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

July 2016 – June 2017

EXECUTIVE SUMMARY

Background

Overview of the Initiative

In 2014, the Oregon legislature allocated funding to the Oregon Health Authority (OHA) for the Behavioral Health Initiative (BHI) for Older Adults and People with Disabilities. A Statewide Coordinator, Nirmala Dhar, was named to lead the BHI within OHA early in 2015. Community Mental Health Programs and other nonprofit entities were awarded contracts to hire 24 Behavioral Health Specialists located in communities throughout Oregon. Most Specialists have graduate degrees in social work, psychology, or related fields. Most have extensive clinical experience in behavioral health; some also have extensive experience working in aging services. In July 2016, Portland State University Institute on Aging (PSU) received a contract from OHA to evaluate the BHI. This report describes the evaluation and findings to date.

Behavioral Health Specialists

The role of the Behavioral Health Specialist is central for addressing gaps in services. Specialists have three core job functions: collaboration and coordination, complex case consultation, and education – both workforce development and increasing awareness of behavioral health in the general community (Figure 1).

Portland State UNIVERSITY
Institute on Aging

Partnerships to Improve Behavioral Health for Older Adults and People with Disabilities

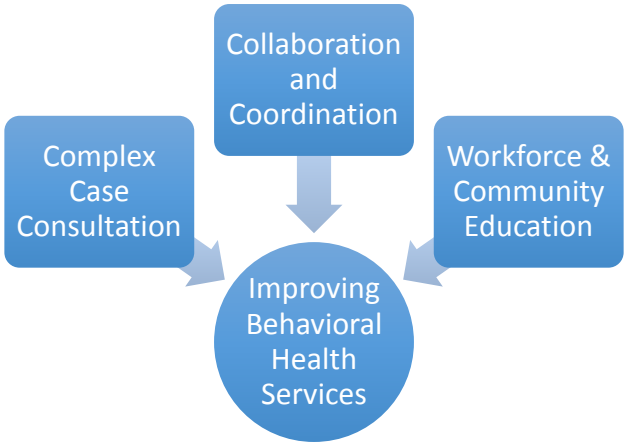


Figure 1. Job Functions of Behavioral Health Specialists

Evaluation Purpose and Methods

The purpose of the evaluation was: (1) to systematically collect and analyze data to inform OHA and the Oregon State Legislature of progress being made toward achieving the goals and objectives of the BHI and (2) to identify ways to continue to improve behavioral health services for older adults and people with disabilities. Data were gathered from the Specialists and from community stakeholders using three data sources:

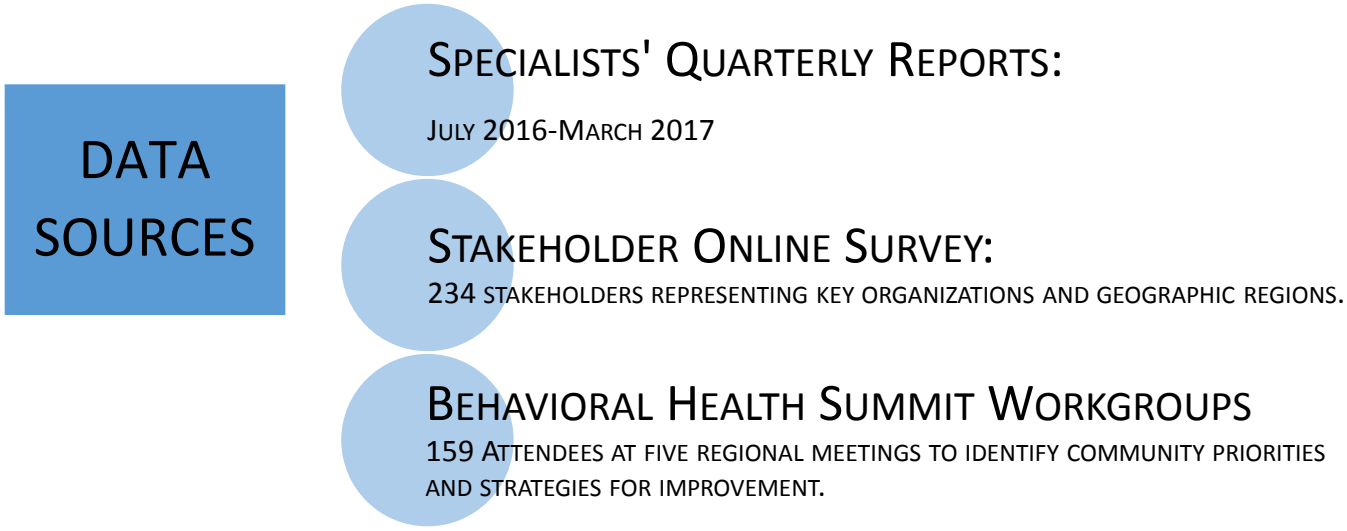


Figure 2. Data Sources

Findings

Findings from the data from Specialists and stakeholders focus on barriers and gaps in services, the three core job functions of Specialists, and areas for improvement. Results of the Summit workgroups are then presented followed by recommendations to policy makers from Specialists, and Summit participants.

Barriers and Gaps in Services

Barriers to multidisciplinary teams. Specialists were asked about barriers related to *multidisciplinary teams (MDTs),* and 39% of Specialists indicated that needed expertise was not

available in the community and that HIPAA or other privacy requirements limited information sharing. About 25% of the Specialists reported that core stakeholders were not represented on MDTs and referrals for complex case consultations were not being made.

Barriers to consumer needs. Specialists were also asked about *consumer needs*. Most of the Specialists indicated that the following issues were barriers to a fair or great extent:

- Co-occurring medical conditions (84%)
- Dementia (70%)
- Can't afford services, insurance won't cover costs (64%)
- Activities of daily living and other functional limitations (58%)
- Lack of natural supports (58%)
- Behaviors (55%)
- History of serious mental illness (55%)
- Consumer or family unable to navigate the system (52%)
- Depression (51%)

Barriers to access. Both stakeholders and Specialists were asked about barriers related to *access*. For most items, the two groups were consistent in their reporting. The access barriers were categorized into five groups:

Coordination

- Lack of integration of behavioral services and primary care

Accessibility

- Lack of transportation

Availability of providers

- Lack of primary care providers knowledgeable about behavioral health
- Lack of people with the required expertise to *provide* quality behavioral health services
- Lack of providers with the credentials required to *get reimbursed* for providing behavioral health services

Availability of services

- Lack of behavioral health services in long-term care settings (e.g., nursing homes, assisted living, adult care homes)
- Lack of in-home services (those offered in the consumer's residence)
- Lack of prevention or wellness services
- Services are present, but wait list is full or would take too long

Affordability

- Lack of affordable housing
- Restrictive eligibility criteria or person does not qualify for services
- Lack of credentialed providers *willing* to accept Medicare reimbursement for behavioral health services

Specialists address all of these barriers through their core job functions, as described below.

Specialists' Job Functions

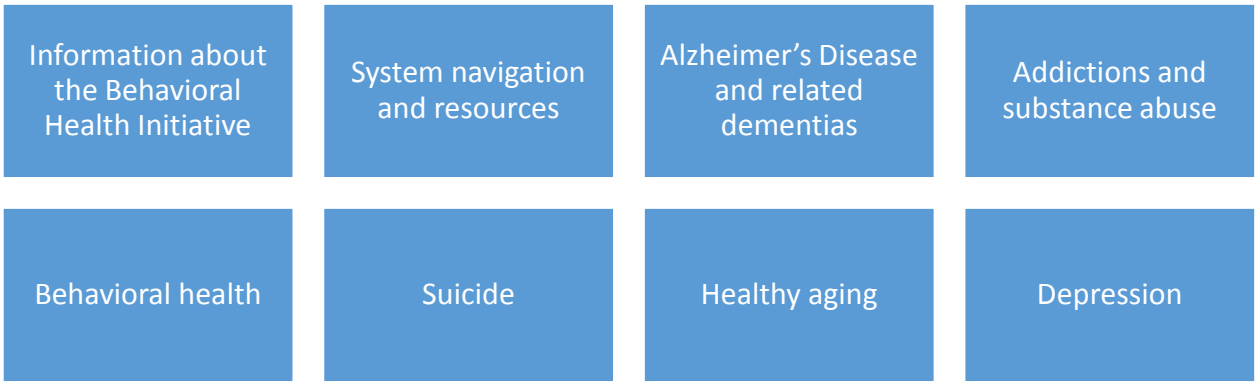
Collaboration and Coordination. Specialists partner with others in multiple service systems. Findings from both Specialists and stakeholders indicate that some progress in collaboration and coordination has been made since the beginning of the BHI. Each group reported that agencies are more engaged with one another, and the population of older adults and people with disabilities is more visible and a higher priority for partners. The vast majority of Specialists reported they have active partners in aging services and behavioral health services, and three-quarters have involvement from their local Coordinated Care Organizations. Fewer are working with tribal organizations, faith communities, Centers for Independent Living, or governmental officials.

Most stakeholders (81%) reported that they have participated at least occasionally in discussions or meetings about the planning and coordination of behavioral health services for older adults and people with disabilities. Of those who participated, 86% agreed that participants in those activities were committed to the process, 72% felt that agencies were more knowledgeable about each other, and 71% felt there was agreement on gaps in services. More than half (53%) indicated that the BHI was a priority for their organization. In contrast, only about 25% agreed that advocates, consumers, and families were well represented in these meetings and discussions.

Two statistically significant differences emerged between rural and urban stakeholders' perceptions of collaboration and coordination activities. Urban stakeholders were more likely to report partners were in agreement on what the gaps in behavioral health services were. Rural and frontier stakeholders were more likely to report that old resentments between agencies got in the way of progress.

Complex Case Consultation. Complex case consultation has been an important mechanism for engaging partners, sharing knowledge, and directly affecting the services provided to those whose needs are complicated by a combination of age-related changes, disability, poor health, and limited resources. Specialists have been able to provide education about behavioral health, aging, and resources. They have helped partners to resolve or reduce gaps in services and improve communication. During the nine-month reporting period, Specialists participated in over 1,600 consultations.

Workforce Development and Community Awareness. Between July 2016 and March 2017, Specialists conducted 273 trainings and reached at least 7,021 training participants across Oregon. Training covered a wide range of topics. Those presented most frequently were:



The target audience for these training activities was wide ranging and fell into more than 18 categories. Those most frequently listed were behavioral health service staff; advocacy groups, family members, consumers, community members; aging services staff; community-based care staff, and primary care clinics.

Behavioral Health Summit

Participants at the Behavioral Health Summit identified community priorities and specific actions to improve access to behavioral health services and improve outcomes for consumers. These actions reflect the different communities and the needs in those communities. Communities will continue to work on these and other priorities over the next two years. Some of the priorities identified include:

- Increasing collaboration between OHA and Aging and People with Disabilities to meet older adults' and people with disabilities' behavioral health and physical health needs regardless of etiology.
- Focusing on licensed facilities.
- Increasing the number of providers willing to accept Medicare reimbursement for behavioral health services.
- Improving communication between partner agencies and between consumers and providers.
- Establishing a call-in line to address loneliness.
- Addressing social isolation.
- Developing agency-specific workforce training on behavioral health challenges specific to the agency
- Educating long-term care providers.
- Addressing housing issues.
- Addressing transportation needs.

Summit participants were overwhelmingly positive about the BHI. This bodes well for continued enhancements to systems to improve coordination, training, and meeting the complex needs of older adults and people with disabilities who have behavioral health needs.

Consumer Outcomes

The ultimate success of the BHI will be measured by consumer outcomes. Stakeholders were asked how much progress had been made for consumers since June of 2015. Compared to findings from the 2014 gaps analysis, a significant amount of progress has been made given the short amount of time the Initiative has been on the ground; however, more progress is needed.

Percent of stakeholders who **agree that progress has been made** to a fair or great extent for older adults and/or people with physical disabilities who have behavioral health needs:

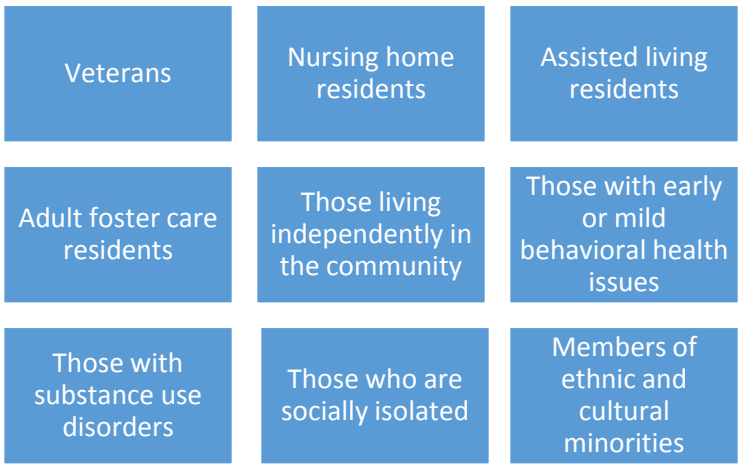
- 31% — Community partners have been successful in resolving complex cases.
- 29% — These consumers are recognized as a priority population in the community.
- 29% — These consumers have their signs/symptoms recognized as BH needs rather than being due to "aging" or a previously diagnosed disability.
- 25% — These consumers seek advice or help from direct service or primary care providers to better understand their signs and symptoms.
- 22% — These consumers receive help from knowledgeable and skilled direct service and/or primary care providers.
- 18% — These consumers have access to programs or services that have demonstrated effectiveness.
- 17% — These consumers experience reduced lengths of stay for Emergency Departments, hospitals, jails, inpatient psychiatric units, and the Oregon State Hospital.
- 14% — These consumers rarely experience "evictions" from various housing situations.
- 13% — These consumers have information about ways to promote mental health well-being (e.g., social engagement, physical activities).
- 9% — These consumers have timely access to services.

Areas for Improvement

Although advancements in behavioral health services for older adults and people with physical disabilities have been made, Specialists identified areas where more progress is needed:

- Increasing representation of consumers at community partner meetings.
- Reducing barriers to workforce development, especially release time and scheduling.
- Increasing attendance at trainings to reach a critical mass.
- Reaching out to community partners such as Centers for Independent Living, tribal organizations, and faith communities.
- Encouraging providers to accept Medicare reimbursement for this population and to obtain/grant waivers to existing eligibility criteria to expand access to services.

Finally, Specialists indicated more effort is needed so that meeting the behavioral health needs of older adults and people with physical disabilities is a priority. More than two-thirds of stakeholders felt specific subgroups were underserved to a fair or great extent. Those served the least include cultural minority populations, such as ethnic minorities and LGBT individuals, and those at risk due to isolation. While veterans and those with substance use disorders were somewhat more likely to receive behavioral health services, only about 25% of the stakeholders felt these subgroups were being served well.



Call to Action

In June 2017, PSU presented the findings from the evaluation to the leadership in the Oregon Health Authority and Aging and People with Disabilities. Included were recommendations from Specialists and Summit participants to policy makers to address barriers related to access to care and workforce development, as summarized below.

Coordination and delivery of services

- Formalize infrastructure at the state level to bridge aging services, behavioral health services, and health care services. Seek waivers as needed.
- Use “person-first” approaches (e.g., integrate funding streams to support people with needs that cross service sectors).
- Revise eligibility criteria to support coordinated services.

- Increase behavioral health services in primary health care clinics, and increase primary health care in mental health clinics.
- Provide opportunities for relationship building across service sectors (e.g., opportunities for socialization, cross training).
- Review Oregon Administrative Rules (OARs) to identify and reduce barriers to integrated services for older adults (e.g., peer support programs)

Availability

- Provide funds to support program development and innovation generated through local initiatives, such as those described below.
- Increase availability of clinical services designed for and targeting older adults and/or people with disabilities.

Accessibility

- Reallocate state funds for staff and services to take into account travel time required in rural and frontier parts of the state.

Affordability

- Advocate for Medicare reform (e.g., expand Medicare-approved providers, increase coverage for behavioral health to achieve parity, reimburse telemedicine, expand resources for those needing personal care attendants).
- Provide subsidized and low-income housing with behavioral health and aging services to reduce evictions and risk for homelessness.

Workforce development

- Mandate agency support for training in all service sectors to enhance knowledge of aging, living with disabilities, behavioral health, understanding of local resources, and understanding of "person-centered" care.
- Provide behavioral health training for long-term services and supports (LTSS) staff (e.g., home and community-based care as well as nursing home staff).
- Support peer-to-peer counselor training and supervision.
- Support train-the-trainer programs.
- Recruit and provide incentives for service providers (e.g., in-home care, adult foster care, LCSW, licensed professional counselors) in underserved areas, especially in rural and frontier parts of the state.

Conclusions

Considerable progress has been made to improve behavioral health services for older adults and adults with physical disabilities who have behavioral health needs in Oregon. In addition to the Behavioral Health Specialists, key stakeholders have become actively engaged in this work and communities have made important gains in addressing gaps in services related to collaboration and coordination, addressing complex needs, developing a more knowledgeable workforce, and raising community awareness. Significant challenges remain, however, which will require sustained efforts at the state, regional, and local levels to attain the goals of the Initiative. Based on data obtained through this evaluation process (i.e., quarterly reports, stakeholder survey, and Summit activities), we offer the

objectives to support and guide the Behavioral Health Initiative over the next few years. Some objectives target the Specialists and others are for policy makers.

For BHI Specialists:

Training

1. Increase knowledge of providers including members, or potential members, of multidisciplinary teams to assure that expertise needed for complex case consultation is available in every community.

2. Provide training to all providers about causes and evidence-based non pharmaceutical interventions for difficult behaviors.

3. Continue to provide community awareness and workforce training on topics relevant to community needs and interests; increase training that focuses on disabilities and behavioral health.

Collaboration

4. Conduct outreach to assure that providers of services for older adults, people with disabilities, and behavioral health are knowledgeable about available resources, including those in support of complex case consultation.

5. Conduct outreach to aging services, disabilities services, health care, and behavioral health providers to assure that they are knowledgeable about needs of older adults and people with disabilities with behavioral health needs.

6. Collaborate with aging services, disabilities services, health care, and behavioral health providers to build community capacity and reduce gaps in services including:
    a. Prevention and wellness services
    b. Long-term care residential settings
    c. In-home services
    d. Transportation
    e. housing

7. Collaborate with policy makers and other providers to identify and provide incentives for providers with expertise and credentials to provide behavioral health services for older adults and people with disabilities. Seek waivers and revise eligibility criteria for services as needed.

8. Continue to build collaborative relationships with key community stakeholders, with increased attention to tribal organizations and other ethnic and cultural minority communities, Centers for Independent Living, local governmental officials, and faith communities.

For policy makers

1. Formalize infrastructure at the state level to bridge aging services, behavioral health services, and health care services.

2. Support BHI Specialists through professional development funds and seed money to support community pilot projects.

3. Prioritize support for services that serve older adults and people with disabilities who have behavioral health needs. Services should include preventive services (e.g., reducing isolation, addressing mild to moderate depression, integrating health and behavioral health services).

4. Support parity in health and behavioral health services and system integration through various public and private insurance programs.

5. Support behavioral health navigators to assist older adults, people with disabilities, and their families to identify and secure needed services.

6. Increase transportation options for older adults and people with disabilities

7. Advocate to expand Medicare and Medicaid reimbursement for behavioral health to include qualified counselors and other professionals not currently allowed by law (e.g., substance abuse counselors).

8. Increase requirements for providers of long-term services and supports to receive training in behavioral health needs and evidence-based interventions.

9. Address housing issues with the aim of increasing affordable housing options, reducing evictions from all settings, and increasing wrap around services for individuals living in home or community-based care settings.

10. Revisit strategies for allocating Specialists based on population and take into account large geographic areas and limited resources in rural and frontier counties.