Oregon
Older Adult Behavioral Health Initiative

Interim Report
2023- 2024

Evaluation of the Older Adult Behavioral Health Initiative

Portland State
Institute on Aging

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Introduction and background

The Older Adult Behavioral Health Initiative (referred to as “the Initiative” in this report) is an innovative program established in 2015 and funded by the Oregon Health Authority (OHA). Twenty- four Older Adult Behavioral Health Specialists (referred to as “the Specialists” in this report) are located in every county in the state of Oregon and facilitate outreach and services to older adults and people with physical disabilities who have behavioral health needs.

The Specialists’ three primary job functions include: promoting collaboration and coordination among community partners, providing complex care consultations for older adults and people with physical disabilities who have behavioral health needs, and offering workforce development training and community health and wellness promotion. The overall goal of the Initiative is to better meet the needs of older adults and people living with physical 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.

This 2023-2024 interim report provides results from Portland State University’s (PSU) Institute on Aging’s (IOA) evaluation of the Initiative. The data to support the findings and recommendations provided within this report are drawn from several sources collected by the PSU Evaluation team (see “Methods” section below). The findings presented here are built on data collected from January 2022 to March 2023 as well as those that emerged from the most recent evaluation period, April 2023 to June 2024.

Methods

Complex Care Consultations (CCC)

The Specialists provide information on every CCC they conduct, and submit this data quarterly to the PSU Evaluation team through the CCC form, which was jointly developed by the PSU Evaluation team, with feedback from the Specialists and the Initiative’s Project Director. The Specialists provide a variety of information such as the behavioral health needs of the consumer participating in the care consultation, recommendations provided by the Specialists, and sociodemographic information (e.g., veteran status, age, gender).

Training: Workforce Development

As part of every workforce development training, the Specialists provide information on training events through rosters which are submitted to the PSU Evaluation team. Information provided through training event rosters include training/workshop titles, the trainer(s), target audience,

location (virtual or city if in-person), and behavioral health topics covered in the training. Participants of workforce development trainings/workshops planned, hosted, or delivered by the Specialists provide their email addresses to permit the PSU Evaluation team to follow up with an online evaluation survey of the training. Participants provide feedback on knowledge of the topic prior to attending the training, perceived knowledge gained, level of confidence to use knowledge learned from the training/workshop, and perceptions of the training and trainer(s).

Quarterly Reports

The Specialists submit reports detailing their activities over the previous quarter, and plans for the subsequent quarter. These reports primarily consist of open-ended qualitative questions, though quantitative data are also collected on the use of evidence-based practices (EBPs), assessment tools, and their participation in different activities with community partners.

Key Informant Focus Groups

As the Initiative nears ten years of existence, the PSU Evaluation team conducted a new evaluation approach by facilitating virtual focus groups with key community partners of the Initiative: Aging and People with Disabilities (APD) regional offices, Area Agencies on Aging-Aging and Disability Resource Centers (AAA-ADRCs) and Community Mental Health Programs (CMHPs) in addition to older adults (65+) with lived experience navigating behavioral health services, primary care providers (PCPs), and senior center staff. The evaluation had not previously collected data directly from older adults, PCPs, and senior center staff. A mixed-methods approach was used, drawing on both quantitative survey items and focus group questions. The PSU Evaluation team aimed to assess the impact of the Initiative, how it could be improved, and identify opportunities to improve collaboration and coordination with key community partners.

Statistical Software

Analyses were conducted using the RStudio Integrated Development Environment. The R packages tidyverse, tidymodels, and poissonreg were instrumental in the analyses carried out of the data included in this report (Team n.d., team, n.d.; Wickham et al., 2019; Kuhn, 2023a; Kuhn, 2023b). Data cleaning and descriptive statistics for the training evaluations portion of the report were conducted using Stata 18 (StataCorp. 2023. Stata Statistical Software: Release 18. College Station, TX: StataCorp LLC.).

Key findings

Complex care consultation

Complex care consultation (CCC) is a core job function of the Older Adult Behavioral Health Specialists (or “the Specialists”). The Specialists work to promote a multi-disciplinary team and multi-morbidity approach to ensure older adults and people with disabilities receive the appropriate help at the right time and at the right level of care. Keeping detailed track of these CCCs is intended to inform the Initiative as well as key community partners 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.

The Specialists across Oregon used a data entry tool prepared by the Portland State University (PSU) Evaluation team to collect information about each CCC in which they participated between January 2022 and June 2024. From January 2022 through June 2024, the Specialists reported participating in a total of 3,604 CCCs that took place in at least 28 counties. During the most recent reporting period from April 2023 through June 2024, the Specialists reported participating in a total of 1,891 CCCs that took place across all of Oregon’s counties. These CCCs constitute the sample for this report.

Gender

During the current measurement period (from April 2023 through June 2024), focusing only on cases with non-missing information, consumers were most likely to be female (61% (1,143); Table 1.1). The proportion of female identifying consumers was significantly higher than the previous reporting period (56% (958) female) (2(3) = 9.92, p = .02).

Table 1.1. Gender

Gender	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Female	56% (958)	61% (1,143)	59% (2,101)
Male	44% (746)	39% (731)	41% (1,477)
Transfeminine (Transwoman)	<1% (1)	0% (0)	<1% (1)
Transmasculine (Transman)	0% (0)	0% (0)	0% (0)
Questioning	0% (0)	0% (0)	0% (0)
Other	0% (0)	0% (0)	0% (0)
Total	100% (1,705)	100% (1,874)	100% (3,579)

Note. Missing, non-standard, or don't know values were found for 0.5% (8) of cases in the previous reporting period and 0.9% (17) of cases in the current reporting period. Percentages may not add up to 100 due to rounding.

Veteran status

During the current reporting period, focusing only on cases with non-missing information, the Specialists reported that only 8% (114) percent of consumers were veterans and 92% (1,369) were not (among cases with known veteran status; Table 1.2). The Specialists either reported that veteran status was not known or had missing data for 22% (408) of cases during the current reporting period and 25% (431) of cases during the previous reporting period. The share of CCCs involving consumers who were veterans during the current reporting period compared to the previous period was statistically insignificant (2(1) = 0.04, p = .84).

Table 1.2. Veteran status

Veteran?	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Yes	7% (95)	8% (114)	8% (209)
No	93% (1,187)	92% (1,369)	92% (2,556)
Total	100% (1,282)	100% (1,483)	100% (2,765)

Note. Missing, non-standard, or don't know values were found for 25% (431) cases in the previous reporting period and 22% (408) cases in the current reporting period. Percentages may not add up to 100 due to rounding.

Race/Ethnicity

During the current reporting period, focusing on cases with non-missing information, the overwhelming majority of CCC consumers were white (91% (1,528)), an increase of 2.7%-pts (Table 1.3). Lower rates of First Nations (4% (64)) and Pacific Islander consumers (<1% (5)) were reported in current reporting period than the prior reporting periods, but the proportion of Black, Asian American, and Hispanic or Latino consumers involved in CCCs stayed consistent from the previous to the current reporting period. Overall, the distributions of race/ethnicity between the previous and current reporting periods stayed consistent ($\chi^2(5) = 11.68$, $p = .039$).

Table 1.3. Race/Ethnicity

Race/Ethnicity?	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
American Indian or Alaskan Native	6% (62)	4% (64)	5% (126)
Asian or Asian American	1% (10)	1% (21)	1% (31)
Black or African American	1% (9)	1% (12)	1% (21)
Hispanic or Latino	3% (27)	3% (42)	3% (69)
Native Hawaiian or Other Pacific Islander	1% (9)	<1% (5)	1% (14)
White	89% (917)	91% (1,528)	90% (2,445)
Total	100% (1,034)	100% (1,672)	100% (2,706)

Note. Missing, non-standard, or don't know values were found for 11% (216) cases in the previous reporting period and 1% (21) cases in the current reporting period. Consumers were also able to select "Not included in this list", with <1% (3) cases in the previous reporting period and 39% (672) cases in the current reporting period selecting this option. Percentages may not add up to 100 due to rounding.

Physical disability

From April 2023 through June 2024, in 35% (513) of cases with non-missing data, consumers had a known physical disability, a similar share as the previous reporting period 38% (528) ($\chi^2(1) = 1.47$, $p = .226$) (Table 1.4).

Table 1.4. Physical Disability

Physical disability	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Yes	38% (528)	35% (513)	36% (1,041)
No	62% (876)	65% (938)	64% (1,814)
Total	100% (1,404)	100% (1,451)	100% (2,855)

Note. Missing, non-standard, or don't know values were found for 38% (528) of cases in the previous reporting period and 35% (513) of cases in the current reporting period. Percentages may not add up to 100 due to rounding.

Insurance coverage

During the current reporting period, focusing only on cases with non-missing information, most consultations were about consumers with Medicaid insurance (47% (775)) followed by those who were Dual eligible (Medicaid and Medicare) (28% (455)). A far smaller share of consumers were insured through Private Insurance (excl. Medicare Advantage) (2% (39)) and Veterans Health (<1% (8)), and only 1% (9) had no coverage (Table 1.5). The distribution of consumers' insurance coverage shifted significantly from the previous to current reporting periods ($2(6) = 43.07$, $p < .001$) with some evidence that this shift can be attributed to decreases in consumers with coverage from Medicare Traditional and an increase in coverage from Medicare Advantage.

Table 1.5. Insurance Coverage

Insurance	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Medicaid	47% (635)	47% (775)	47% (1,410)
Medicare Fee-for-Service	14% (195)	10% (160)	12% (355)
Medicare Advantage	7% (100)	12% (194)	10% (294)
Dual eligible (Medicaid and Medicare)	29% (392)	28% (455)	28% (847)
Private Insurance (excl. Medicare Advantage)	3% (36)	2% (39)	3% (75)
Veterans Health	0% (0)	<1% (8)	<1% (8)
No Coverage	0% (0)	1% (9)	<1% (9)
Total	100% (1,358)	100% (1,640)	100% (2,998)

Note. Missing, non-standard, or don't know values were found for 13% (251) of cases in the previous reporting period and 21% (355) of cases in the current reporting period. Percentages may not add up to 100 due to rounding.

Age

During the current reporting period, focusing only on cases with non-missing information, the largest age group was 65-74 consisting of 33% (617) of all CCCs, followed by consumers who were younger than 60 (27% (501)) (Table 1.6). Only 6% (105) of consumers were 85 years and older. The age distribution for the previous measurement period and across all quarters was similar, with the largest age group being between 65-74 (previous: 31% (526), across all quarters: 32% (1,143)), followed by consumers who were younger than 60 (previous: 29% (501), across all quarters: 28% (1,002)) and between 60-64 (previous: 18% (301), across all quarters: 18% (638)). The age distribution of consumers was statistically similar between April 2023 through June 2024 and January 2022 through March 2023 ($2(4) = 5.88$, $p = .209$).

Table 1.6 Age

Age	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
<60	29% (501)	27% (501)	28% (1,002)
60-64	18% (301)	18% (337)	18% (638)
65-74	31% (526)	33% (617)	32% (1,143)
75-84	18% (299)	16% (306)	17% (605)
85+	5% (79)	6% (105)	5% (184)
Total	100% (1,706)	100% (1,866)	100% (3,572)

Note. Missing, non-standard, or don't know values were found for 0% (7) of cases in the previous reporting period and 1% (25) of cases in the current reporting period. Percentages may not add up to 100 due to rounding.

The Specialists' previous involvement in a CCC

During the current reporting period, in cases with non-missing information, the Specialists reported having consulted on the consumer on a previous occasion in 48% (890) of cases (Table 1.7). This is statistically similar to the previous reporting period 48% (778) ($2(1) = 0.07$, $p = .791$).

Table 1.7. Previous involvement in a CCC

Have you consulted on this client before?	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Yes	48% (778)	48% (890)	48% (1,668)
No	52% (844)	52% (946)	52% (1,790)
Total	100% (1,622)	100% (1,836)	100% (3,458)

Note. Missing, non-standard, or don't know values were found for 5% (91) of cases in the previous reporting period and 3% (55) of cases in the current reporting period. Percentages may not add up to 100 due to rounding.

Planning

Focusing only on cases with valid responses, over half of all consultations were planned during the current reporting period (57% (1,058)) (Table 1.8), a significant decrease compared to the previous reporting period (62% (1,016), $2(1) = 6.58$, $p = .01$).

Table 1.8 Planned and unplanned CCCs

Consulted planning?	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Planned	62% (1,016)	57% (1,058)	60% (2,074)
Unplanned	38% (628)	43% (783)	40% (1,411)

Consulted planning?	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Total	100% (1,644)	100% (1,841)	100% (3,485)

Note. Missing, non-standard, or don't know values were found for 4% (69) of cases in the previous reporting period and 3% (50) of cases in the current reporting period. Percentages may not add up to 100 due to rounding.

Consumers' residence and change in residence

The Specialists reported their discussions on change in residence. During the current reporting period, in 49% (874) of cases no discussion of change in residence occurred, a larger share compared to last reporting period (43% (674)). A similar share of CCCs involved a discussion of residence change that did not lead to a recommendation this period (7% (117)) compared to last (6% (90)). In a smaller share of CCCs during the current period (26% (457)) compared to the last period (31% (491)), a change in residence was recommended but the option was not available. Regarding CCCs in which a recommendation was made and the option was or will be available, a similar share during the current period (12% (215)) compared with the previous period (13% (202)) were identified by the Specialists. Additionally, in a similar share of CCCs this period (6% (103)) compared to last (7% (111)), consumers refused the recommended change in residence even though it was or would soon be available. The distribution of residence recommendations significantly shifted between the previous and current reporting periods ($2(4) = 19.6$, $p < .001$), with increases in residence changes not discussed and a change being discussed but not recommended, and decreases in all other categories (Table 1.9).

Table 1.9. Change in residence

Change in residence recommended?	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Change not discussed	43% (674)	49% (874)	46% (1,548)
Change discussed, not recommended	6% (90)	7% (117)	6% (207)
Recommended, option not available	31% (491)	26% (457)	28% (948)
Recommended, option is/will be available	13% (202)	12% (215)	13% (417)
Recommended and option is/will be available, consumer refused	7% (111)	6% (103)	6% (214)
Total	100% (1,568)	100% (1,766)	100% (3,334)

Note. Missing, non-standard, or "don't know" responses were found in 8% (145) cases during the current period and 7% (125) of cases from the previous reporting period. Percentages may not add up to 100 due to rounding.

When all of the changes in residential setting were reported, 72% (634) of CCCs involved changes at settings with a higher level of care; which was substantially lower than the share

during the last reporting period (80% (649)). The distribution of the residence level of care change recommendations has shifted significantly between the previous and current reporting periods ($2(2) = 35.93$, $p < .001$), with increases in the share of shifts to the same level of care and decreases in shifts to lower and higher levels of care (Table 1.10). This suggests that during the current reporting period, the Specialists were more likely to perceive consumers' current residential level of care to be appropriate compared to the previous reporting period. Of note, for a majority of CCCs across the prior and current reporting period, information on residential setting changes were Missing, non-standard, or "don't know" responses (53% (1,911)).

Table 1.10. Recommendations for a change in care level

Change in residence	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
To lower level of care	6% (45)	3% (27)	4% (72)
To same level of care	14% (115)	25% (223)	20% (338)
To higher level of care	80% (649)	72% (634)	76% (1,283)
Total	100% (809)	100% (884)	100% (1,693)

Note. Missing, non-standard, or "don't know" responses were found in 53% (904) cases during the current period and 53% (1,007) of cases from the previous reporting period. Percentages may not add up to 100 due to rounding.

Referral source

In cases with non-missing information during the current measurement period, the Specialists reported that most CCCs were referred by Multidisciplinary Teams (32% (564)), by "Other" referral sources not listed (19% (329)), or by Mental health/behavioral health/community mental health programs (16% (286)). Least frequently, referrals came from Long-term care or Community-based care (e.g., Assisted living facility, Residential care, Nursing home) (3% (51)), Adult Protective Services (3% (50)), Family member, guardian or other person responsible for consumer's wellbeing (1% (23)), or Law enforcement/first respondents (1% (16)). During the current reporting period, all referral sources were reported by the Specialists at least once with the least referrals coming from Centers for Independent Living (<1% (3)) and Options Counselor/ADRCs (<1% (2)). The distribution of CCC referral sources shifted significantly from the previous to the current reporting period ($2(11) = 204.4$, $p < .001$), with some evidence for an increase in the share of referrals from Other sources, a substantial decrease from Multidisciplinary Teams, and smaller decreases from mental health agencies, Area Agencies on Aging, and Long-term care and Community-based care (Table 1.11).

Table 1.11. Referral sources

Referral source	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Multidisciplinary Team	41% (522)	32% (564)	36% (1,086)
Other	4% (54)	19% (329)	13% (383)
Mental health/behavioral health/community mental health program	19% (239)	16% (286)	17% (525)
Aging and People with Disabilities	14% (177)	15% (267)	15% (444)
Area Agency on Aging	9% (112)	5% (79)	6% (191)
Health care setting (e.g., primary care, acute care)	5% (61)	4% (72)	4% (133)
Long-term care or community-based care (e.g., Assisted Living Facility, Residential Care, Nursing Home)	6% (77)	3% (51)	4% (128)
Adult Protective Services	2% (31)	3% (50)	3% (81)
Family member, guardian or other person responsible for consumer's wellbeing	0% (0)	1% (23)	1% (23)
Law enforcement/first respondents	1% (9)	1% (16)	1% (25)
Centers for Independent Living	0% (0)	<1% (3)	<1% (3)
Options Counselor/ADRC	<1% (6)	<1% (2)	<1% (8)
Total	100% (1,288)	100% (1,742)	100% (3,030)

Note. Data were missing, non-standard, or reported as "don't know" for 25% (425) of cases during the previous reporting period and 8% (149) of cases during the current reporting period. Percentages may not add up to 100 due to rounding.

Prevalence of diagnosed or suspected/diagnosis pending problems/issues reported per consumer

During the current reporting period, there were a total of 16,575 problems/issues reported related to the CCCs (excluding the "Other" categories), 1,769 of which were suspected/diagnosis pending (Mean = 0.94) across all quarters. The total number of diagnosed or suspected problems/issues is slightly smaller this reporting period compared to the last reporting period (n = 16,611), as was the average per consumer this period (Mean = 8.77) compared to last period (Mean = 9.7). The number of suspected problems/issues was much higher this reporting period (1,769) compared to the previous (1,438) reporting period, while the average number of suspected diagnoses was slightly higher this period (Mean = 0.94 vs. Mean = 0.84). Currently, 71% of cases had five or more reported issues (5-9 issues: 35% (657) and 10+ issues: 36% (687))

during the current period which is a lower share compared to the previous reporting period (75%) (Table 1.12). Finally, most consumers during the current reporting period had at least one physical / medical (78% (1,477)), neurological/cognitive (56% (1,051)), psychiatric / mental health (83% (1,565)), social / individual (82% (1,560)), or systems (77% (1,455)) problem or issue (Table 1.13). The share of consumers with at least one issue was similar this reporting period compared to last reporting period for physical / medical (previous: 78% (1,336)), and neurological/cognitive (previous: 55% (950)), and psychiatric / mental health (previous: 84% (1,447)), and social / individual (previous: 82% (1,408)) categories of issues, and was slightly higher during the current reporting period for systems (previous: 75% (1,288)).

Table 1.12. Percentage of diagnosed or suspected/diagnosis pending problems/issues reported per consumer (excluding "Other" categories)

# Diagnosed or suspected problems/issues per consumer	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
0	4% (70)	4% (74)	4% (144)
1-2	8% (139)	11% (212)	10% (351)
3-4	13% (221)	14% (261)	13% (482)
5-9	27% (463)	35% (657)	31% (1,120)
10+	48% (820)	36% (687)	42% (1,507)
Total	100% (1,713)	100% (1,891)	100% (3,604)

Table 1.13. At least one diagnosed or suspected/diagnosis pending problems/issues reported by broad categories

Categories of Diagnoses or Suspected/Pending Diagnoses	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Physical / Medical	78% (1,336)	78% (1,477)	78% (2,813)
Neurological/Cognitive	55% (950)	56% (1,051)	56% (2,001)
Psychiatric / Mental Health	84% (1,447)	83% (1,565)	84% (3,012)
Social / Individual	82% (1,408)	82% (1,560)	82% (2,968)
Systems	75% (1,288)	77% (1,455)	76% (2,743)
Any	96% (1,643)	96% (1,817)	96% (3,460)

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

During the current reporting period, *co-occurring medical conditions*, *geriatric syndromes (e.g., frailty, falls, self-neglect)*, and *unresolved medical need* were most likely to be diagnosed (51%,

40%, and 33% of all CCCs, respectively) within the **physical/medical category**, followed by *ADL and other functional limitations* (32%). *Polypharmacy* (6%) and *delirium* (< 1%) were the least cited reasons in this category (Table 1.14). Prevalence rates of these problems/issues were similar between the current reporting period and the previous reporting period.

Under the **neurological/cognitive category**, during the current reporting period, *lack of capacity, competence for decision making* (18% diagnosed and 17% suspected) and *dementia* (13% diagnosed and 14% suspected) were the most frequently selected problems/issues. *Acquired or traumatic brain injury (e.g., stroke), intellectual disability*, and *neurological disorder (e.g., seizures, Parkinson's)* were less frequently selected (6%, 5%, and < 1% diagnosed, respectively) (Table 1.14).

For the **psychiatric/mental health category**, during the current reporting period, *serious mental illness* (36% diagnosed and 8% suspected) and *depression*; 18% diagnosed and 15% suspected) were most likely to be selected, followed by *disruptive behaviors* (15% diagnosed and 3% suspected) and *anxiety* (11% diagnosed and 13% suspected). Least likely to be reported as a presenting problem/issue for CCCs were *suicidality* (3%), *hoarding* (2%), and *opioid use disorder* (< 1%) (Table 1.14). The order of the prevalence of problems/issues was similar between the current reporting period and the previous reporting period, with the exception of *disruptive behaviors* (15%) and *substance use disorders (excl. opioid use disorder)* (10%) which were relatively more prevalent in the previous period. In this *psychiatric mental health* category, prevalence levels were generally slightly lower during the current reporting period compared to the previous period.

During the current reporting period, *Lack of or poor family/natural supports* was the most frequently cited problem/issue (52% of all CCCs) in the **social/individual category**, followed by *financial (e.g., cannot afford services, limited income)* (35%). Additionally, 25% or more of CCCs included *housing* (31%), *loneliness* (27%), and *consumer refuses services* (26%) as presenting problems. The least commonly selected problem/issue in this category was *law enforcement/criminal justice involvement* (13%) (Table 1.14). Prevalence rates and the prevalence order of social/individual problems/issues selected were consistently lower during the current reporting period compared to the previous reporting period. The largest drops in prevalence rates include a 5%-pt. decrease for *lack of or poor family/natural supports* and a 6%-pt. decrease for *isolation*. Across all *social individual* issues, our data show at least a 2%-pt. drop in prevalence rates from the previous to the current reporting period.

The **system-related issues** category included the largest number of potential problems/issues that could be selected compared to other categories, because one of the primary goals of the Initiative is to improve the wellbeing of older adults and people with disabilities who have behavioral health challenges by improving system level issues. During the most current reporting period, the most frequently involved system-related issues were *system navigation (difficult for consumer/family/supports)* (58%) and *understanding eligibility* (39%). These problems/issues were followed in prevalence by *lack of communication between agencies* (16%), *does not qualify for aging supports due to BH needs* (15%), *lack of or limited transportation* (12%), *guardianship issues* (10%), and *lack of BH services* (10%). Fewer than five percent of the time, *wait list is full or would take too long* (2%), *lack of case managers* (2%), *legal issue (e.g., inappropriate*

evictions; guardianship issues) (2%), *health insurance limitations* (1%), and *can't afford services* (< 1%) were selected during the current reporting period (Table 1.14). Compared to the previous reporting period, the largest drops in prevalence rates were found for *lack of BH services* (8%-pts) and *understanding eligibility* (4%-pts). Smaller decreases in prevalence rates were found for *does not qualify for aging supports due to BH needs* (3%-pts), *does not qualify for BH supports due to ADL needs* (3%-pts), and *inadequate workforce (insufficient, lack of training)* (3%-pts). Additional problems issues that were more prevalent during the current reporting period compared to the previous reporting period were *lack of or limited transportation* (12% vs. 10%) and *Medicare limitations* (8% vs. 6%).

Regardless of broad categories into which problems/issues were grouped, across all quarters, the most prevalent diagnosed issues during the current reporting period are *system navigation (difficult for consumer/family/supports)* (58%), *lack of or poor family/natural supports* (52%), and *co-occurring medical conditions* (51%). The most prevalent suspected/diagnosis pending issues regardless of broad category are *lack of capacity, competence for decision making* (17%), *depression* (15%), and *dementia* (14%). Similar to the last reporting period, these problems remain as the most prevalent issues presenting in CCCs.

In the past, the CCC form also included an open-ended comment box for the Specialists to describe "other reasons for a consultation." Most comments written in this section usually include further description of the reasons for a consultation that are already included in the predetermined list of reasons in the CCC form.

Table 1.14. Percentage of issues/problems reported by the Specialists by reporting period

Broad Category	Problem/Issue	Diag '22 Q1-'23 Q1	Diag '23 Q2-'24 Q2	Diag All	Susp '22 Q1-'23 Q1	Susp '23 Q2-'24 Q2	Susp All
Physical Medical	Co-occurring medical conditions	50%	51%	51%	2%	3%	3%
	Geriatric syndromes (e.g., frailty, falls, self-neglect)	44%	40%	42%	1%	2%	2%
	Unresolved medical need	34%	33%	33%	2%	4%	3%
	ADL and other functional limitations	34%	32%	33%	1%	1%	1%
	Medical assistive device	17%	14%	15%	< 1%	< 1%	< 1%
	High utilization of emergency department and/or 911	11%	11%	11%	< 1%	< 1%	< 1%
	Polypharmacy	6%	6%	6%	1%	1%	1%
	Delirium	1%	< 1%	1%	1%	1%	1%
Neurological Cognitive	Lack of capacity, competence for decision making	22%	18%	20%	18%	17%	17%
	Dementia	13%	13%	13%	12%	14%	13%
	Acquired or traumatic brain injury (e.g., stroke)	7%	6%	7%	1%	2%	1%

Broad Category	Problem/Issue	Diag '22 Q1-'23 Q1	Diag '23 Q2-'24 Q2	Diag All	Susp '22 Q1-'23 Q1	Susp '23 Q2-'24 Q2	Susp All
	Intellectual disability	5%	5%	5%	3%	2%	3%
	Neurological disorder (e.g., seizures, Parkinson's)	1%	< 1%	< 1%	< 1%	< 1%	< 1%
Psychiatric Mental Health	Serious mental illness	41%	36%	39%	11%	8%	9%
	Depression	20%	18%	19%	11%	15%	13%
	Disruptive behaviors	21%	15%	18%	3%	3%	3%
	Anxiety	15%	11%	13%	9%	13%	11%
	Substance Use Disorders (excl. Opioid Use Disorder)	16%	10%	12%	4%	4%	4%
	Suicidality	3%	3%	3%	2%	1%	1%
	Hoarding	3%	2%	3%	2%	1%	1%
	Opioid Use Disorder	2%	< 1%	1%	< 1%	< 1%	< 1%
Social Individual	Lack of or poor family/natural supports	57%	52%	54%			
	Financial (e.g., cannot afford services, limited income)	38%	35%	36%			
	Housing	33%	31%	32%			
	Loneliness	29%	27%	28%			
	Consumer refuses services	32%	26%	29%			
	Isolation	27%	21%	24%			
	Homelessness	24%	20%	22%			
	Food insecurity	22%	20%	21%			
	Law enforcement/criminal justice involvement	17%	13%	15%			
System	System navigation (difficult for consumer/family/supports)	59%	58%	58%			
	Understanding eligibility	43%	39%	41%			
	Lack of communication between agencies	18%	16%	17%			
	Does not qualify for aging supports due to BH needs	18%	15%	16%			
	Lack of or limited transportation	10%	12%	11%			
	Guardianship issues	9%	10%	9%			
	Lack of BH services	18%	10%	14%			
	In home services needed, but not available	10%	8%	9%			

Broad Category	Problem/Issue	Diag '22 Q1-'23 Q1	Diag '23 Q2-'24 Q2	Diag All	Susp '22 Q1-'23 Q1	Susp '23 Q2-'24 Q2	Susp All
	Medicare limitations	6%	8%	7%			
	Does not qualify for BH supports due to ADL needs	10%	7%	8%			
	Inadequate workforce (insufficient, lack of training)	9%	6%	7%			
	Lack of aging services	6%	5%	5%			
	Wait list is full or would take too long	2%	2%	2%			
	Lack of case managers	4%	2%	3%			
	Legal issue (e.g., inappropriate evictions; guardianship issues)	4%	2%	3%			
	Health insurance limitations	1%	1%	1%			
	Can't afford services	2%	< 1%	1%			

The Specialists' actions during a consultation

Actions taken by the Specialists during consultations included assisting with information/referrals to services required by the consumer (62% (1,054) previous; 50% (949) current), providing clinical information about the consumer's presenting problems (49% (847) previous; 38% (712) current), providing additional staff training/coaching (27% (466) previous; 16% (301) current), providing short-term help in accessing services (51% (881) previous; 36% (690) current), facilitating discussion among community partners (7% (125) previous, 12% (228) current), and other various activities (28% (478) previous; 28% (538) current) (Table 1.15).

Table 1.15. The Specialists' actions during the consultation

The Specialists' actions taken	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Assisted with info/referrals to services required by the consumer	62% (1,054)	50% (949)	56% (2,003)
Provided the referral source with clinical info about consumer's presenting problem(s)	49% (847)	38% (712)	43% (1,559)
Provided the referral source with additional staff training/coaching	27% (466)	16% (301)	21% (767)
Provided consumer and/or surrogate with short-term help in accessing services	51% (881)	36% (690)	44% (1,571)

The Specialists' actions taken	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Facilitated discussion amongst community partners	7% (125)	12% (228)	10% (353)
Other	28% (478)	28% (538)	28% (1,016)

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

General recommendations for consumers during case discussions

Based on what was discussed during each CCC, the Specialists provide recommendations to improve services and outcomes for consumers. The Specialists' recommendations during consultations included a change in residence (40% (682) previous; 31% (593) current), a change in services and/or care plan (55% (936) previous; 52% (984) current), a review of current medications (38% (650) previous; 32% (599) current), admission to emergency department or the hospital (11% (188) previous; 8% (146) current), and other recommendations (37% (632) previous; 38% (703) current) (Table 1.16)

Table 1.16. General recommendations for consumers during case discussions

General Recommendations	22 Q1 - '23 Q1 Valid % (n)	'23 Q2 - '24 Q2 Valid % (n)	All Valid % (n)
Change in residence	40% (682)	31% (593)	35% (1,275)
Change in services and/or care plan	55% (936)	52% (984)	53% (1,920)
Review of current medications	38% (650)	32% (599)	35% (1,249)
Admission to emergency department or hospital	11% (188)	8% (146)	9% (334)
Other	37% (632)	38% (703)	37% (1,335)

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

Training Evaluation Findings

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

The findings below describe post-training evaluations for training events that occurred over the last 10 quarters (the current and previous quarters) from January 2022 through June 2024. During this time, 479 workforce development training events were planned, conducted, or sponsored by the Specialists (Table 2.1). Over this period, the PSU Evaluation team received a roster with participants' emails representing 227 training events (47.4%). Rosters were not received for 252 training events in time to send out evaluations, or because participant emails were not collected. For example, if the event was part of a larger conference where collecting emails would not be feasible.

The rosters received from 227 training events reflected 6,606 training participants, of whom 98% had an email address documented. The PSU Evaluation team attempted to reach out to all these participants, with a 5.1% email bounce back rate (Table 2.1.). Undeliverable emails represented an estimated 332 training participants that could have potentially responded to the evaluation survey. Participants had two weeks to complete the online questionnaire. Non-respondents received two reminder emails after the initial attempt. Overall, 2,638 participants filled out the questionnaire during this reporting quarter for a response rate of 43.1 percent.

Table 2.1. Response patterns for training participants with names on rosters

	'22 Q1 - '23 Q1	'23 Q2 - '24 Q2	Total
Number of workforce development events	190	289	479
Number of events evaluated	120	107	227
Number of names on rosters	3,969	2,637	6,606
Names with valid email address	3,876	2,576	6,452
Number of successful emails	3,732	2,388	6,120
Total valid responses	1,092	1,546	2,638
Fully completed	993	1,387	2,380
Partially completed	99	159	258

Response rate (valid responses/emails sent out)	29.3%	64.7%	43.1%

Participants' credentials

Participants were asked whether they had any credentials from a list, and 2,536 responses contained valid data. Overall, across all quarters, over half of participants reported having none of the credentials listed. On average, of participants with at least one credential, most held a master's degree in arts, science, or social work (15.8%) followed by a licensed clinical social worker (12.7%), a licensed professional counselor (6.0%), and registered nurse (4.2%). All other types of credentials held by participants ranged between <1% and 2.6% (Table 2.2).

Table 2.2. Training/workshop participants' credentials

Credential	'22 Q1 - '23 Q1 %	'23 Q2 - '24 Q2 %	Total %
I don't have any of these credentials	54.7	55.4	55.0
Master's degree in arts, science or social work	15.7	16.0	15.8
Licensed clinical social worker (LCSW)	13.8	11.3	12.7
Licensed professional counselor (LPC)	6.5	5.0	6.0
Registered nurse (RN)	4.1	4.4	4.2
Certified nursing assistant / Certified medical assistant	1.8	3.7	2.6
PhD degree or equivalent	2.8	1.7	2.4
Licensed marriage and family therapist (LMFT)	1.8	1.2	1.4
Nurse Practitioner (NP)	<1	1.2	1
Licensed professional/vocational nurse (LPN/LVN)	<1	1	1

Licensed clinical alcohol and drug abuse counselor (LCADAC)	<1	1	1
Medical doctor or Doctor of Osteopathic Medicine (MD/DO)	1	<1	1
Physician assistant (PA)	<1	<1	<1
Qualified mental health associate/professional (QMHA/QMHP)*	X	1.1	<1
Clinical alcohol and drug counselor (CADC)*	X	<1	<1
Home health aide (HHA)*	X	<1	<1
Personal care attendant (PCA)*	X	<1	<1
Peer support/wellness specialist (PSS/PWS) *	X	0	0

Note. Percentages do not add up to 100% because participants were able to select multiple credentials. *Added to survey evaluation in Q2 of 2024. X means category was not included on evaluation for that time period.

Topics covered in trainings

Between January 2022 and June 2024, the Specialists hosted, planned, and sponsored training events on a variety of different behavioral health topics. Training or workshop events could cover a single topic (e.g., hoarding) or encompass multiple topics (e.g., Depression, Delirium, and Dementia). Table 2.3 describes the distribution of training topics covered in events hosted over the evaluations period. Most training topics were about the Initiative (36.6%), followed by depression (28.4%), Alzheimer's disease and related dementias (27.2%) and serious mental illness* (19.8%) (Table 2.3).

Table 2.3 Topics Covered in Trainings: 2022-2024

Topic	n	%
About the Initiative	170	36.6
Depression	132	28.4

Alzheimer's disease and related dementia	126	27.2
Anxiety	100	21.6
Other (e.g., death and dying, de-escalation, burnout and compassion fatigue, trauma-informed care)	95	20.4
Serious mental illness, serious mental illness and aging*, serious mental illness and dementia*	92	19.8
System navigation/Resources/Communicating needs	88	19.0
Psychiatric/Mental health	86	18.5
Social isolation	86	18.5
Suicide	81	17.5
Addressing complex behaviors	70	15.1
Addiction/Substance use	70	15.1
Medication use or misuse, Pharmacology	61	13.1
Functional Impairment (e.g., IADL or ADL Limitations)	55	11.9%
Caregiver Support	54	11.6%
Lack of Capacity, Competence for Decision-Making	51	11.0%
Wellness and Prevention (e.g., nutrition, health literacy, brain health)	51	11.0%
Geriatric Syndromes (e.g., frailty, common age-related disease, multiple morbidities)	50	10.8%
Aging Services	45	9.7%
Cognition and cognitive assessment*	35	9.7%
Hoarding	41	8.8%
Grief	41	8.8%
Risk assessment and capacity*	31	8.6%
Mental Health First Aid	39	8.4%

Positive aging and reframing aging*	29	8.0%
Elder abuse and Elder rights	37	8.0%
Normal aging*	26	7.2%
Social determinants of health*	25	6.9%
Delirium	32	6.9%
Independent Living Concerns	31	6.7%
Health disparities and inequities*	24	6.6%
Advance Planning/End-of-life Care	29	6.3%
Somatic/ medical co-morbidity*	22	6.1%
Traumatic Brain Injury	28	6.0%
Age-friendly infrastructure*	21	5.8%
Culture, race/ ethnicity and MH*	21	5.8%
Legal Issues (e.g., guardianship)	26	5.6%
Special Populations	18	3.9%
Types of Physical Disabilities (e.g., chronic pain, spinal cord injury)	15	3.2%
Disability Adjustment	14	3.0%
Accommodations or Assistive Technology	12	2.6%
Falls Prevention*	8	2.2%
Other Aspects of a Physical Disability	4	0.9%
Employment or Vocational Rehabilitation	2	0.4%

Note. Percentages do not add up to 100% because trainings could cover more than one topic area. * indicates topic was added to roster beginning in October 2022 (Q4 2022).

Pre-training knowledge and knowledge gains attributed to training, and confidence items across quarters

Training participants rated their knowledge of a training topic before and after a training event on scales of 1 to 5. Table 2.4 compares mean scores between January 2022 through March 2023 (‘22 Q1 - ‘23 Q1) and April 2023 through June 2024 (‘23 Q2 - ‘24 Q2) for knowledge of a training subject prior to training, perceived knowledge gains as a result of training (nothing at all, a little, a moderate amount a good deal, or a great deal), and confidence in ability to use the knowledge gained from training (not at all confident, or slightly, moderately, pretty, or extremely confident). Average scores for self-reported knowledge prior to a training decreased by a mean score of 0.14 between the two periods. Perceived knowledge gained from training and confidence to use knowledge about a training topic increased between the two periods (Table 2.4.).

Table 2.4. Means of pre-training knowledge, knowledge gains attributed to training, and confidence items across quarters

	‘22 Q1 - ‘23 Q1	‘23 Q2 - ‘24 Q2	Total
Knowledge prior to training	3.22	3.08	3.16
Knowledge gained from training	3.84	3.92	3.88
Confidence to use knowledge	4.09	4.14	4.11

Knowledge before attending a training. Participants rated their level of knowledge about a training subject before they attended a training. Of 2,536 participants with valid data, most reported having a moderate to a good deal amount of knowledge before a training (69%). Overall, between 20.5% and 25.2% of participants described having a little knowledge about the training topic, while a small percentage reported knowing nothing at all, or a great deal (Table 2.5).

Table 2.5 Participants’ self-reported knowledge of subject before attending training

	‘22 Q1 - ‘23 Q1 %	‘23 Q2 - ‘24 Q2 %	Total %
Nothing at all	2.2	3.6	2.8

A little	20.5	25.2	22.5
A moderate amount	36.2	36.9	36.5
A good deal	35.5	28.2	32.5
A great deal	5.6	6.1	5.8

Perceived knowledge gained after attending a training. According to 2,536 participants with valid data, workforce development trainings provided them with invaluable information. Most had gained a great or good deal of knowledge (71.6%). Approximately one in five participants said they gained a moderate amount of knowledge, and far fewer respondents (8.4%) reported having learned a little or nothing at all (Table 2.6).

Table 2.6 Participants' perceptions of knowledge gained from a training

	‘22 Q1 - ‘23 Q1 %	‘23 Q2 - ‘24 Q2 %	Total %
Nothing at all	0.5	0.8	0.6
A little	9.0	6.1	7.8
A moderate amount	20.3	19.3	19.9
A good deal	46.1	47.5	46.6
A great deal	24.1	26.3	25.0

Confidence to use knowledge gained in work. The ability to use knowledge gained from a training event is an important workforce development objective. After each training event, participants were asked to describe confidence in their ability to use knowledge acquired in their work. Of the 2,499 respondents with valid data, most were pretty or extremely confident that they would use the knowledge they gained in their work (82%). Fewer than five percent of respondents reported slight or no confidence in their ability to use knowledge gained (Table 2.7).

Table 2.7 Participants' confidence to use knowledge gained in their work

	‘22 Q1 - ‘23 Q1 %	‘23 Q2 - ‘24 Q2 %	Total %

Not at all confident	1.0	0.9	0.9
Slightly confident	3.4	3.0	3.2
Moderately confident	13.6	12.8	13.2
Pretty confident	49.8	48.5	49.2
Extremely confident	32.3	34.9	33.4

Participants' perceptions of training/workshop characteristics

Training participants rated a training/workshop, the trainer(s), and the environment in which a training took place. Participants rated how relevant a workshop or training was, and how well it prepared them to work with older adults and people with physical disabilities. On a scale of 1 to 5, most participants agreed or strongly agreed that the training or workshop was beneficial (Table 2.8).

Table 2.8. Mean scores of participants' perceptions of training/workshop characteristics

The training/workshop…	'22 Q1 - '23 Q1	'23 Q2 - '24 Q2	Total
Met my expectations	4.53	4.54	4.53
Is useful in my work	4.59	4.57	4.59
Is supported by employer	4.60	4.58	4.59
Prepared me to work with older adults who have behavioral health needs	4.52	4.49	4.51
Prepared me to work with people with disabilities who have behavioral health needs	4.40	4.39	4.39

Overall, participants somewhat or strongly agreed that the training met their expectations (88.7%; 2,481 valid responses) and provided information that would be useful in their work (91.9%; 2,445 valid responses). Participants also felt that trainings prepared them to work with

people with disabilities (85.9%; 2,404 valid responses) and older adults (81.9%; 2,415 valid responses) who have behavioral health needs (Table 2.9).

Table 2.9 Participants' perceptions of trainings and workshop characteristics

The training/workshop …	Response categories	'22 Q1 - '23 Q1 %	'23 Q2 - '24 Q2 %	Total %
Met my expectations	Strongly disagree	2.2	3.5	2.7
	Somewhat disagree	2.9	2.0	2.5
	Neutral	6.5	5.3	6.0
	Somewhat agree	16.2	15.4	15.9
	Strongly agree	72.1	73.8	72.8
Is useful in my work	Strongly disagree	2.0	3.3	2.6
	Somewhat disagree	1.8	1.5	1.7
	Neutral	3.7	3.9	3.8
	Somewhat agree	19.5	17.0	18.4
	Strongly agree	72.9	74.3	73.5
Is supported by employer	Strongly disagree	2.2	3.1	2.6
	Somewhat disagree	1.0	0.9	1.0
	Neutral	6.2	6.8	6.5
	Somewhat agree	15.8	13.5	14.9
	Strongly agree	74.7	75.7	75.1

Prepared me to work with older adults who have behavioral health needs	Strongly disagree	1.8	2.7	2.2
	Somewhat disagree	2.1	1.8	1.9
	Neutral	5.9	6.3	6.1
	Somewhat agree	23.0	22.1	22.6
	Strongly agree	67.2	67.1	67.2
Prepared me to work with people with disabilities who have behavioral health needs	Strongly disagree	2.1	3.1	2.5
	Somewhat disagree	2.6	2.6	2.6
	Neutral	9.4	8.2	8.9
	Somewhat agree	25.0	24.3	24.7
	Strongly agree	60.8	61.8	61.2

Participants' perceptions of training/workshop and trainer(s)

Table 2.10 below describes participants' perceptions of trainer(s) based on their level of agreement with statements on a scale from 1 to 5. From Q1 of 2022 to Q2 of 2024, the majority of training participants reported that trainer(s) were well prepared (mean score = 4.61), gave clear explanations of training topics (mean score = 4.61), and welcomed and responded to their questions (mean score = 4.60). Average scores for perceptions of trainers were similar between the two reporting periods.

Table 2.10. Mean scores of participants' perception of trainer(s)

The trainer(s)...	'22 Q1 - '23 Q1	'23 Q2 - '24 Q2	Total
Was/were well prepared	4.61	4.60	4.61
Gave clear explanations of the topic	4.62	4.59	4.61

Welcomed questions and responded to them appropriately	4.60	4.59	4.60

Similar to perceptions of the training and workshop characteristics, most participants perceived the trainer or trainers as effective, as shown in Table 2.11. Based on 2,499 valid responses, less than five percent of respondents somewhat or strongly disagreed that trainers were well prepared, gave clear explanations of the topic, or responded to questions appropriately.

Table 2.11 Participants' perceptions of trainer(s)

The trainer(s)...	Response categories	'22 Q1 - '23 Q1 %	'23 Q2 - '24 Q2 %	Total %
Was/were well prepared	Strongly disagree	2.2	2.5	2.3
	Somewhat disagree	1.0	1.1	1.0
	Neutral	3.1	2.1	2.7
	Somewhat agree	21.0	22.2	21.5
	Strongly agree	72.7	72.2	72.5
Gave clear explanations of the topic	Strongly disagree	1.9	2.7	2.2
	Somewhat disagree	1.1	1.5	1.3
	Neutral	2.8	1.6	2.3
	Somewhat agree	21.6	22.6	22.0
	Strongly agree	72.6	71.6	72.2
Welcomed questions and responded to them appropriately	Strongly disagree	2.0	3.0	2.4
	Somewhat disagree	1.0	0.7	0.9
	Neutral	4.7	3.0	4.0

	Somewhat agree	19.7	20.8	20.2
	Strongly agree	72.6	72.6	72.6

Participants' perceptions of training/workshop environment and time allotted for training

Participants provided their level of agreement on a scale of 1 to 5 on their perception of the training/workshop environment, and were generally positive. Participants agreed that training/workshop facilities were adequate (mean = 4.27), locations worked well (mean = 4.29), and time allotted for the training/workshop was sufficient (mean = 4.53). Average scores for perceptions of the environment and time allotted were higher in the most recent quarters compared to Q1 2022 - Q1 2023 (Table 2.12).

Table 2.12. Mean scores of participants' perception of the training/workshop environment and time allotted for training

The training/workshop…	'22 Q1 - '23 Q1	'23 Q2 - '24 Q2	Total
Facilities and room were adequate	4.25	4.30	4.27
Location worked well for me	4.26	4.35	4.29
Time allotted was sufficient	4.50	4.58	4.53

Based on 2,499 participants with valid data, most agreed or strongly agreed that the time allotted for the training was sufficient (87.6%), the training took place at a location that worked well for them (76.5%), and the environment was adequate (85.1%) (Table 2.13).

Table 2.13. Participants' perceptions of participants' perception of the training/workshop environment and time allotted for training

The training/workshop …	Response categories	'22 Q1 - '23 Q1 %	'23 Q2 - '24 Q2 %	Total %
Facilities and room were adequate	Strongly disagree	2.5	3.0	2.7
	Somewhat disagree	5.8	5.3	5.6

	Neutral	7.4	5.6	6.6
	Somewhat agree	33.2	31.5	32.5
	Strongly agree	51.1	54.7	52.6
Location worked well for me	Strongly disagree	1.5	2.3	1.8
	Somewhat disagree	1.4	0.9	1.2
	Neutral	23.0	17.0	20.5
	Somewhat agree	18.3	19.4	18.8
	Strongly agree	55.8	60.4	57.7
Time allotted was sufficient	Strongly disagree	1.8	2.3	2.0
	Somewhat disagree	1.2	0.4	0.9
	Neutral	11.4	7.1	9.6
	Somewhat agree	16.4	17.5	16.9
	Strongly agree	69.2	72.8	70.7

Quarterly Report Data

The Specialists quarterly reports mostly consist of quantitative scaling items to assess the Specialists' perception of coordination and collaboration among community partners. This section presents the Specialists' assessments of their collaboration efforts as well as the evidence-based practices and screening tools they've used during the period from 2023 Q2 through 2024 Q2 period. During this period, the Specialists submitted 106 quantitative quarterly reports with data collected on all 36 Oregon counties.

Community partner engagement

During the reporting period, the Specialists engaged with 18 distinct types of community partners including "other" community partners across CCC/MDTs, formal community partner meetings, training, and other community partner meetings.

Of the community partner engagements that occurred through CCC/MDTs, the largest share was conducted with coordinated care organizations (49.5% (47/95)) which was a significantly greater proportion than the community partner average, followed by behavioral health (non-CMHP) (41.0% (39/95)) and consumers or family members (40.0% (38/95)) (Table 3.1).

Of the collaborations that occurred through planned/scheduled community partner meetings, the largest share was similarly conducted with coordinated care organizations (30.5% (29/95); a significantly greater proportion than average), followed by behavioral health (non-CMHP) (25.3% (24/95)) and advocacy organizations (24.2% (23/95)). Similarly, unplanned or ad hoc community partner meetings were most often between the Specialists and coordinated care organizations (21.0% (20/95)) at a significantly higher rate than the community partner average. This was followed by unplanned/ad hoc meetings with behavioral health (non-CMHP) (19.0% (18/95)), veteran services (16.8% (16/95)), and local law enforcement (15.8% (15/95)) (Table 3.1).

For community partner engagements through training, behavioral health (non-CMHP) made up the largest share of training engagements (34.7% (33/95); a significantly greater proportion than average), followed by coordinated care organizations (33.7% (32/95)) and consumers or family members (32.6% (31/95)). Elected government officials engaged with the Specialists through training at a significantly lower rate than the community partner average (1.0% (1/95)). Finally, veteran's services were the most likely to engage with the Specialists through other opportunities (28.4% (27/95); a significantly higher proportion than average), followed by coordinated care organizations (25.3% (24/95)) and community-based care (AL/RC, AFH) (25.3% (24/95)) (Table 3.1)

Table 3.1. Community partner engagement by activity type

	CCC/MDT[1]	Planned/Scheduled Community Partner Meeting(s)[1]	Unplanned/Ad Hoc Community Partner Meeting(s)[1]	Training[1]	Other
Long-term care Ombuds	11.6% (11/95)	13.7% (13/95)	12.6% (12/95)	23.2% (22/95)	19.0% (18/95)
Behavioral health (non-CMHP	41.0% (39/95)	25.3% (24/95)	19.0% (18/95)	34.7% (33/95) *	23.2% (22/95)
Center for Independent Living	6.3% (6/95)	6.3% (6/95)	8.4% (8/95)	5.3% (5/95)	15.8% (15/95)
Veterans services	25.3% (24/95)	13.7% (13/95)	16.8% (16/95)	20.0% (19/95)	28.4% (27/95) *
Coordinated care organization	49.5% (47/95) *	30.5% (29/95) *	21.0% (20/95) *	33.7% (32/95) *	25.3% (24/95)
Hospital/emergency department	32.6% (31/95)	9.5% (9/95)	8.4% (8/95)	14.7% (14/95)	12.6% (12/95)
Local law enforcement	33.7% (32/95)	7.4% (7/95)	15.8% (15/95)	15.8% (15/95)	17.9% (17/95)
EMT or similar emergency responder	29.5% (28/95)	9.5% (9/95)	9.5% (9/95)	13.7% (13/95)	11.6% (11/95)
Tribal organization	13.7% (13/95)	4.2% (4/95)	8.4% (8/95)	6.3% (6/95)	12.6% (12/95)
Consumer, or family member	40.0% (38/95)	13.7% (13/95)	3.2% (3/95) *	32.6% (31/95)	21.0% (20/95)
Advocacy organization (e.g., NAMI)	14.7% (14/95)	24.2% (23/95)	11.6% (11/95)	17.9% (17/95)	23.2% (22/95)
Community-based care (AL/RC, AFH)	26.3% (25/95)	9.5% (9/95)	15.8% (15/95)	26.3% (25/95)	25.3% (24/95)
Nursing home	20.0% (19/95)	5.3% (5/95)	10.5% (10/95)	13.7% (13/95)	16.8% (16/95)
Faith community	9.5% (9/95)	1.0% (1/95)	5.3% (5/95)	16.8% (16/95)	11.6% (11/95)
Elected government official	3.2% (3/95)	6.3% (6/95)	10.5% (10/95)	1.0% (1/95) *	14.7% (14/95)
Home care/Home health care	17.9% (17/95)	21.0% (20/95)	10.5% (10/95)	20.0% (19/95)	12.6% (12/95)
Hospice	14.7% (14/95)	20.0% (19/95)	13.7% (13/95)	17.9% (17/95)	17.9% (17/95)

	CCC/MDT[1]	Planned/Scheduled Community Partner Meeting(s)[1]	Unplanned/Ad Hoc Community Partner Meeting(s)[1]	Training[1]	Other
Other	8.4% (8/95)	8.4% (8/95)	10.5% (10/95)	11.6% (11/95)	14.7% (14/95)

[1]Students' t-test; * p<.05, ** p<.01, *** p<.001

Dedicated time and involvement with key community partner agencies

Table 3.2 summarizes the availability of the Specialists at the various offices of key community partners agencies. Physically, 24% are available at APD, 15% at AAA, another 10% at combined AAA/APD offices, and 26% at CMHP. Virtually, availability increases to 37% for APD, 33% for AAA, 26% for combined offices, and 50% for CMHP.

Table 3.2. The Specialists' dedicated time at key community partner agencies

Dedicated time available	APD % (n)	AAA % (n)	AAA/APD combined % (n)	CMHP % (n)	Total (n)
Yes, physically	24% (30)	15% (19)	10% (13)	26% (33)	57
Yes, virtually	37% (46)	33% (41)	26% (33)	50% (63)	90

Note: 23 missing values

Table 3.3 displays the frequency at which the Specialists are available at APD, AAA, or AAA/APD combined offices compared to CMHP offices. Monthly availability is most common for the combined offices (38%) and nearly as frequent at CMHP with (31%). The next highest frequency for the combined offices is one day a week (12%). In contrast, the next largest share for CMHP is those available four or five days a week (30%). A small percentage (1%) are never available at the combined offices, slightly less than the 3% for CMHP.

Table 3.3 Frequency of the Specialists' dedicated time at key community partner agencies

Frequency of availability	APD, AAA, or AAA/APD combined office % (n)	CMHP office % (n)
Never	1% (1)	3% (4)
Less than once a month	7% (9)	8% (10)
About monthly	38% (47)	31% (38)
Half-day or less per week	5% (6)	4% (5)
One day a week	12% (15)	4% (5)
Two or three days a week	7% (9)	2% (3)
Four or five days a week	11% (14)	30% (37)

Note: 22 missing values

Table 3.4 summarizes the Specialists involvement in various activities across key community partner agencies. The Specialists most frequently participated in training events with APD (91%), and were available to answer questions with AAA-ADRC (93%), and CMHP (97%). Regularly scheduled complex care consultations and the other activities listed had high engagement as well.

Table 3.4 Percentage of the Specialists' involvement with key community partner agencies by activity type

Activity Type	APD %	AAA-ADRC %	CMHP %	Total (n)
Regularly scheduled complex case consultations	88%	77%	86%	81
Ad hoc consultations (e.g., huddles, care conferences)	77%	60%	84%	75
Attend formal staff meetings (regularly scheduled)	45%	37%	88%	65
Attend other staff meetings (unplanned)	36%	56%	87%	39
Available to answer questions	89%	93%	97%	94
Training events	91%	88%	87%	74
Other	86%	73%	73%	22

Barriers when scheduling time with community partners

Table 3.5 shows the percentages of the Specialists who faced barriers when scheduling time with community partners. A total of 13% encountered barriers, while a larger proportion, 65% did not experience any scheduling difficulties.

Table 3.5 Percentage of Specialists who faced any barriers for scheduling time with community partners

Faced any barriers for scheduling time	Percent (n)
Yes	13% (16)
No	65% (79)

Note: 27 missing values

Memorandums of Understanding (MOUs) or other data-sharing agreements

Table 3.6 presents data on the presence of Memorandums of Understanding (MOUs) or other data-sharing agreements in place with APD, AAA, and/or CMHP offices. The majority of the Specialists (40%) do have an MOU or data-sharing agreement in place, while 31% do not have established agreements.

Table 3.6 Percentage of the Specialists with an established MOU or other data-sharing agreement

Have an MOU or other data-sharing agreement	Percent (n)
No	31% (38)
Yes	40% (49)

Note: 35 missing values

Involvement with local senior centers

Table 3.7 shows the frequency at which the Specialists engage with their local senior centers. A majority (35%) engage about monthly. The Specialists reported that they engage with senior centers less than once a month 21% of the time. A smaller fraction of the Specialists engage with senior centers more frequently, with 19% engaging one day a week and 10% engaging two or three days a week. Very few (4%) engage with their senior center four or five days a week.

Table 3.7. Frequency of the Specialists' engagement with local senior centers

Frequency of engagement with your local senior center(s)	Percent (n)
Four or five days a week	4% (4)
Two or three days a week	10% (11)
One day a week	19% (20)
Half-day or less per week	6% (6)
Less than once a month	21% (22)
About monthly	35% (36)
Never	7% (7)

Note: 18 missing values

Involvement with local primary care clinics

Table 3.8 outlines the frequency at which the Specialists engage with their local primary care clinics. A majority of the Specialists (46%) engage about monthly, while 37% engage with their local clinics less than once a month. A smaller percentage never engage, or engage one day a week, each 6%. An even smaller group engage with their local clinics four or five days a week, or half a day or less per week, each 2%. No Specialist reported engaging with their local primary care clinic two or three days a week.

Table 3.8. Frequency of the Specialists' engagement with local primary care clinics

Frequency of engagement with your local primary care clinic(s)	Percent (n)
Four or five days a week	2% (2)
Two or three days a week	0% (0)
One day a week	6% (6)
Half-day or less per week	2% (2)
Less than once a month	37% (35)
About monthly	46% (43)
Never	6% (6)

Note: 28 missing values

Specialist collaboration with new community partners

In addition to maintaining relationships with community partners, another key aspect of The Specialists work is to collaborate and develop relationships with new partners. During the current

reporting period, the vast majority of the Specialists reported collaborating with at least one new community partner (Table 3.9).

Table 3.9. Specialist collaboration with any new community partner during the report period

	N	%	Valid %
Yes	140	63%	79%
No	38	17%	21%
Missing	45	20%	-

Evidence Based Practices (EBPs)

Use of EBPs by training or meeting type (training, CCC, community partner meeting, health/wellness prevention and promotion, other)

Suicide, Depression, Anxiety

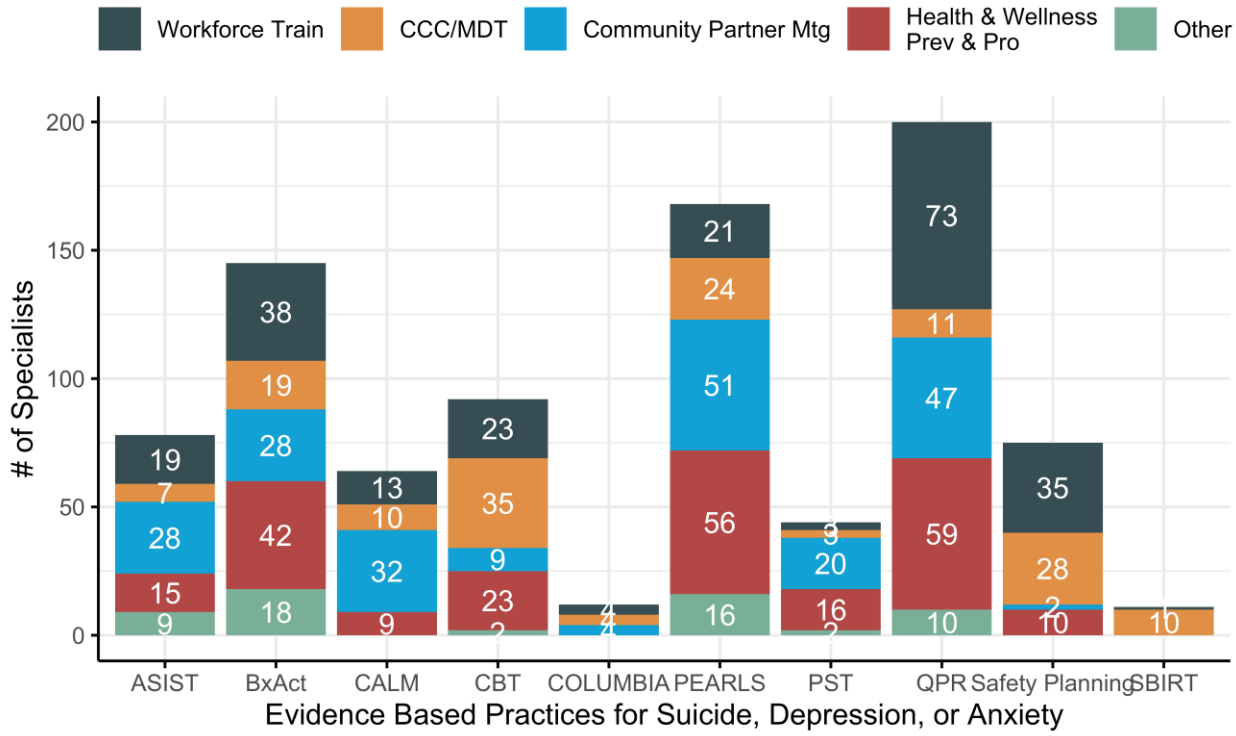
EBPs in suicide, depression, and anxiety (pre)(inter)vention include ASIST, Behavioral Activation, CALM, CBT for Anxiety/Depression, COLUMBIA, PEARLS, PST, QPR, SBIRT, and Safety Planning. With regard to these suicide, depression, and anxiety EBPs (Table 3.10), the Specialists most often used the QPR (32.7% (73)) in workforce trainings followed by Behavioral Activation (17.0% (38)). In CCC/MDTs, the Specialists most often used CBT for Anxiety/Depression (15.7% (35)) followed by Safety Planning (12.6% (28)). PEARLS was the preferred EBP for suicide, depression, and anxiety in community partner meetings (22.9% (51)), and the second most preferred EBP in health & wellness prevention and promotion events (25.1% (56)) just behind QPR (26.5% (59)). In other settings the Specialists most often used Behavioral Activation (8.1% (18)). Across all settings, the Specialists were most likely to use PEARLS and were least likely to use COLUMBIA and SBIRT as EBPs for suicide, depression, and anxiety (Figure 3.1).

Table 3.10. Number of Specialists who use evidence-based practices for suicide, depression, or anxiety by setting

	Workforce Train	CCC/MDT	Community Partner Mtg	Health & Wellness Prev & Pro	Other
ASIST	8.5% (19)	3.1% (7)	12.6% (28)	6.7% (15)	4.0% (9)
Behavioral Activation	17.0% (38)	8.5% (19)	12.6% (28)	18.8% (42)	8.1% (18)

	Workforce Train	CCC/MDT	Community Partner Mtg	Health & Wellness Prev & Pro	Other
CALM	5.8% (13)	4.5% (10)	14.3% (32)	4.0% (9)	0.0% (0)
CBT for Anxiety/Depression	10.3% (23)	15.7% (35)	4.0% (9)	10.3% (23)	0.9% (2)
COLUMBIA	1.8% (4)	1.8% (4)	1.8% (4)	0.0% (0)	0.0% (0)
PEARLS	9.4% (21)	10.8% (24)	22.9% (51)	25.1% (56)	7.2% (16)
PST	1.3% (3)	1.3% (3)	9.0% (20)	7.2% (16)	0.9% (2)
QPR	32.7% (73)	4.9% (11)	21.1% (47)	26.5% (59)	4.5% (10)
SBIRT	0.4% (1)	4.5% (10)	0.0% (0)	0.0% (0)	0.0% (0)
Safety Planning	15.7% (35)	12.6% (28)	0.9% (2)	4.5% (10)	0.0% (0)

Figure 3.1. Number of Specialists who use evidence-based practices for suicide, depression, or anxiety by setting



Note. BxAct = Behavioral Activation, CBT = CBT for Anxiety and Depression. The same Specialists can be counted more than once in an EBP column because they can and do use the same evidence-based practice across multiple settings (e.g., using ASIST in both workforce trainings and at meetings).

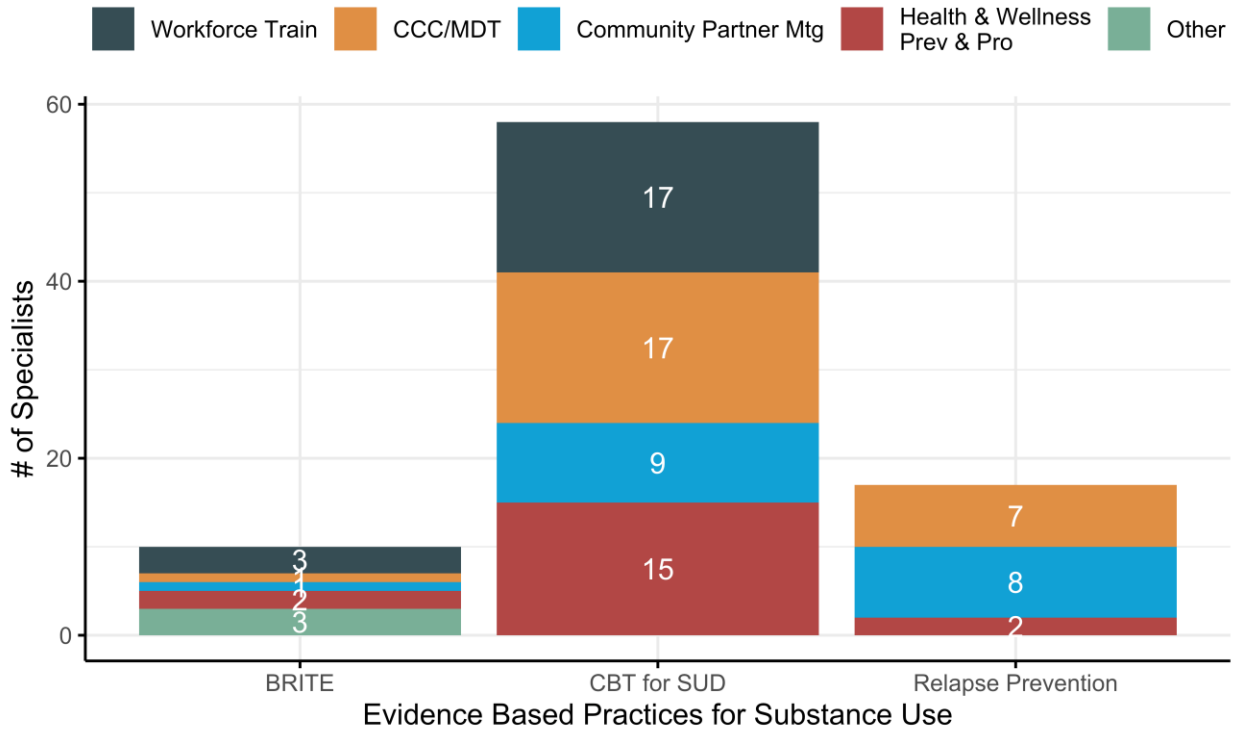
Substance Use

EBPs in substance use (pre)(inter)vention include BRITE, CBT for SUD, and Relapse Prevention. Of these three substance use EBPs (Table 3.11), the Specialists most often used CBT for SUD in workforce training (7.6% (17)), CCC/MDTs (7.6% (17)), community partner meetings (4.0% (9)), and health and wellness prevention and promotion events (6.7% (15)), and in other settings, used BRITE the most (1.3% (3)). Across all settings, the Specialists were most likely to use CBT for SUD and least likely to use BRITE as an EBP for substance use (Figure 3.2).

Table 3.11. Number of Specialists who use evidence-based practices for substance use by setting

	Workforce Train	CCC/MDT	Community Partner Mtg	Health & Wellness Prev & Pro	Other
BRITE	1.3% (3)	0.4% (1)	0.4% (1)	0.9% (2)	1.3% (3)
CBT for SUD	7.6% (17)	7.6% (17)	4.0% (9)	6.7% (15)	0.0% (0)
Relapse Prevention	0.0% (0)	3.1% (7)	3.6% (8)	0.9% (2)	0.0% (0)

Figure 3.2. Number of Specialists who use evidence-based practices for substance use by setting



Note. CP = Community Partner. The same Specialists can be counted more than once in an EBP column because they can and do use the same evidence-based practice across multiple settings (e.g., using CBT for SUD in both CCC/MDTs and at community partner meetings).

Hoarding

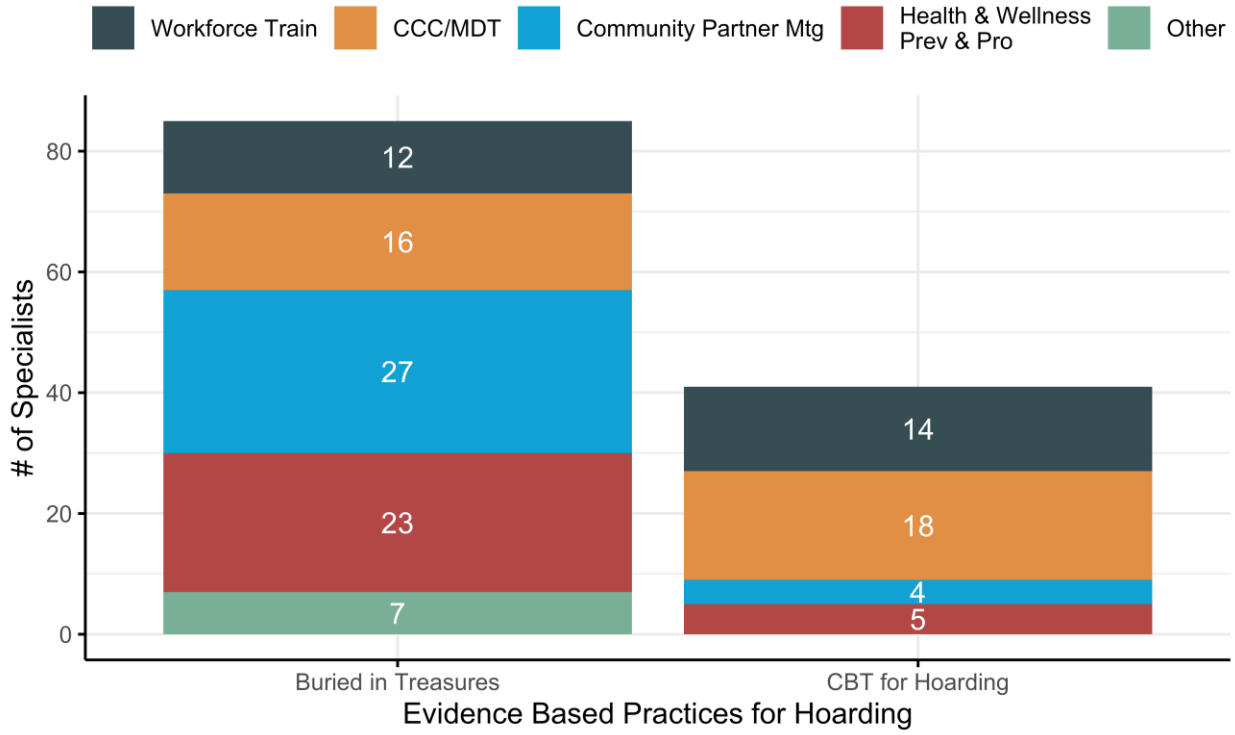
EBPs in hoarding (pre)(inter)vention include Buried in Treasures and CBT for hoarding. The Specialists most often used Buried in Treasures in community partner meetings (12.1% (27)), health and wellness prevention and promotion events (10.3% (23)), and other settings (3.1% (7)),

and most often used CBT for Hoarding in workforce training (6.3% (14)) and CCC/MDTs (8.1% (18)) (Table 3.12). Across all settings, the Specialists more often used Buried in Treasures (Figure 3.3).

Table 3.12. Number of Specialists who use evidence-based practices for hoarding by setting

	Workforce Train	CCC/MDT	Community Partner Mtg	Health & Wellness Prev & Pro	Other
Buried in Treasures	5.4% (12)	7.2% (16)	12.1% (27)	10.3% (23)	3.1% (7)
CBT for Hoarding	6.3% (14)	8.1% (18)	1.8% (4)	2.2% (5)	0.0% (0)

Figure 3.3. Number of Specialists who use evidence-based practices for hoarding by setting



Note. The same Specialists can be counted more than once in an EBP column because they can and do use the same evidence-based practice across multiple settings (e.g., using Buried in Treasure in both health and wellness prevention and promotion events and in other BHI settings).

Other

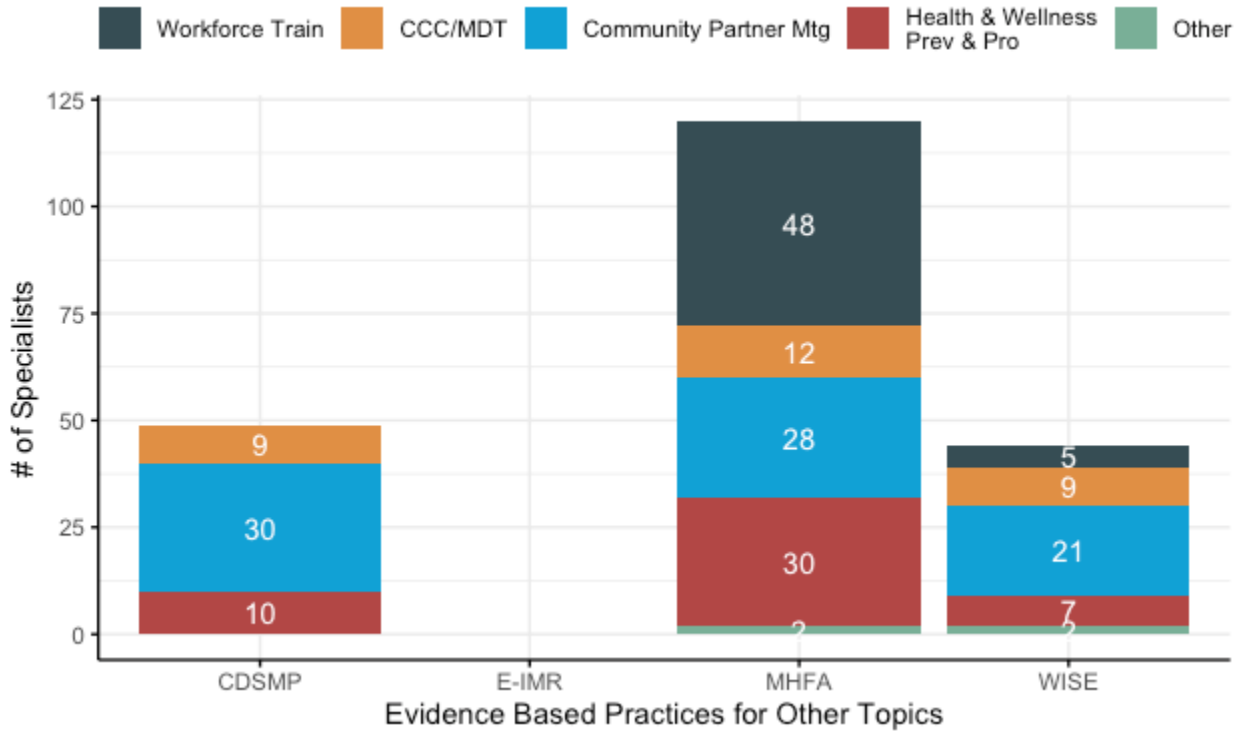
Other EBPs used by the Specialists include CDSMP, E-IMR, MHFA and WISE. Of these other EBPs (Table 3.13), MHFA was most often used by the Specialists across several settings including workforce training (21.5% (48)), CCC/MDTs (5.4% (12)), and health and wellness prevention and promotion events

(13.5% (30)). CDSMP was most often used in community partner meetings (13.5% (30)), and both MHFA and WISE were most often used in other settings (0.9% (2) for both EBPs). Across all settings, the Specialists most often used MHFA and no Specialists used E-IMR (Figure 3.4).

Table 3.13. Number of Specialists who use evidence-based practices for other topics by setting

	Workforce Train	CCC/MDT	Community Partner Mtg	Health & Wellness Prev & Pro	Other
CDSMP	0.0% (0)	4.0% (9)	13.5% (30)	4.5% (10)	0.0% (0)
E-IMR	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
MHFA	21.5% (48)	5.4% (12)	12.6% (28)	13.5% (30)	0.9% (2)
WISE	2.2% (5)	4.0% (9)	9.4% (21)	3.1% (7)	0.9% (2)

Figure 3.4. Number of Specialists who use evidence-based practices for other topics by setting



Note. The same Specialists can be counted more than once in an EBP column because they can and do use the same evidence-based practice across multiple settings (e.g., using WISE in both health and wellness prevention and promotion events and in other BHI settings).

Some additional evidence based practices not included in our list that Specialists reported using include *HAP-8* which was used in a health and wellness promotion and prevention event by one Specialist, *H.O.P.E Senior Peer Mentor Program* which was used in a health and wellness promotion and prevention event by one Specialist, *Powerful Tools for Caregivers* was used in

community partner meetings by two Specialists, *Positive Approach to Care* and *Alzheimer's Association Curriculum* used in a CCC/MDT and community partner meeting by one specialist, *Solution Focused Approaches* and *4Ms* used at a workforce training by one Specialist, *CPI* used in a workforce training by one Specialist, and *Caregivers* used in a health and wellness promotion and prevention event by one Specialist.

Evidence Based Screening/Assessment Tools (EBTs)

Use of screening/assessment tools by setting (training, CCC, community partner meeting, health/wellness prevention and promotion, other)

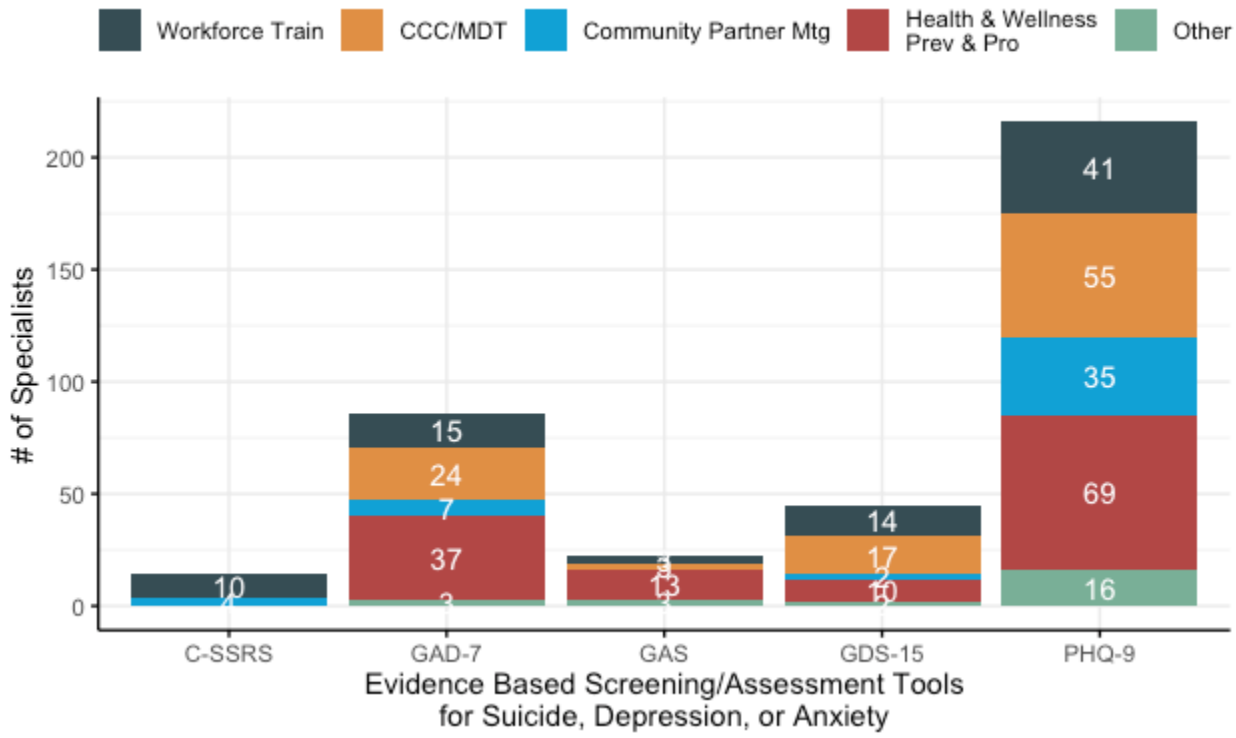
Suicide, Depression, Anxiety

Evidence-based screening and assessment tools (EBTs) in suicide, depression, and anxiety (pre)(inter)vention used by the Specialists included C-SSRS, GAD-7, GAS, GDS-15, and PHQ-9 (Table 3.14). Of these EBTs for suicide, depression, and anxiety, the PHQ-9 was used most often across all engagement settings including in workforce training (18.4% (41)), CCC/MDTs (24.7% (55)), community partner meetings (15.7% (35)), health and wellness prevention and promotion events (30.9% (69)), and other engagement settings (7.2% (16)). Across all settings, the second most often used EBT for suicide, depression, and anxiety was the GAD-7 (Figure 3.5).

Table 3.14. Number of Specialists who use evidence-based screening/assessment tools for suicide, depression, or anxiety by setting

	Workforce Train	CCC/MDT	Community Partner Mtg	Health & Wellness Prev & Pro	Other
C-SSRS	4.5% (10)	0.0% (0)	1.8% (4)	0.0% (0)	0.0% (0)
GAD-7	6.7% (15)	10.8% (24)	3.1% (7)	16.6% (37)	1.3% (3)
GAS	1.3% (3)	1.3% (3)	0.0% (0)	5.8% (13)	1.3% (3)
GDS-15	6.3% (14)	7.6% (17)	0.9% (2)	4.5% (10)	0.9% (2)
PHQ-9	18.4% (41)	24.7% (55)	15.7% (35)	30.9% (69)	7.2% (16)

Figure 3.5. Number of Specialists who use evidence-based screening/assessment tools for suicide, depression, or anxiety by setting



Note. The same Specialists can be counted more than once in an EBT column because they can and do use the same evidence-based screening tool across multiple settings (e.g., using PHQ-9 in both community partner meetings and in other BHI settings).

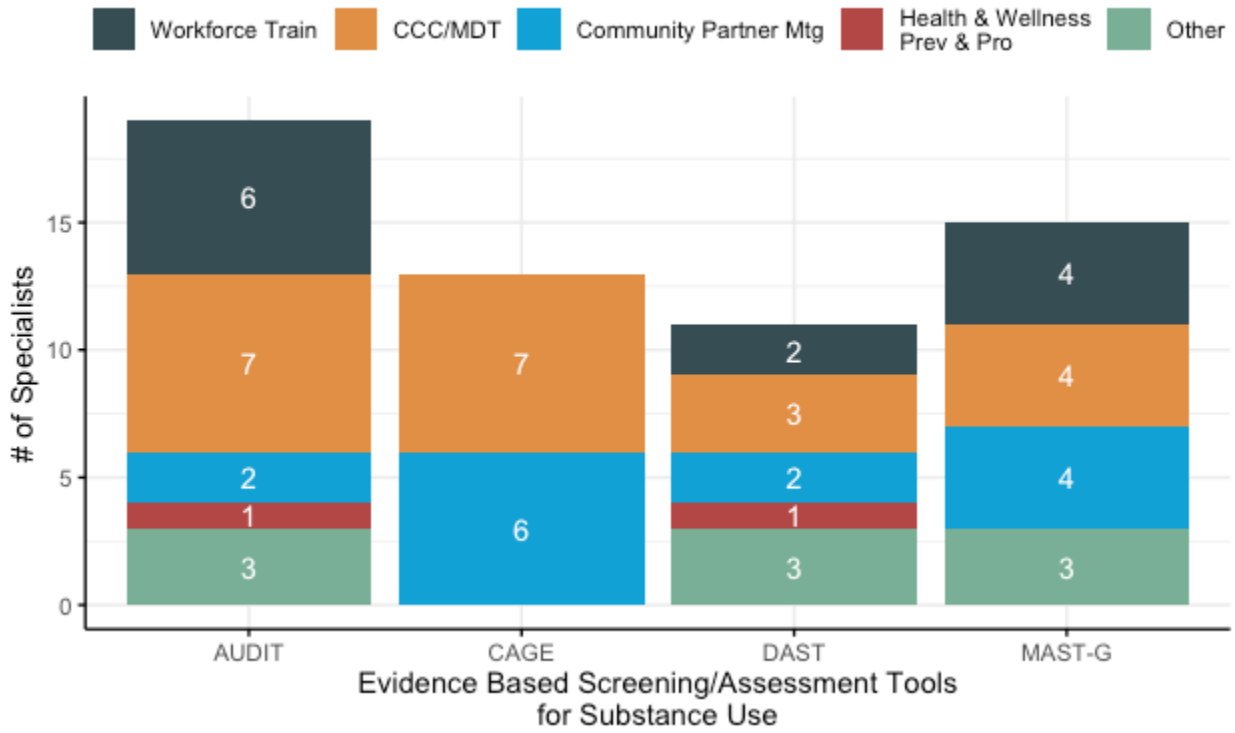
Substance Use

EBTs in substance use (pre)(inter)used by the Specialists include AUDIT, CAGE, DAST, and MAST-G (Table 3.15). Of those substance abuse EBTs, the Specialists most often used the AUDIT in workforce trainings (2.7% (6)), AUDIT and CAGE in CCC/MDTs (3.1% (7) for both), CAGE (2.7% (6)) in community partner meetings, AUDIT and DAST (0.4% (1) for both) in health and wellness prevention and promotion events, and AUDIT, DAST, and MAST-G (1.3% (3) for all) in other engagement settings. Across all settings, the AUDIT was used most often and the DAST was used least often by the Specialists (Figure 3.6).

Table 3.15. Number of Specialists who use evidence-based screening/assessment tools for substance use by setting

	Workforce Train	CCC/MDT	Community Partner Mtg	Health & Wellness Prev & Pro	Other
AUDIT	2.7% (6)	3.1% (7)	0.9% (2)	0.4% (1)	1.3% (3)
CAGE	0.0% (0)	3.1% (7)	2.7% (6)	0.0% (0)	0.0% (0)
DAST	0.9% (2)	1.3% (3)	0.9% (2)	0.4% (1)	1.3% (3)
MAST-G	1.8% (4)	1.8% (4)	1.8% (4)	0.0% (0)	1.3% (3)

Figure 3.6. Number of Specialists who use evidence-based screening/assessment tools for substance use by setting



Note. The same Specialists can be counted more than once in an EBT column because they can and do use the same evidence-based screening tool across multiple settings (e.g., using CAGE in both workforce training and CCC/MDTs).

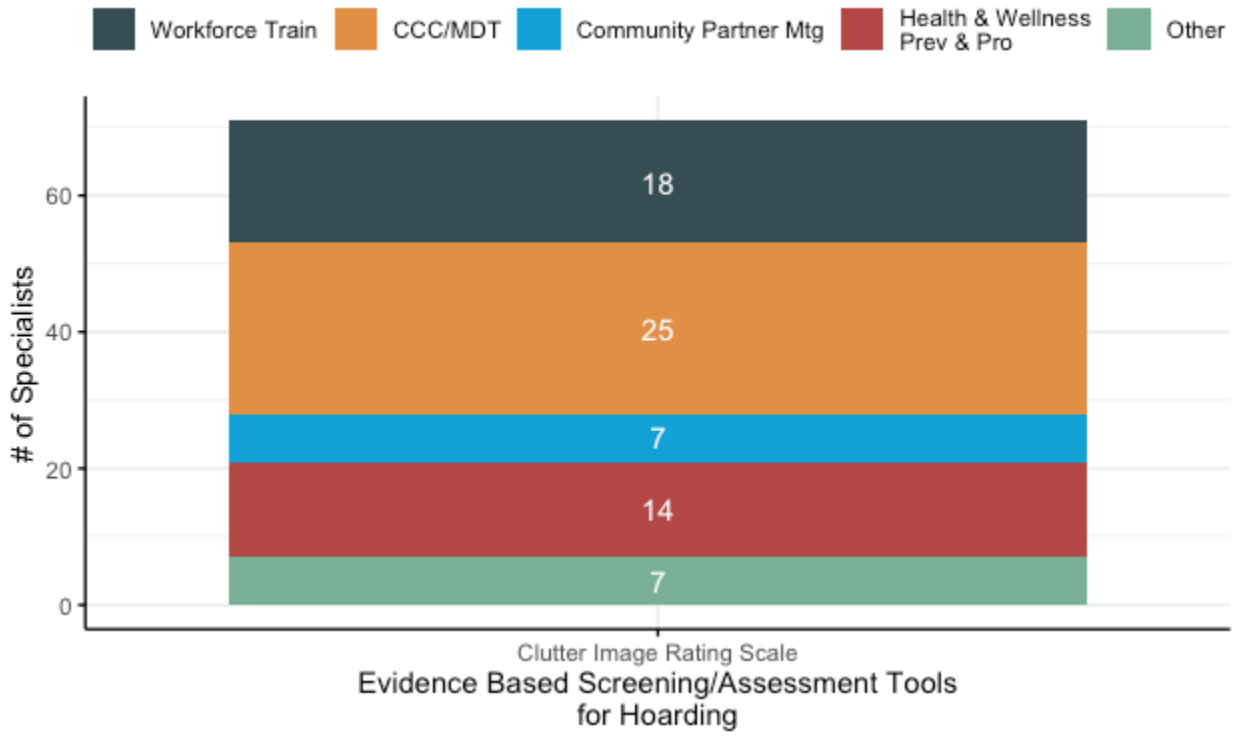
Hoarding

The EBT for hoarding (pre)(inter)vention used by the Specialists is the Clutter Image Rating Scale (Clutter) (Table 3.16). The Clutter Image Rating Scale was used in workforce training (8.1% (18)), CCC/MDTs (11.2% (25)), community partner meetings (3.1% (7)), health and wellness prevention and promotion events (6.3% (14)), and in other engagement settings (3.1% (7)) (Figure 3.7).

Table 3.16. Number of Specialists who use evidence-based screening/assessment tools for hoarding by setting

	Workforce Train	CCC/MDT	Community Partner Mtg	Health & Wellness Prev & Pro	Other
Clutter Image Rating Scale	8.1% (18)	11.2% (25)	3.1% (7)	6.3% (14)	3.1% (7)

Figure 3.7. Number of Specialists who use evidence-based screening/assessment tools for hoarding by setting



Note. The same Specialists can be counted more than once in an EBT column because they can and do use the same evidence-based screening tool across multiple settings (e.g., using the Clutter Image Rating Scale in both health and wellness prevention and promotion events and in other BHI settings).

Dementia or delirium

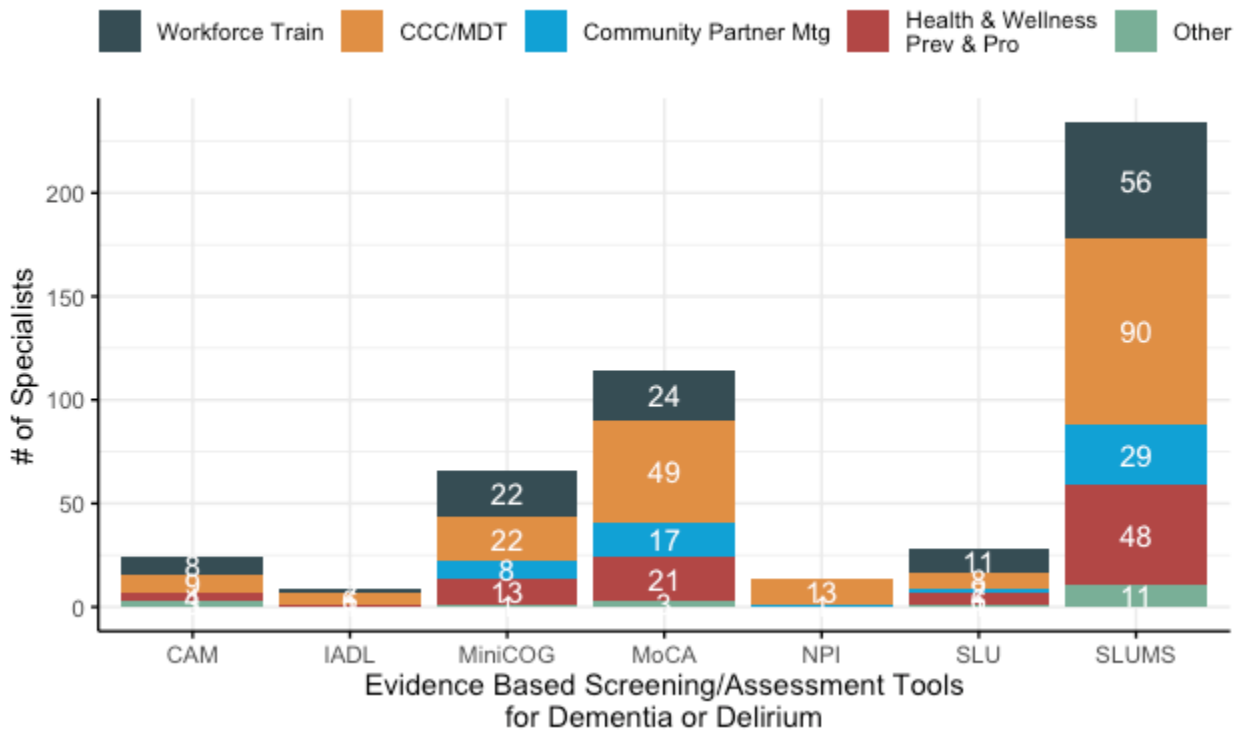
EBTs in dementia or delirium (pre)(inter)vention used by the Specialists include the CAM, IADL, MiniCOG, MoCA, NPI, SLU, and SLUMS (Table 3.17). Of these dementia or delirium EBTs, the Specialists were most likely to use the SLUMS across all engagement settings including workforce training (25.1% (56)), CCC/MDT (40.4% (90)), community partner meetings (13.0% (29)), health and wellness prevention and promotion events (21.5% (48)), and

in other engagement settings (4.9% (11)). Across all settings, the Specialists were least likely to use the SLUMS and MoCA as dementia or delirium EBTs (Figure 3.8)

Table 3.17. Number of Specialists who use evidence-based screening/assessment tools for dementia or delirium by setting

	Workforce Train	CCC/MDT	Community Partner Mtg	Health & Wellness Prev & Pro	Other
CAM	3.6% (8)	4.0% (9)	0.0% (0)	1.8% (4)	1.3% (3)
IADL	0.9% (2)	2.7% (6)	0.0% (0)	0.4% (1)	0.0% (0)
MiniCOG	9.9% (22)	9.9% (22)	3.6% (8)	5.8% (13)	0.4% (1)
MoCA	10.8% (24)	22.0% (49)	7.6% (17)	9.4% (21)	1.3% (3)
NPI	0.0% (0)	5.8% (13)	0.4% (1)	0.0% (0)	0.0% (0)
SLU	4.9% (11)	3.6% (8)	0.9% (2)	2.7% (6)	0.4% (1)
SLUMS	25.1% (56)	40.4% (90)	13.0% (29)	21.5% (48)	4.9% (11)

Figure 3.8. Number of Specialists who use evidence-based screening/assessment tools for dementia or delirium by setting



Note. The same Specialists can be counted more than once in an EBT column because they can and do use the same evidence-based screening tool across multiple settings (e.g., using SLUMS in both community partner meetings and in health and wellness prevention and promotion events).

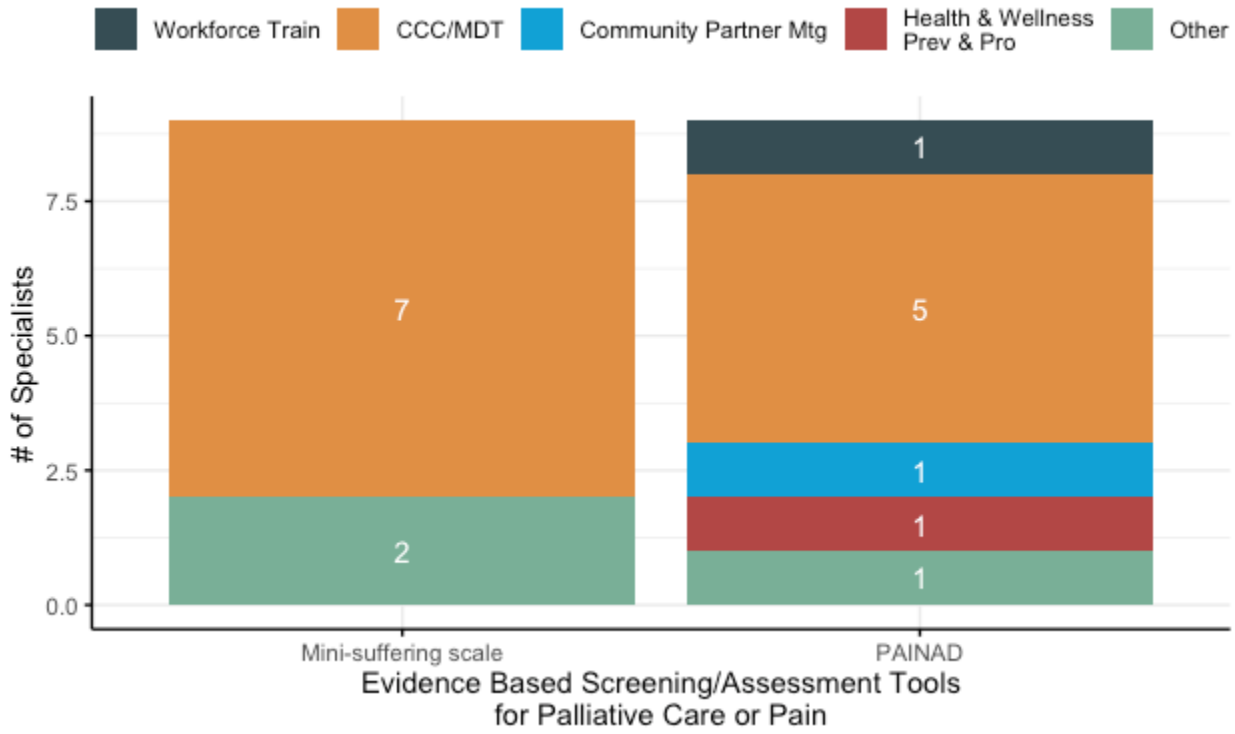
Palliative care or pain

EBTs in palliative care or pain (pre)(inter)vention used by the Specialists included PAINAD and Mini-suffering scale. Across almost all settings (Table 3.18; Figure 3.9), the Specialists more often used the PAINAD than the Mini-suffering scale including in workforce training (0.4% (1)), CCC/MDTs (2.2% (5)), community partner meetings (0.4% (1)), and health and wellness prevention and promotion events (0.4% (1)). For other engagement settings, both PAINAD and Mini-suffering scale were used just as frequently (0.4% (1) for both).

Table 3.18. Number of Specialists who use evidence-based screening/assessment tools for palliative care or pain by setting

	Workforce Train	CCC/MDT	Community Partner Mtg	Health & Wellness Prev & Pro	Other
PAINAD	0.4% (1)	2.2% (5)	0.4% (1)	0.4% (1)	0.4% (1)
Mini-suffering scale	0.0% (0)	3.1% (7)	0.0% (0)	0.0% (0)	0.9% (2)

Figure 3.9. Number of Specialists who use evidence-based screening/assessment tools for palliative care or pain by setting



Note. The same Specialists can be counted more than once in an EBT column because they can and do use the same evidence-based screening tool across multiple settings (e.g., using Mini-suffering scale in both workforce training and in CCC/MDTs).

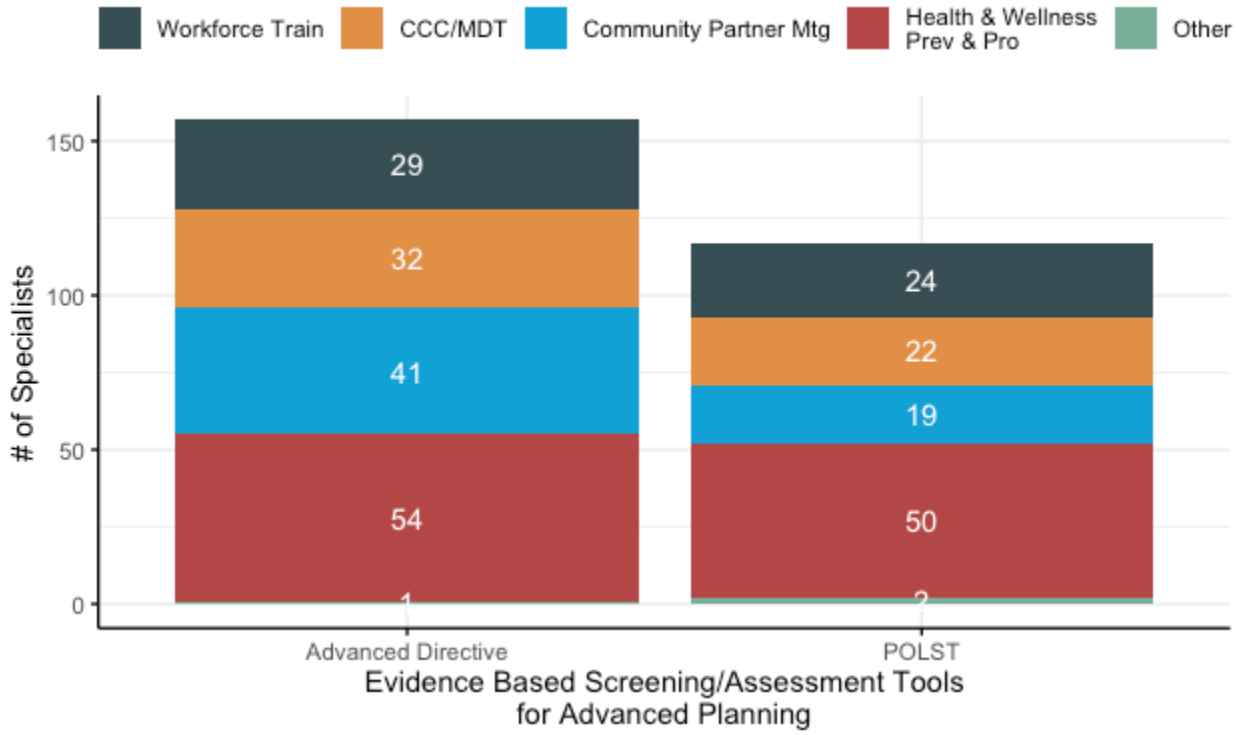
Advanced planning

EBTs in advanced planning used by the Specialists include Advanced Directive and POLST. The Specialists most frequently used Advanced Directive in workforce training (13.0% (29)), CCC/MDTs (14.3% (32)), community partner meetings (18.4% (41)), and health and wellness prevention and promotion events (24.2% (54)). The POLST was only used slightly more frequently than Advanced Directive in other settings (0.9% (2) vs. 0.4% (1); Table 3.19; Figure 3.10).

Table 3.19. Number of Specialists who use evidence-based screening/assessment tools for advanced planning by setting

	Workforce Train	CCC/MDT	Community Partner Mtg	Health & Wellness Prev & Pro	Other
Advanced Directive	13.0% (29)	14.3% (32)	18.4% (41)	24.2% (54)	0.4% (1)
POLST	10.8% (24)	9.9% (22)	8.5% (19)	22.4% (50)	0.9% (2)

Figure 3.10. Number of Specialists who use evidence-based screening/assessment tools for advanced planning by setting



Note. The same Specialists can be counted more than once in an EBT column because they can and do use the same evidence-based screening tool across multiple settings (e.g., using Advanced Directive in both community partner meetings and health and wellness prevention and promotion events).

Other

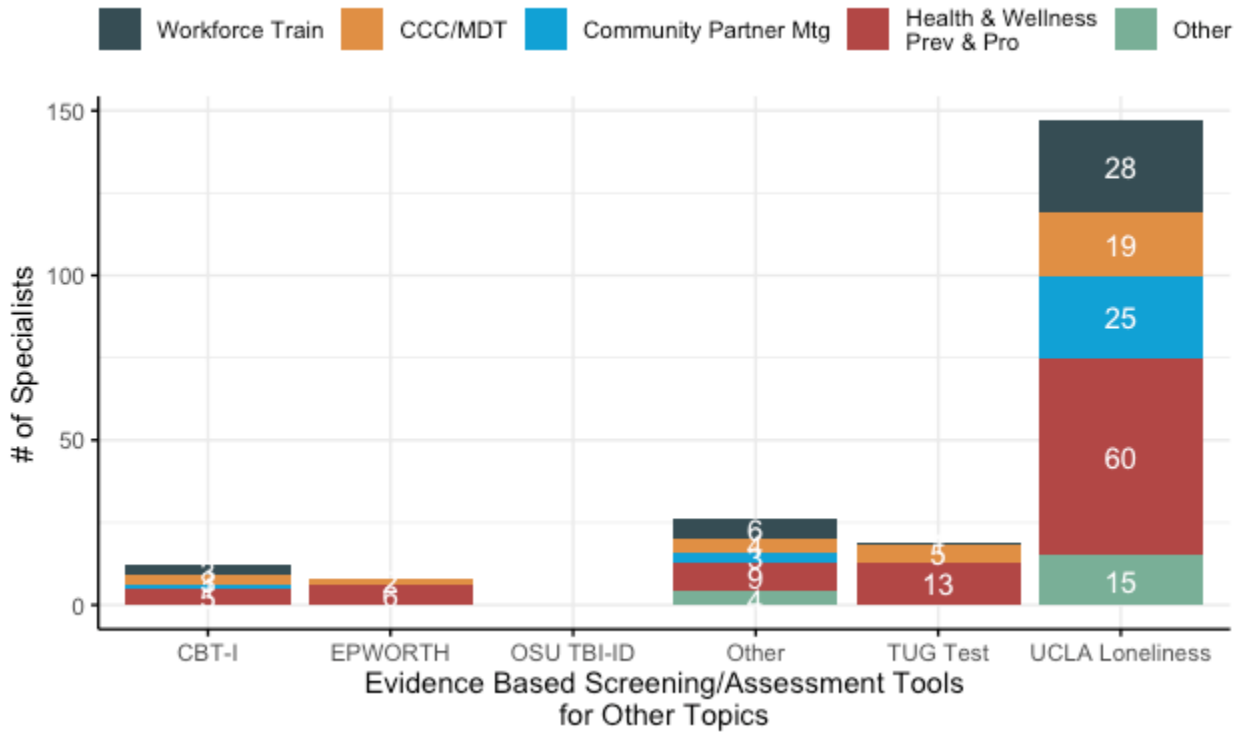
The Specialists also used evidence-based screening and assessment tools (EBTs) that did not fit into the categories above. These include the CBT for Insomnia (CBT-I), the Epworth Sleepiness

Scale (EPWORTH), The Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID), TUG Test for mobility and balance, the UCLA Loneliness Scale, and other tools (Table 3.20) Across all settings, the Specialists most often used the UCLA Loneliness Scale including in workforce trainings (12.6% (28)), CCC/MDTs (8.5% (19)), community partner meetings (11.2% (25)), health and wellness prevention and promotion events (26.9% (60)), and other settings (6.7% (15)). Across all settings, no Specialists used the OSU TBI Identification test (Figure 3.11).

Table 3.20. Number of Specialists who use evidence-based screening/assessment tools for other topics by setting

	Workforce Train	CCC/MDT	Community Partner Mtg	Health & Wellness Prev & Pro	Other
CBT-I	1.3% (3)	1.3% (3)	0.4% (1)	2.2% (5)	0.0% (0)
EPWORTH	0.0% (0)	0.9% (2)	0.0% (0)	2.7% (6)	0.0% (0)
OSU TBI-ID	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)
TUG Test	0.4% (1)	2.2% (5)	0.0% (0)	5.8% (13)	0.0% (0)
UCLA Loneliness	12.6% (28)	8.5% (19)	11.2% (25)	26.9% (60)	6.7% (15)
Other	2.7% (6)	1.8% (4)	1.3% (3)	4.0% (9)	1.8% (4)

Figure 3.11. Number of Specialists who use evidence-based screening/assessment tools for other topics by setting



Note. The same Specialists can be counted more than once in an EBT column because they can and do use the same evidence-based screening tool across multiple settings (e.g., using TUG test in both CCC/MDTs and in other BHI settings).

Key Informant Focus Groups

The PSU Evaluation team conducted focus groups on Zoom from May 2024 through August 2024. Participants took a brief, pre-focus group online survey prior to attending the focus group. The primary objectives of the key informant survey and focus groups were to assess the impact of the Initiative, including what components are working well, and where improvements can be made to best support older adults and people living with physical disabilities who have behavioral health needs. Second, the evaluation assessed opportunities to improve coordination and collaboration between the Initiative and key community partners.

Sample

Staff from CMHPs, AAA-ADRCs, APD regional offices, and senior centers, in addition to primary care providers and older adults, were included in the focus group sample. AAA-ADRC and APD staff were initially identified from the March 2024 publication of "DHS Aging and People with Disabilities (APD) Branch Contact Information for APD and AAA Field Offices." The sample consisted of case managers, options counselors, Information & Referral (I&R) Specialists, eligibility case managers, managers, and directors. Staff at CMHPs were identified through the "Association of Oregon's Community Mental Health Programs: Behavioral Health and Intellectual & Developmental Disabilities Directors and Managers" webpage. Staff from senior centers were ascertained from the Oregon Care Planning Council's "Oregon Senior Centers" list, supplemented by additional Google searches to refine the list and locate the names and contact information of senior center managers and directors. Primary care providers were identified through contact information provided by the Specialists in an effort to identify providers with some existing familiarity of the Initiative. This resulted in a sampling frame of 192 key informants. Stratified random sampling was employed based on two grouping variables to construct the sample. Grouping variables were key informant type (i.e., AAA-ADRCs, APD, CMHPs, senior centers, older adults, and PCPs), and county type (counties with a metropolitan area were grouped as urban). Key informants were replaced in the sample based on random ordering if they could not be reached after three contact attempts (email and phone). Additionally, when certain strata included fewer than the desired number of seven key informants, the PSU Evaluation team oversampled from the most similar strata (i.e., same urban/rural status and same key informant group) to support a balanced sample.

Participant recruitment began in April 2024 and ended in June 2024.The final sample included 49 key informants out of a total recruited sample of 192, with a response rate of 26%. Older adults were omitted from these figures due to a different recruitment method (explanation provided in the following paragraph). Missing contact information and turnover within key informants' roles lowered the response rate. The PSU Evaluation team sought to include an equal

number of key informants for each stratum to collect equal amounts of information from each group. The sample groups varied slightly based on the number of respondents from each group (see Table x). Ten focus groups were conducted in total. The PSU Evaluation team conducted one urban-represented and one rural-represented focus group with staff from APD (*n* = 9), AAA-ADRCs (*n* = 10), CMHPs (*n* = 11), and senior centers (*n* = 13). One focus group was conducted with primary care providers (*n* = 6) and one with older adults (*n* = 5), with mixed urban and rural representation. The sample was more urban (*n* = 32) than rural (*n* = 22) (Table 4.1).

Key Informant Type		APD	AAA-ADRC	CMHP	Senior Centers	PCPs	Older Adults	Area Subtotal
Area	Urban	6	5	6	8	3	4	32
	Rural	3	5	5	5	3	1	22
Key Informant Type Subtotal		9	10	11	13	6	5	54

Table 4.1: Sample of key informants by group and geographical location

The PSU Evaluation team posted fliers on community boards and at senior centers in Portland, Oregon to recruit older adults. The Specialists and colleagues from Portland State University's Institute on Aging also distributed recruitment fliers within their networks. Older adults contacted the PSU Evaluation team if they were interested in participating. Six older adults reached out and five participated.

Key Findings

Involvement

Participants completed a pre-focus group survey to assess their involvement with the Initiative, focusing on interactions with their local Specialist. The figures below describe key informants' responses to five survey questions on a scale of one to five. The questions addressed various aspects of engagement with the Specialists, ranging from communication frequency to collaborative activities. The first question asked how often the respondent was in contact with their Specialist (one being never and five being always). The responses to questions two, three, four, and five ranged from one to five, with one being "We haven't started yet," to five being

“We do this all the time." Overall, involvement with the Initiative varied by key informant type. Older adults with lived experience, senior center staff, and primary care providers were less involved with the Initiative compared to agency staff (CMHPs, AAA-ADRCs, APD regional offices) (Figures 4.1-4.4).

Figure 4.1: Agency responses to pre-focus group questions (involvement)

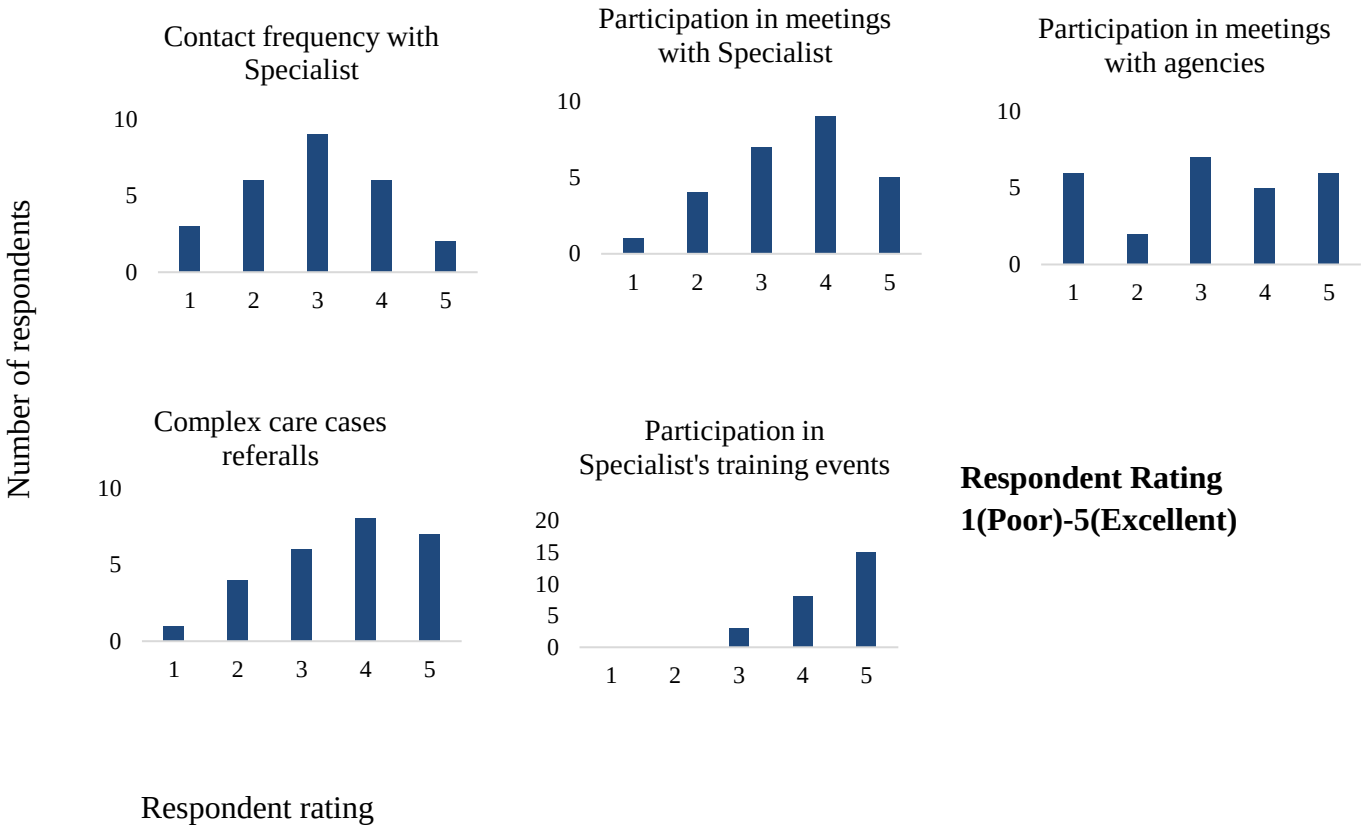


Figure 4.2: Primary care provider responses to pre-focus group questions (involvement)

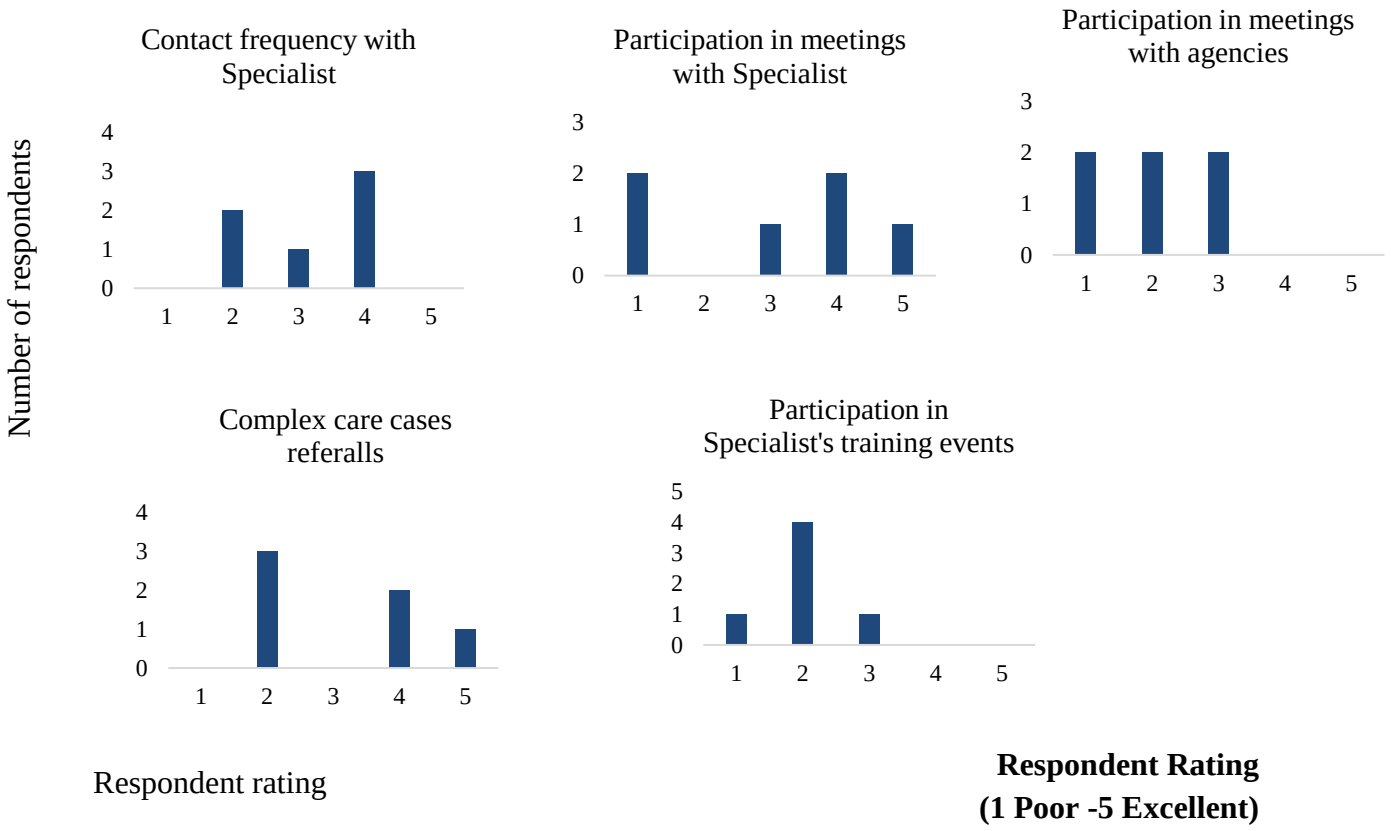


Figure 4.3: Older adult responses to pre-focus group questions (involvement)

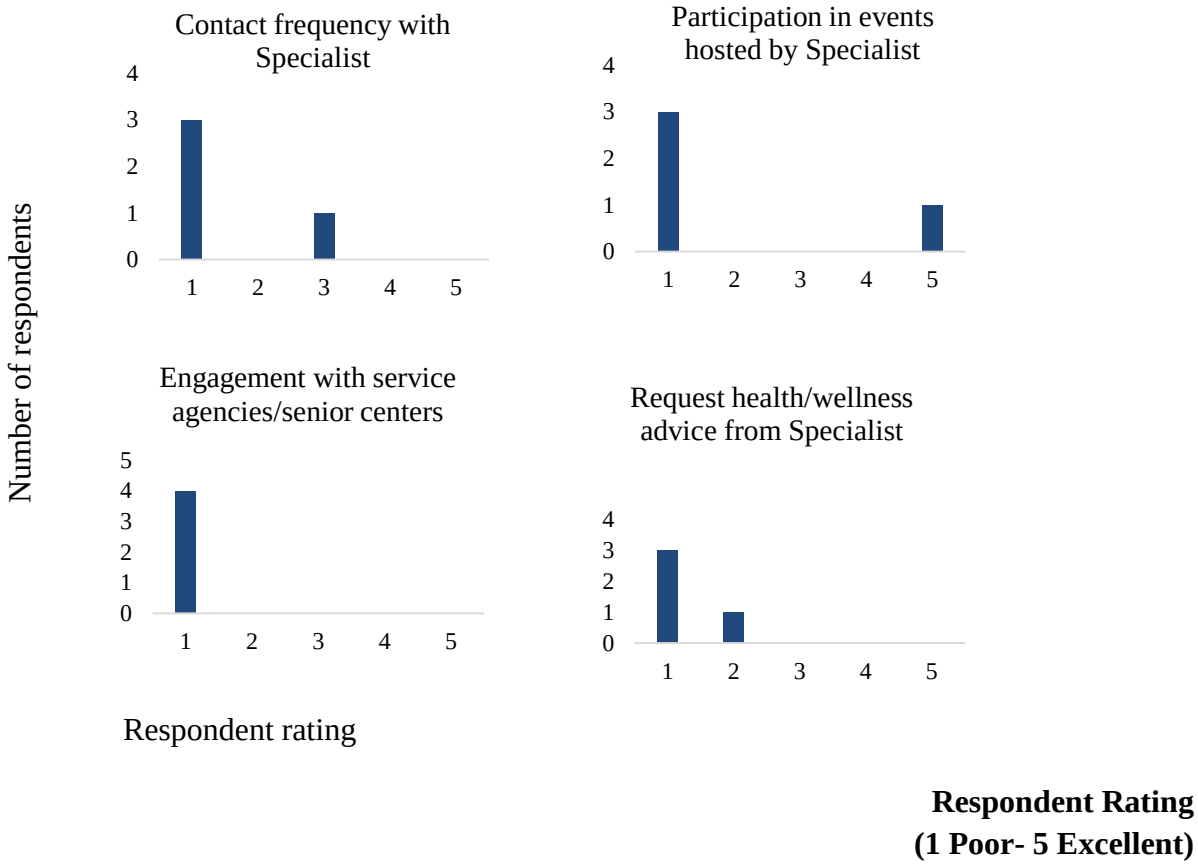
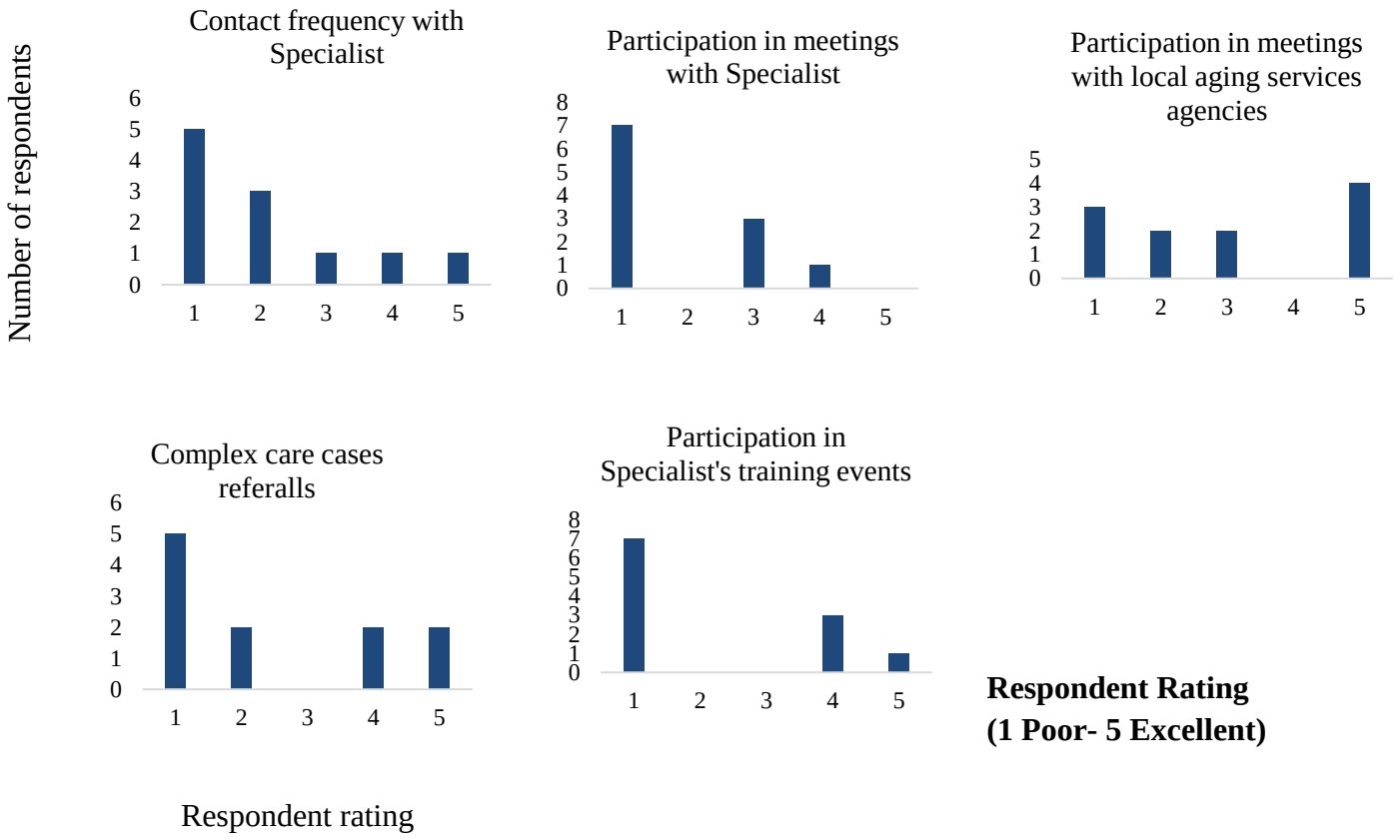


Figure 4.4: Senior center responses to pre-focus group questions (involvement)



Addressing the goals of the Initiative

Providing training and education to the workforce and general community is one of the primary job functions of the Specialists. Key informants preferred various training modalities based on their needs and constraints. Older adults and agency staff generally preferred in-person training while senior center staff and PCPs strongly preferred virtual or remote training formats. Older adults preferred in-person activities and community-based classes, emphasizing the importance of having a physical presence where they can engage with instructors and peers directly. Senior centers preferred to have educational opportunities brought directly to the consumers of their centers, but they requested virtual sessions for staff so they could continue serving their center without leaving to attend training events. Similarly, PCPs preferred virtual or remote formats for training, including live video conferencing and pre-recorded modules, to manage their time efficiently and avoid disruptions in their service delivery.

Key informants shared factors that may facilitate outreach for complex care consultations as well as barriers that may hinder outreach for support. Questions regarding complex care consultations were omitted from the focus group with older adults. Regularly scheduled MDT meetings to discuss complex cases and frequent communication with the Specialists were primary factors that facilitated collaboration on complex care consultations. Some key informants indicated that they were unaware or forgot that consulting on complex care cases was a function offered by the Specialists, while others noted that they were unfamiliar with their Specialist(s) in general. Senior centers expressed interest in collaborating with the Specialists on CCC referrals. Overall, AAA-ADRCs, APD staff, and CMHPs requested and collaborated with the Specialists on CCCs more than the other key informant groups (senior centers and PCPs).

Key informants also discussed the factors that improve coordination and collaboration with the Initiative and the barriers that prevent them from collaborating with it. Participation in scheduled meetings, collaborative training, and the Specialists serving as a key connector across organizations and systems were all factors that contributed to effective coordination and collaboration with the Initiative. Specialist turnover and a lack of awareness of the Initiative's services were barriers that prevented coordination and collaboration from occurring. Many key informants who were not involved with the Initiative expressed the need for the Specialists to enhance their presence in the community by hosting in-person events or sharing resources with consumers in-person.

Key informants expressed the need for culturally specific services and increased collaboration to better address diverse community needs. Key informants' feedback indicates that advocating for services to be culturally relevant and fostering collaboration with diverse community partners could enhance the Initiative's effectiveness and reach. The key informants suggest that the Specialists could improve their efforts to learn about different cultures while referring consumers to culturally specific providers if needed.

Impact of the Initiative

Overall, the Initiative is making a positive difference for older adults and people with physical disabilities with behavioral health needs. Key informants reported that regular meetings with the Specialists improve their service delivery and care coordination, training opportunities enhance their understanding of the BH needs of older adults and people with physical disabilities, and the Specialists are effective in bringing systems and community partners together. Key informants who were more involved with the Initiative indicated that it needs additional resources to expand its reach across urban and rural communities. Suggestions included increasing the number of Specialists and further integrating the Initiative across agencies and programs. Key informants who were less involved with the Initiative shared ideas about how the Initiative could best support older adults with behavioral health needs. Suggestions included increased outreach to

less involved community partners and providing more events that focus on destigmatizing conversations around mental and behavioral health.

Discussion

The findings from this recent evaluation period suggest that the population characteristics of consumers served by the Initiative shifted in the current reporting period, April 2023 to June 2024. Only 7% of all consumers served by the Initiative identified as a non-white race or ethnicity, a decrease from the previous reporting period (10%). Increased efforts to serve consumers of color may help more consumers receive behavioral health services and supports. Additionally, the distribution of consumers' insurance coverage shifted significantly from the previous reporting period, with some evidence that this shift can be attributed to increases in coverage for Medicare Advantage. This finding aligns with insurance coverage trends in Oregon, which indicate that consumers are shifting from Medicare Fee-for-Service to Medicare Advantage overall (Centers for Medicare & Medicaid Services, 2025).

The training evaluation data shows consistent findings between the current and previous reporting periods. This finding may suggest that the PSU Evaluation team needs to work with the Initiative to update the training evaluation to capture new forms of feedback on training preferences to better understand training needs of the workforce.

This report also presented findings from PSU's evaluation of key informants' perceptions of the Initiative, using a mixed method approach. The inclusion of additional key community partners in the evaluation (senior centers, primary care providers, and older adults) and the use of focus groups provided new insight into opportunities to improve coordination and collaboration between the Initiative and key community partners.

The recommendations provided within this report focus on building Oregon's behavioral health workforce, and ensuring there are adequate transportation options in urban and rural/remote counties. Recommendations offer the Initiative ways to help achieve these goals and include continued focus on accessibility and outreach, breaking down silos between agencies and systems, and workforce development. This multilevel approach is needed to achieve improved behavioral health for older adults and people with physical disabilities.

Recommendations and Policy Options

Initiative-level recommendations: Accessibility and Outreach

- Enhance outreach to communities whose historical engagement with the Initiative may be limited (e.g., culturally-specific providers, faith communities, long-term care facilities) through the use of additional presentations, and regular presence at faith community events.
- Increase collaboration between organizations that provide culturally-specific services to improve representation of consumers of color in CCCs.
- Facilitate greater collaboration with Veterans' Services and inform them about the Initiatives' services to increase CCC referrals and attendance for health and wellness prevention and promotion events.

Initiative-level recommendations: Breaking Down Silos

- Advocate for MOUs and other data sharing and confidentiality agreements between agencies to better coordinate the work of the Specialists to support the behavioral health needs of older adults and people with disabilities. This advocacy could be carried out by supervisors.
- Develop further partnerships with coordinated care organizations (CCOs) across Oregon to ensure that Medicaid-funded behavioral health services are meeting the specific and unique needs of older adults.
- Enhance both formal and informal lines of communication through the use of a regular newsletter to community partners and/or in order to promote greater collaboration and coordination of services.
- Connect with local transportation services to improve the behavioral health outcomes of older adults experiencing transportation barriers, especially in rural/remote areas.

Initiative-level recommendations: Workforce development and health and wellness promotion and prevention

- Ensure flexibility in the training options available to meet the varied needs of community partners by taking a multimodal approach to training delivery formats (learning collaboratives, virtual, pre-recorded modules, live in-person events, micro-learning sessions, etc.).
- Implement creative strategies in health and wellness prevention and promotion events to reach more consumers and reduce stigma about behavioral health and aging. For example, incorporate collaborative activities when discussing mental health topics with consumers.

- Provide targeted behavioral health services trainings in long-term care Settings (e.g., assisted living, adult foster homes, residential care, nursing facilities) to increase direct care workers' knowledge and awareness.
- Prioritize the submission of workforce development rosters to the PSU team within three business days of the training to increase the number of evaluated events overall.
- Assist in providing post-training evaluation to learn more about how training events may improve, preferred modalities, and specific training needs (finding from the post-training evaluation tool).
- Collect surveys from health and wellness training participants to learn more about how training events may improve, their preferred modalities, and specific training needs (finding from Key Informant focus groups).

Systems-level recommendations

- Increase the use of incentives such as the Oregon Behavioral Health Loan Repayment Program or pay differentials (e.g., licensed-based, certificate-based) that support the recruitment of behavioral health providers to work in rural and remote areas of the state.
- Provide support in obtaining and maintaining housing for unhoused older adults and people living with physical disabilities so that behavioral health providers can reach and provide necessary services to this population.
- Address the gaps in accessible transportation options in both rural and urban communities across Oregon to ensure that older adults and people with physical disabilities are able to reach behavioral health services.

Other Exemplar Programs

Program Name	DHS Writing Guide for a Memorandum of Understanding (MOU)
Population Served	Agencies looking to improve interagency coordination.
Scope	This tool focuses on the Governance element of the Continuum and is specifically aimed to help communities interested in establishing formal agreements, such as Memorandums of Understanding (MOU), to address multi-organization coordination and communications. This tool includes recommendations for structuring MOUs; questions to consider when generating content for each section; and sample language to illustrate how a community could write each MOU section.
Intent	To support communities interested in establishing formal agreements.
Recommendation addressed by this intervention	Advocate for MOUs and other data sharing and confidentiality agreements between agencies to better coordinate the work of the Specialists to support the behavioral health needs of older adults and people with disabilities.

Program Name	Oregon Healthy Aging Listserv
Population Served	Professionals working in the field of aging and related fields.
Scope	Weekly listserv managed by Oregon Department of Human Services (ODHS) that provides timely updates on research, evidence-based initiatives and best practices, training and funding opportunities, and other resources related to aging.
Intent	To connect individuals and organizations across Oregon with resources on aging.
Recommendation addressed by this intervention	Enhance both formal and informal lines of communication between agencies through the use of a regular newsletter to community partners and/or in order to promote greater collaboration and coordination of services.

Program Name	Oregon ECHO Network
Population Served	Healthcare professionals serving individuals with behavioral health needs.
Scope	Oregon-based network of a nationwide program offering web-based learning focused on multiple topics / disciplines including behavioral health and geriatric care.
Intent	Provides a web-based interactive educational and community-building platform for healthcare professionals across Oregon.
Recommendation addressed by this intervention	Ensure flexibility in the training options available to meet the varied needs of communities by taking a multimodal approach to delivery of trainings.

Program Name	Oregon Behavioral Health Loan Repayment Program
Population Served	Multiple underserved populations
Scope	Provides incentives for the BH workforce, including Qualified Mental Health Providers, pre-licensed, and licensed BH care providers, to support underserved populations in Oregon.
Intent	Increase BH workforce available to provide treatment/interventions to underserved populations throughout Oregon.
Recommendation addressed by this intervention	Increase the use of incentives such as the Oregon Behavioral Health Loan Repayment Program or pay differentials to support the recruitment of behavioral health providers to work in rural and remote areas of the state.

Program Name	CAPABLE Pilot in Permanent Supportive Housing
Population Served	Formerly houseless older adults.

Scope	Provides a time limited intervention (10 sessions over five months) of services and supports that include occupational therapy, registered nurse visits, and home maintenance / repairs through the Southern California Clinical and Translational Science Institute (SC CTSI) in Los Angeles, CA.
Intent	An evidence-based intervention to support formerly houseless older adults live independently in the community through improved outcomes in IADLs, depression, and falls.
Recommendation addressed by this intervention	Provide support in obtaining and maintaining housing for unhoused older adults and people living with physical disabilities so that behavioral health providers can reach and provide necessary services to this population.

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