioral health of older adults and people with physical disabilities in your area? *Probe: if they respond with federal-level suggestions, ask them to specify what could be done at the local or state level.*
18.	Anything else you would like to add/anything else that we might have missed?

REFERENCES

R Core Team. R: A language and environment for statistical computing. Published online 2022.

Saunders H, Guth M, Eckhart G. *A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs.* Kaiser Family Foundation; 2023. https://www.kff.org/medicaid/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/

Sjoberg DD, Whiting K, Curry M, Lavery JA, Larmarange J. Reproducible summary tables with the gtsummary package. *The R Journal*. 2021;13(1):570-580. doi:10.32614/RJ-2021-053

Stodola A, Kyler-Yano JZ, Hasworth S, Winfree J, Dawson WD. Supporting the Behavioral Health of Older Adults: Evaluating a Multi-Site, Multi-Actor, Multi-Agency Initiative. *J Appl Gerontol*. 2022;41(4):1011-1019. doi:10.1177/07334648211059155

Team P. RStudio: Integrated Development Environment for R. Published online 2022.

US Government Accountability Office. *Behavioral Health: Available Workforce Information and Federal Actions to Help Recruit and Retain Providers.* GAO; 2022. https://www.gao.gov/assets/gao-23-105250.pdf

Zhu JM, Howington D, Hallett E, et al. *Behavioral Health Workforce Report to the Oregon Health Authority and State Legislature.* Oregon Health & Science University; 2022. https://www.ohsu.edu/sites/default/files/2022-02/PRP_113_Behavioral_Reimbursement_Report_02.01.22_V2.pdf