

Older Adult Behavioral Health: Challenges & Opportunities

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GREETINGS FROM OREGON!



The Silver Tsunami

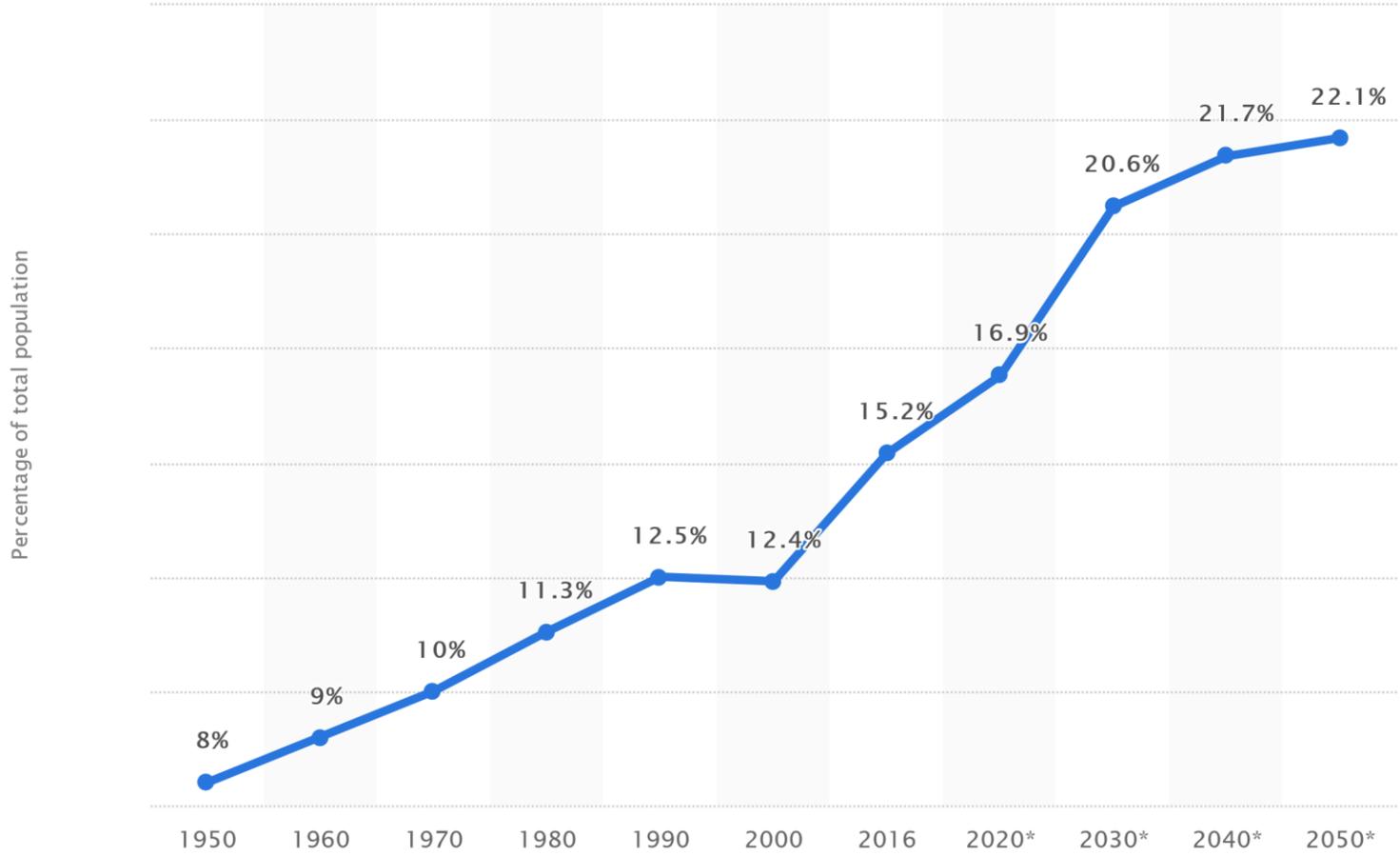
ROUGHLY 10,000 AMERICANS TURN 65 EVERY DAY SINCE 2011 AND THIS WILL CONTINUE FOR THE NEXT 11 YEARS

THE BABY BOOMER COHORT (1946-1964) IS THE FASTEST GROWING SECTOR OF THE US POPULATION - 26% OF THE POPULATION

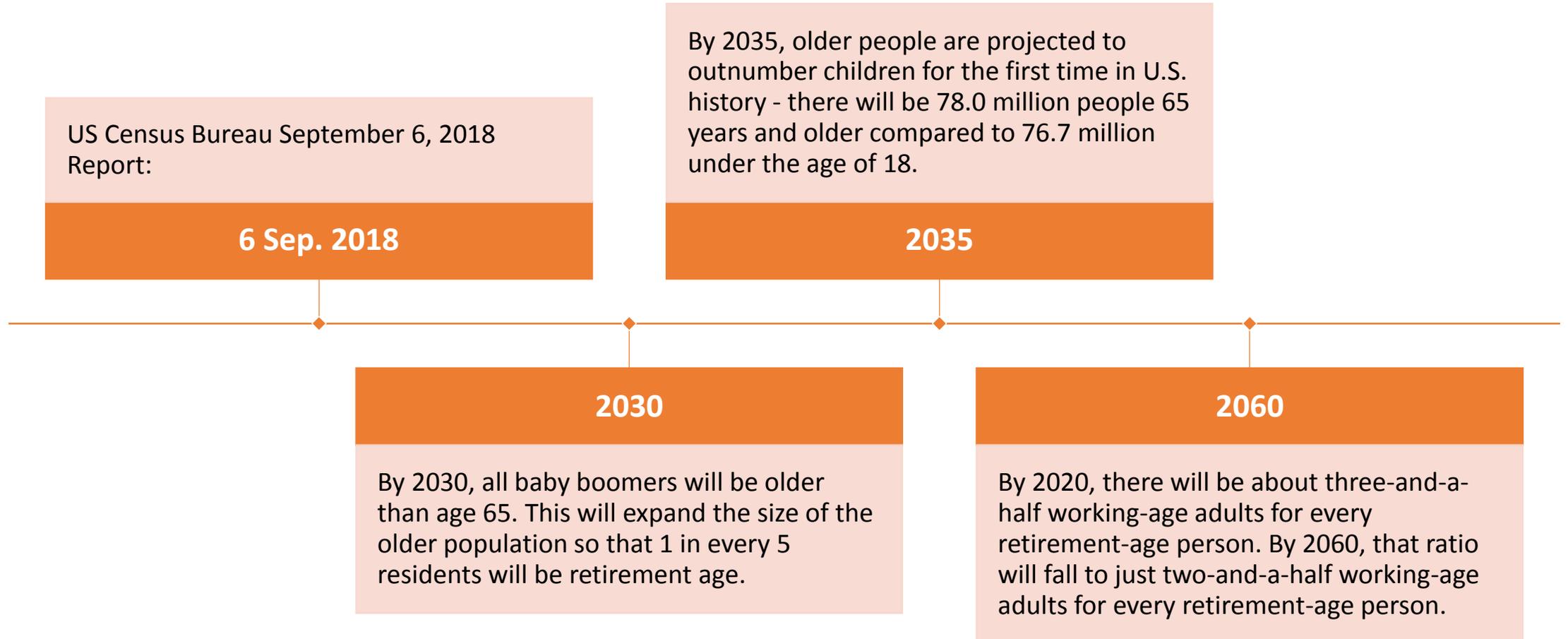
BY 2030 1 IN 5 AMERICANS WILL BE 65 YEARS OR OLDER

AGE 75 AND OLDER FASTEST GROWING COHORT AMONG OLDER ADULTS

65 years and older in total US population 1950 - 2050



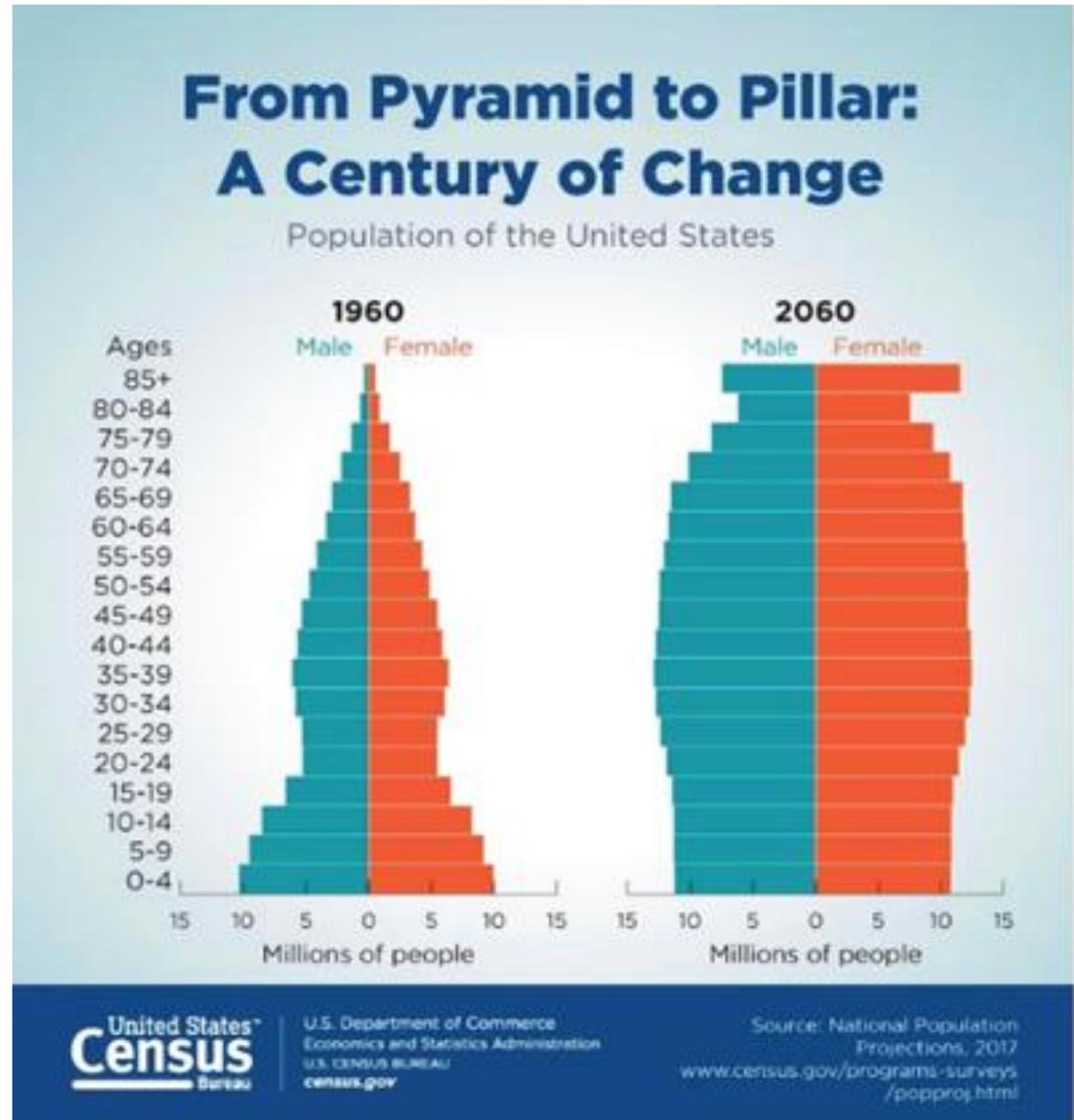
AMERICA IS AGING



MARYLAND DEMOGRAPHICS 2018



2017 US CENSUS REPORT: Older Population at a Glance



THE SILVER
TSUNAMI –
ARE WE
READY?



Mental Health & Aging – What do the numbers show?

Less than 3% of older adults see a mental health professional (Bartels et al 2005; Jeste 2011; Bartels & Naslund 2013; Am Soc on Aging 2014)

Older adults with behavioral health disorders have 47% to 200% higher disability rates, poorer health outcomes, hospitalizations and emergency room visits (Summit on Older Adults, 2014)

The number of older adults with a mental health disorder will double by 2030 – from 7 million in 2013 to 15 million in 2030 (Bartels & Naslund 2013)

20% of people age 55 years or older experience some type of mental health concern. The most common conditions include anxiety, severe cognitive impairment, and mood disorders (such as depression or bipolar disorder).

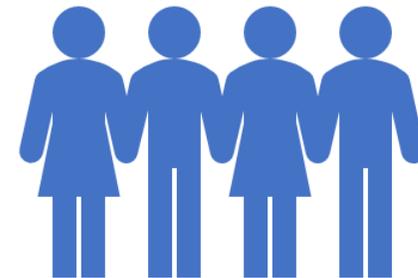
Mental health issues are often implicated as a factor in cases of suicide. Older men have one of the highest suicide rate of any age group

Men aged 85 years or older have a suicide rate of 45.23 per 100,000, compared to an overall rate of 11.01 per 100,000 for all ages.

Mental Health and Aging

THE DEMOGRAPHIC IMPERATIVE

- SUBSTANCE ABUSE DISORDERS (SUD) IN OLDER ADULTS IS EXPECTED TO DOUBLE FROM 2.8 MILLION IN 2002 – 2006 TO 5.7 MILLION BY 2020.
- OLDER ADULTS ARE PRESCRIBED AND USE MORE MEDICATIONS THAN ANY OTHER AGE GROUP AND USE MORE THAN 1/3 OF ALL MEDICATIONS IN THE UNITED STATES



IDENTIFYING RISK FACTORS FOR DEPRESSION

- DEPRESSION IS OFTEN UNDER RECOGNIZED AND UNDERTREATED
- WITHOUT TREATMENT DEPRESSION CAN IMPAIR AN OLDER ADULT'S ABILITY TO FUNCTION AND ENJOY LIFE
- CONTRIBUTES TO OVERALL POOR HEALTH AND HEALTH OUTCOMES

27% OF OLDER ADULTS
ASSESSED BY AGING
SERVICES PROVIDERS MET
CRITERIA FOR DEPRESSION

31% OF OLDER ADULTS HAD
SYMPTOMS OF DEPRESSION
THAT DID NOT QUALIFY AS A
DIAGNOSABLE DISORDER BUT
IMPACTED THEIR LIFE

DEFINITION OF SERIOUS MENTAL ILLNESS

- The definition of **serious mental illnesses** (SMIs) includes one or more diagnoses of mental disorders combined with significant impairment in functioning. Schizophrenia, bipolar illness, and major depressive disorder are the diagnoses most commonly associated with SMI, but people with one or more other disorders may also fit the definition of SMI
- These disorders result in functional impairment

SERIOUS MENTAL ILLNESS

1.4% TO 4.8% OF CURRENT OLDER ADULTS IN THE US (49.2 MILLION) SUFFER FROM A SERIOUS MENTAL ILLNESS (SMI).

THE COMPLEX NEEDS AND GROWTH OF THE OLDER ADULT SMI POPULATION EXCEEDS THE NUMBER OF BEHAVIORAL HEALTH PROVIDERS THAT ARE TRAINED IN GERIATRIC CARE.

THE WORKFORCE THAT WORKS MOST FREQUENTLY WITH GERIATRIC POPULATIONS (PRIMARY CARE PROVIDERS, ASSISTED LIVING, ADULT CARE HOMES AND NURSING HOME STAFF, EMERGENCY DEPARTMENT STAFF, IN PATIENT HOSPITAL STAFF AND FAMILY MEMBERS) ARE NOT TRAINED IN THE NEEDS OF THE OLDER SMI INDIVIDUAL.

OLDER
ADULTS WITH
SERIOUS
MENTAL
ILLNESS

HAVE MORE
HOSPITALIZATIONS

FOUR TIMES GREATER RISK OF
DEATH AT ANY GIVEN AGE
THAN THOSE WITHOUT SMI

3.5 TIMES MORE LIKELY TO
LIVE IN A NURSING HOME

Schizophrenia and the Aging Population

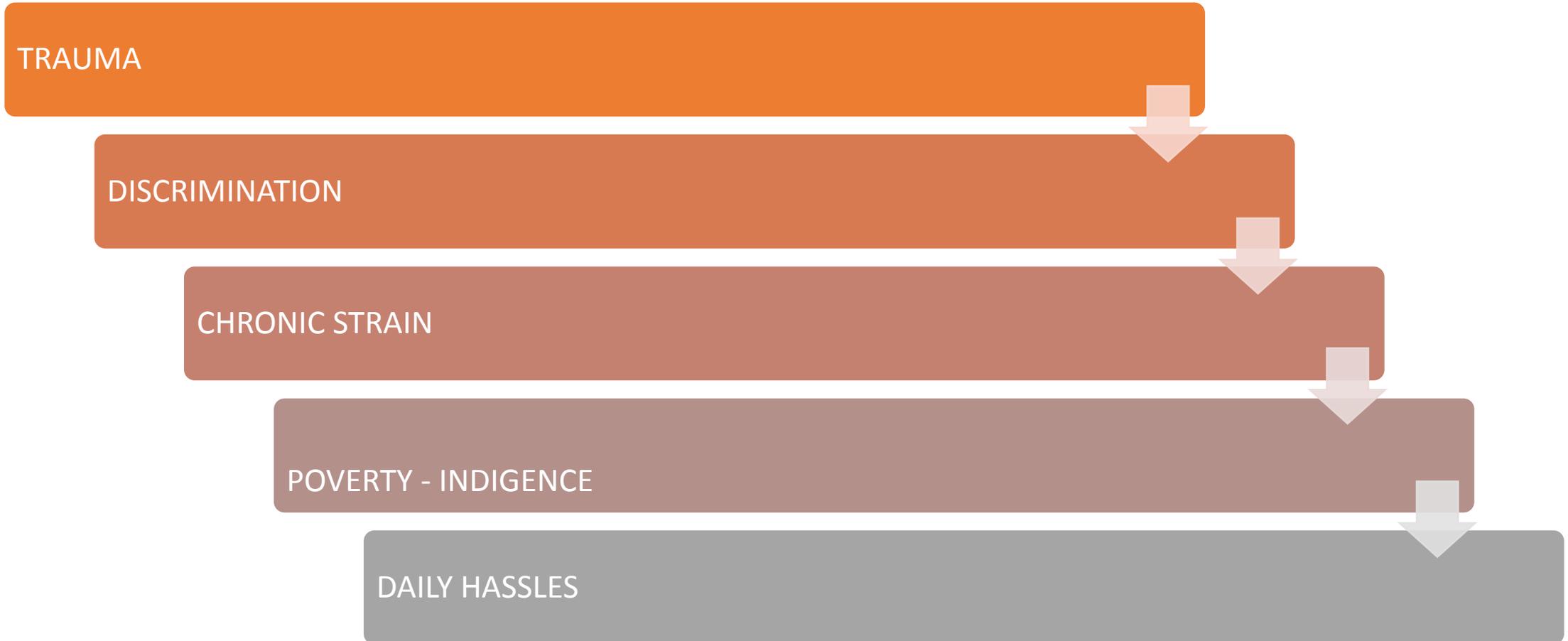
- Approximately 1 million people in the U.S aged 55 and older have severe and persistent mental illness
- People with Schizophrenia represent the majority
- Population expected to double within 30 years
- Most have spent majority of their lives outside of institutions –85% live in community
- This population is largely invisible to researchers, policy makers and service providers
- Mental Health Services for the elderly are fragmented and underutilized
- Geriatric long term care programs primarily focus on those with physical disabilities and dementia



UNIQUE CHALLENGES FOR OLDER ADULTS

- COMPLEX CHRONIC HEALTH CONDITIONS
- MENTAL HEALTH SYMPTOMS UNDER RECOGNIZED, OVERLOOKED OR MISDIAGNOSED
- STIGMA
- UNIQUE LIFE STRESSORS
- SOCIOECONOMIC AND GEOGRAPHIC CONTEXT – URBAN VS RURAL VS FRONTIER; ALSO OLDER ADULTS LIVING IN RURAL AREAS HAVE HIGHER BURDEN OF CHRONIC DISEASE
- COGNITIVE DECLINE & DEMENTIA

LONG TERM IMPACT ON OLDER ADULTS WITH SMI



UNIQUE FACTORS AND CHALLENGES FOR OLDER ADULTS WITH SMI

- AGE RELATED CHANGES IN METABOLISM
- ACUTE AND CHRONIC HEALTH CONDITIONS
- COGNITIVE, SENSORY AND FUNCTIONAL IMPAIRMENTS WITH AGE
- SIDE EFFECTS FROM LONG TERM USE OF PSYCHOTROPIC MEDICATIONS
- ACCELERATED AGING

TEST YOUR
KNOWLEDGE:
What large
population
group in the
USA has the
following
characteristics:

25 years shorter life span than the general public

Accounts for about 3% of Americans

Similar life expectancy to people in Ethiopia

A declining lifespan over the past three decades

Disproportionate risk of death from dramatically increased preventable cardiometabolic risk factors

Substandard health care for common chronic illnesses

Presents a paradigm for a high-risk, disadvantaged cardiovascular health disparity population

50 IS THE NEW 75: Epidemic of Premature Death in Persons with Mental Illness

Mentally ill die 25 years earlier, on average

By Marilyn Elias, USA TODAY

Adults with serious mental illness treated in public systems die about 25 years earlier than Americans overall, a gap that's widened since the early '90s when major mental disorders cut life spans by 10 to 15 years, according to a report due Monday.

Premature disability and death

- Adults with serious mental illness, commonly treated with second-generation antipsychotic (SGA) drugs, have up to two-times-greater prevalence of type 2 diabetes, dyslipidemia, hypertension, and obesity . Cardiovascular disease is the leading contributor to mortality for adults with serious mental illness , resulting in a decades less life expectancy than the general population . Increased risk for premature cardiovascular mortality has been attributed to lower socioeconomic status , physical inactivity and poor dietary choices , obesity , greater smoking and substance abuse , adverse medication effects , and underutilization of primary and secondary prevention . Unfortunately, diabetes and cardiovascular risk is often underrecognized and undertreated in patients with mental illness.

Prevalence of trauma

90% of public mental health clients have been exposed to trauma ***Muesar et al., 2004. Muesar et al., 1998***

51-98% of public health clients have been exposed to trauma ***Goodman et al., 1997. Muesar et al., 1998***

Most have multiple experiences with trauma
Muesar et al., 2004. Muesar et al., 1998

97 % of homeless women with SMI have experienced severe physical & sexual abuse, and 87% experience this abuse both in childhood and adulthood
Goodman et al., 1997

Critical trauma correlates

Adverse Childhood Events (ACE's) have serious health consequences

- Adoption of health risk behaviors as coping mechanisms (eating disorders, smoking, substance abuse, self-harm, sexual promiscuity)
- Severe medical conditions: heart disease, pulmonary disease, liver disease, sexually transmitted infections, cancers
- Early death
- People with higher number of ACEs – four or more – are at higher risk for depression, suicide, alcoholism, drug abuse smoking, obesity, heart disease, cancer, lung disease and liver disease

ALZHEIMER'S DISEASE

ALZHEIMER'S DISEASE IS THE 6TH LEADING CAUSE OF DEATH IN THE UNITED STATES

1 IN 3 SENIORS DIES WITH ALZHEIMER'S OR ANOTHER DEMENTIA. IT KILLS MORE THAN BREAST CANCER AND PROSTATE CANCER COMBINED

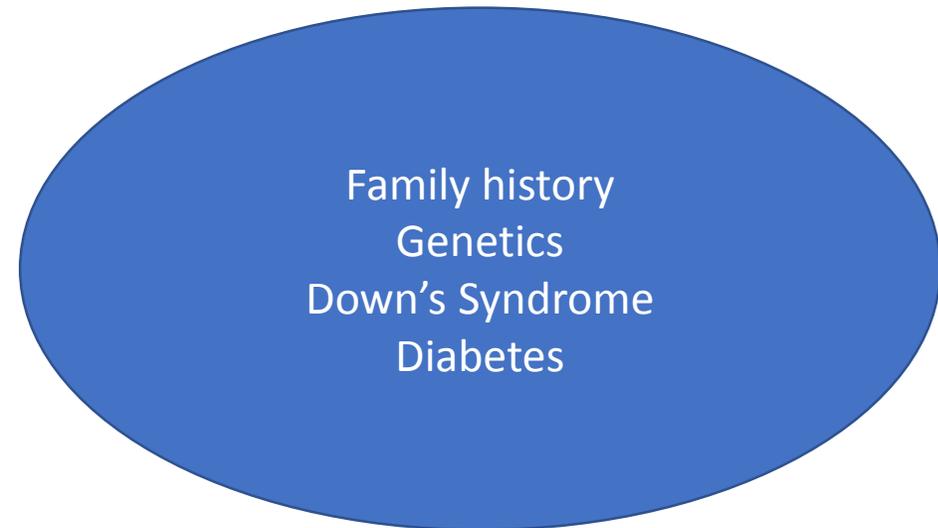
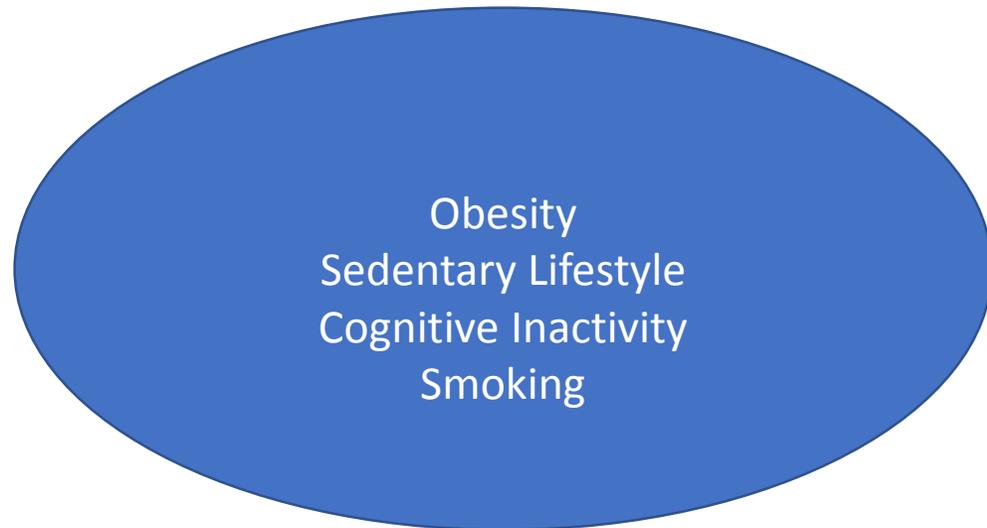
ONLY 16% OF SENIORS RECEIVE REGULAR COGNITIVE ASSESSMENTS DURING ROUTINE HEALTH CHECK-UPS

5.8 MILLION AMERICANS ARE LIVING WITH ALZHEIMER'S. BY 2050, THIS NUMBER IS PROJECTED TO RISE TO NEARLY 14 MILLION

Every 65 SECONDS SOMEONE IN THE UNITED STATES DEVELOPS THE DISEASE

RISK FACTORS FOR EARLY ONSET MEMORY LOSS AND ALZHEIMER'S DISEASE

AGE	HYPERTENSION	DIABETES	ALCOHOL	DEPRESSION
HYPERLIPIDEMIA	SLEEP APNEA	MEDICATIONS	LOW EDUCATION	INACTIVITY



WORKFORCE SHORTAGE

- GENERAL SHORTAGE OF PSYCHIATRIC PROVIDERS ACROSS THE COUNTRY. THE WORKFORCE PREPARED TO SERVE OLDER ADULTS WITH SMI IS INADEQUATE.
- MOST MENTAL HEALTH PROFESSIONALS HAVE LITTLE TRAINING IN GERIATRICS AND MOST GERIATRIC SPECIALISTS HAVE LITTLE TRAINING IN ADDRESSING THE NEEDS OF SMI.
- CORE GERIATRIC COMPETENCIES AND GERIATRIC BH COMPETENCY STANDARDS ARE CREATED IN SILOS AND NOT WELL DISSEMINATED.
- WORKFORCE ISSUES IMPACT ACCESS AND DELIVERY OF SERVICES



Recommendations for developing Workforce Capacity

TABLE 3. Issues and recommendations for developing workforce capacity and caregiver support

Issue	Recommendation
<p><i>A shortage of professional providers with expertise in mental health and aging and in geriatrics</i></p>	<p><i>Increase the number of providers with expertise in mental health and aging.</i></p> <ul style="list-style-type: none"> • A systematic evaluation should be undertaken to evaluate future workforce needs with respect to healthcare providers trained in geriatric psychiatry and in allied professions. Specific attention is warranted in identifying factors that contribute to the failure of geriatric residency programs to fill training slots and to create strategies to improve recruitment into geriatric specialty training programs. • Explore incentive programs, including loan repayment programs and increased authorization of graduate medical education (GME) payments. • Required training in geriatrics should be expanded for long-term care nurses, certified nursing assistants, and other allied professionals in addressing psychiatric disorders and behavioral symptoms of dementia. • Approaches to increasing the number of providers with geriatric mental health training include early educational awareness of geriatrics as a potential healthcare career path,⁷¹ development of multidisciplinary training environments for aging and mental health; increasing provider competencies through information-technology mechanisms; and increasing the proportion of educational programs with training in the identification, assessment, and management of late-life mental disorders.
<p><i>A need for enhanced support and services for family and peer caregivers</i></p>	<p><i>Enhance caregiver and peer support services</i></p> <ul style="list-style-type: none"> • Mental health services should be incorporated into current programs designed to support caregivers. • Enhance educational programs on home-based management of mental disorders and increased knowledge on aging, dementia, mental health, caregiving skills, resources, and options of care. • Provide enhanced support services, direct care services, and mental health services for family caregivers. • Increase the number of peer-support programs by promoting partnership between federal programs and advocacy organizations and directing state and county health systems to support development of peer-support programs.



Roles for Mental Health Clinicians

- All mental health clinicians should be literate in basic medical diagnoses and treatments
- All mental health clinicians should be aware of, and work to coordinate care with, medical providers
- APA provides online and in-person trainings for psychiatrists to develop their primary care skills

INTERVENTIONS

Supporting Self-Management:
How can individuals with SMI learn to better manage their health behaviors and health care?

- Understanding and addressing the social determinates of health in people with SMI

BEWARE
SILOS
AHEAD!



LACK OF INTEGRATED SYSTEMS FOR COMPLEX CARE NEEDS

- SILOED ELIGIBILITY DRIVEN SYSTEMS ANTITHETICAL TO PERSON-CENTERED, COMPLEXITY CAPABLE SYSTEMS OF CARE.
- OUR SYSTEMS ARE NOT DESIGNED TO WELCOME INDIVIDUALS WITH COMPLEXITY AS A PRIORITY FOR CARE.
- FRAGMENTED SYSTEMS OF CARE RESULTING IN ORGANIZATIONAL, FINANCIAL AND POLICY SILOES.

LACK OF
INTEGRATED
SERVICES FOR
COMPLEX
CARE NEEDS
OLDER
ADULTS WITH
SMI

- LACK OF A CONTINUUM OF CARE THAT IS INCLUSIVE OF THE NEEDS OF AGING INDIVIDUALS WITH SMI
- OUR CURRENT SYSTEMS OF CARE DO NOT INTEGRATE ADL, IADL AND MENTAL HEALTH FOR INDIVIDUALS WITH SMI
- CURRENT NURSING HOME WAIVERS ARE DESIGNED TO SERVE INDIVIDUALS WITH NURSING NEEDS AND HAVE LITTLE IN THE WAY OF MENTAL HEALTH SERVICES
- A RANGE OF SUPPORTIVE RESENDERIAL OPTIONS ARE LACKING FOR THE AGING ADULT WITH SMI

OPPORTUNITIES

CREATE	CREATE PARTNERSHIPS WITH MENTAL HEALTH & AGING AGENCIES THROUGH ORGANIZATIONAL, FINANCIAL AND POLICY COLLABORATIONS
EXPLORE	EXPLORE MEDICAID NURSING FACILITY WAIVERS THAT TARGET OLDER ADULTS WITH SMI
BUILD	BUILD CAPACITY IN THE WORKFORCE (PROFESSIONAL, PARA-PROFESSIONAL AND VOLUNTEER) TO BETTER MEET THE NEEDS OF AN AGING POPULATION WITH MENTAL HEALTH NEEDS
DISSEMINATE	DISSEMINATE EVIDENCE BASED PRACTICES FOR OLDER ADULTS WITH MENTAL HEALTH NEEDS AND WITH SERIOUS MENTAL ILLNESS

Best Practices for aging adults with SMI

FAST (FUNCTIONAL ADAPTATION SKILLS TRAINING) PROGRAM – 24 WEEK MODULAR SKILLS TRAINING TO IMPROVE COMMUNITY FUNCTIONING IN OLDER ADULTS WITH PERSISTENT PSYCHOTIC DISORDERS. DELIVERED IN GROUP SESSIONS WHO TEACH SKILLS IN THE AREAS OF COMMUNITY FUNCTIONING, COMMUNICATION, ILLNESS MANAGEMENT USING MODELING, REHEARSAL OF SKILLS AND POSITIVE REINFORCEMENT

Best Practices for aging adults with SMI

- COGNITIVE BEHAVIORAL SOCIAL SKILLS TRAINING PROGRAM – FOR OLDER ADULTS WITH SCHIZOPHRENIA COMBINES CBT AND SST. IT IS MODULAR 12- WEEK GROUP TRAINING IN COGNITIVE RESTRUCTURING AND ILLNESS SELF MANAGEMENT SKILLS
- THREE MODULE PROGRAM CHALLENGES CONVICTIONS REGARDING DELUSIONAL BELIEFS, EXPLORES MEDICATION NON-ADHERENCE, RESISTANCE TO TREATMENT AND HOMEWORK NONCOMPLIANCE.

Best Practices for aging adults with SMI

HOPES Program (Helping Older People Experience Success) – developed for older adults with SMI with the aim of enhancing independent functioning and health care outcomes. Weekly classes over a 12 month period.

The rationale for linking skills training and health management is that both are needed to optimize independent functioning and health to maintain community tenure.

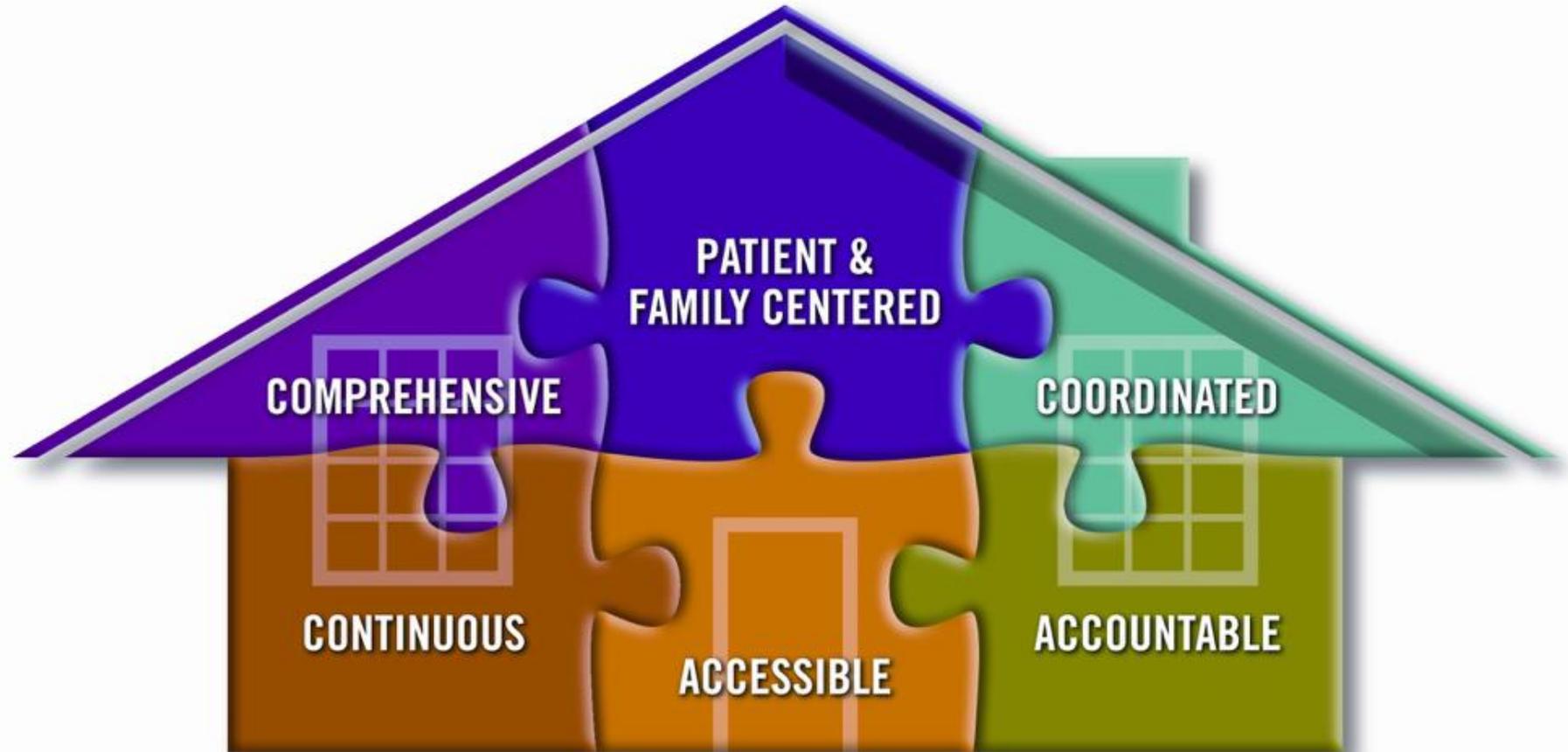
What is a behavioral health home?

Co-locating primary care within mental health settings

Three RCT's assessed impact

Results: higher preventive service uptake, better quality of cardiometabolic care (but showed no clinical significance in blood pressure, cholesterol, blood glucose or 10 year cardiovascular risk).

BEHAVIORAL HEALTH HOME



Evidenced Based Practices for Depression and Substance Use Disorder



- Improving Mood-Access to Collaborative Treatment (**IMPACT**)
- Identifying Depression Empowering Activities for Seniors (**Healthy IDEAS**)
- Certified Older Adult Peer Support Services (**COAPS**)
- Screening, Brief Intervention, and Referral for Treatment (**SBIRT**)
- Program to Encourage Active, Rewarding Lives (**PEARLS**)
- Senior Reach

So what is Oregon doing?



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Conducted a *NEEDS ASSESSMENT* in
2014:
TO IDENTIFY GAPS IN BEHAVIORAL
HEALTH FOR OLDER ADULTS ...
POTLAND STATE UNIVERSITY

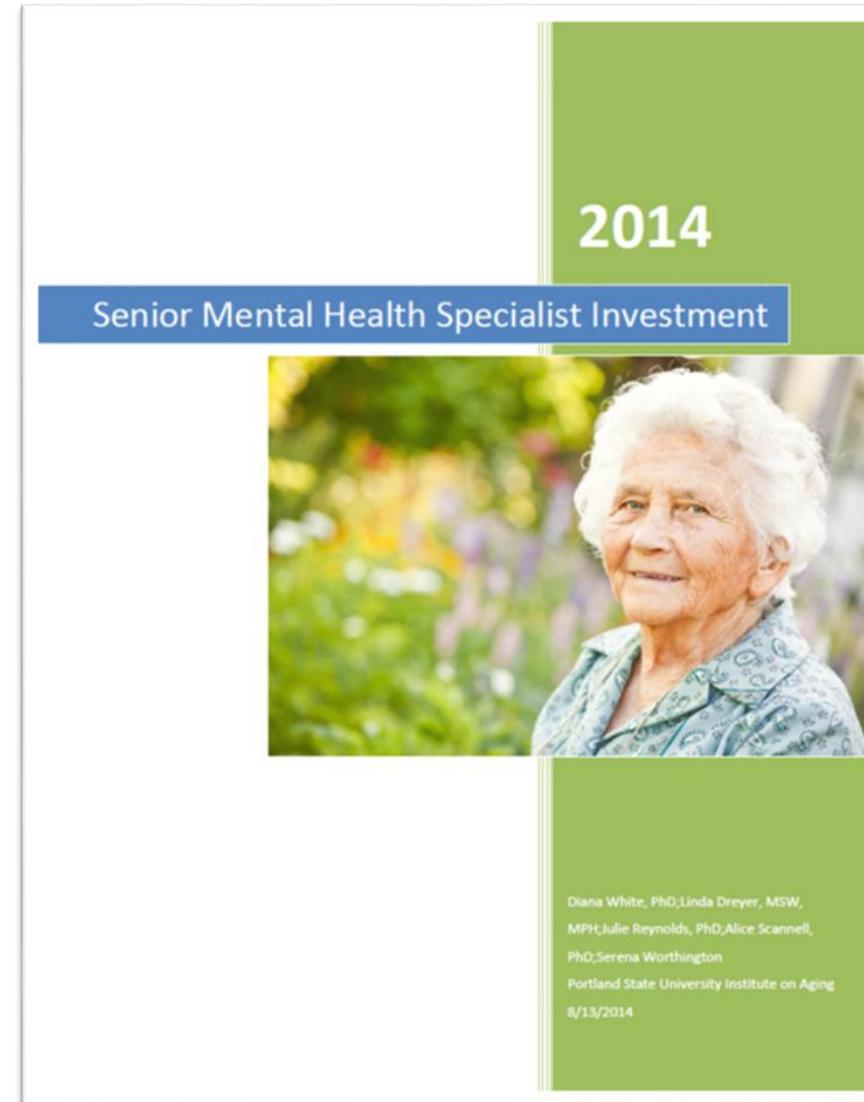
OREGON'S ANSWER

CREATED THE OLDER ADULT (AND PEOPLE WITH DISABILITIES) BEHAVIORAL HEALTH INITIATIVE IN 2015

CURRENTLY A \$7M INVESTMENT

Gaps

- Systems were fragmented
 - Organizations worked in silos
 - Different funding priorities, eligibility requirements, and knowledge base
- Behavioral health for the population was not a priority in any agency
- Existing services were not tailored to the population
- Knowledge gaps were pervasive
- Resources and funding were limited



2014

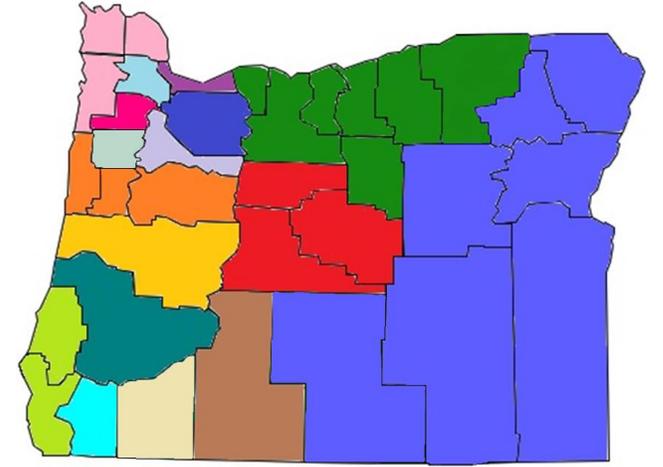
Senior Mental Health Specialist Investment



Diana White, PhD, Linda Dreyer, MSW,
MPH, Julie Reynolds, PhD, Alice Scannell,
PhD, Serena Worthington
Portland State University Institute on Aging
8/13/2014

Behavioral Health Specialists

- 1 Statewide Project Director
- 25 Specialists
- Positions filled
 - May – December 2015
- Clinical Expertise
 - Social work
 - Psychology





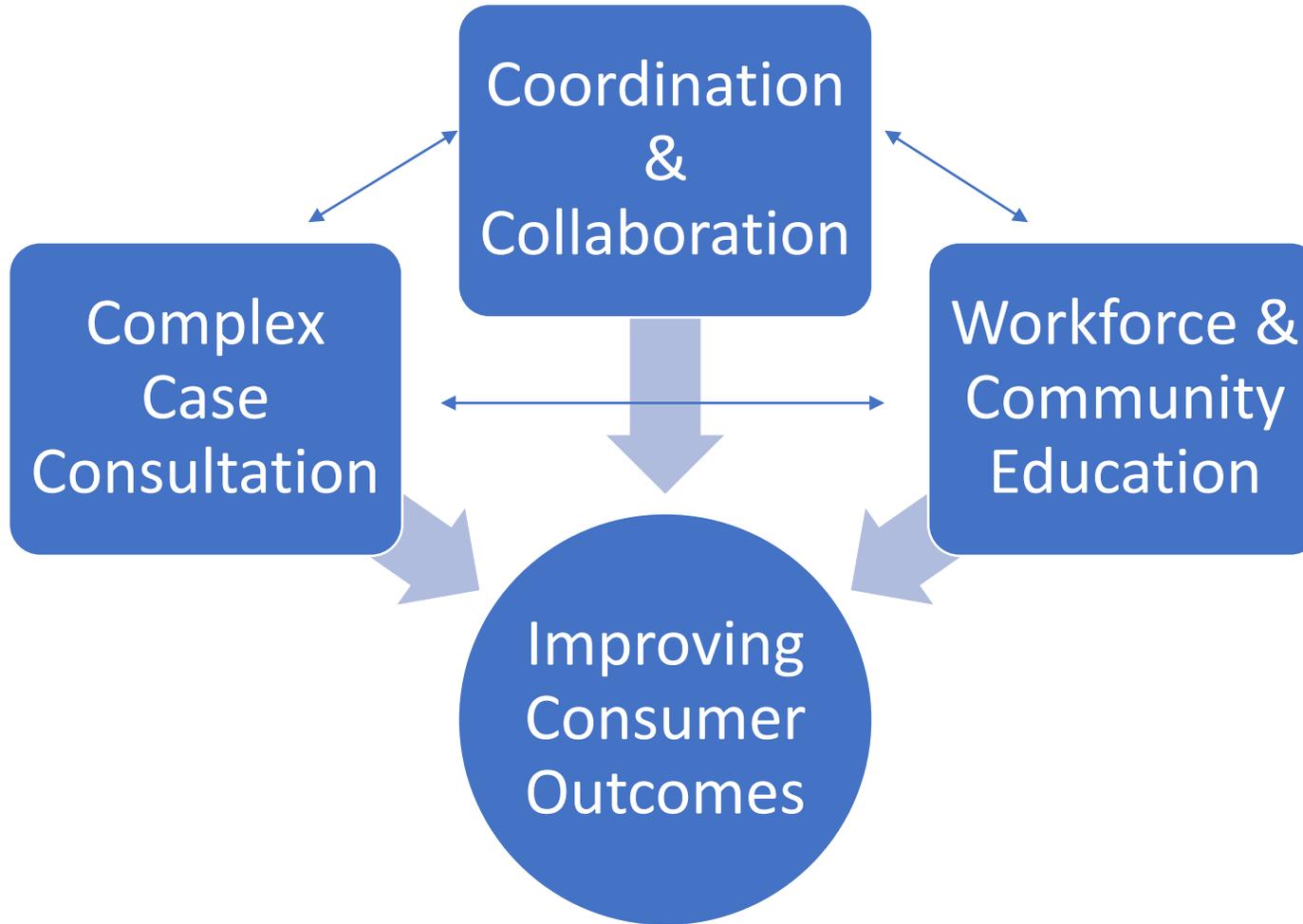
The Specialists!



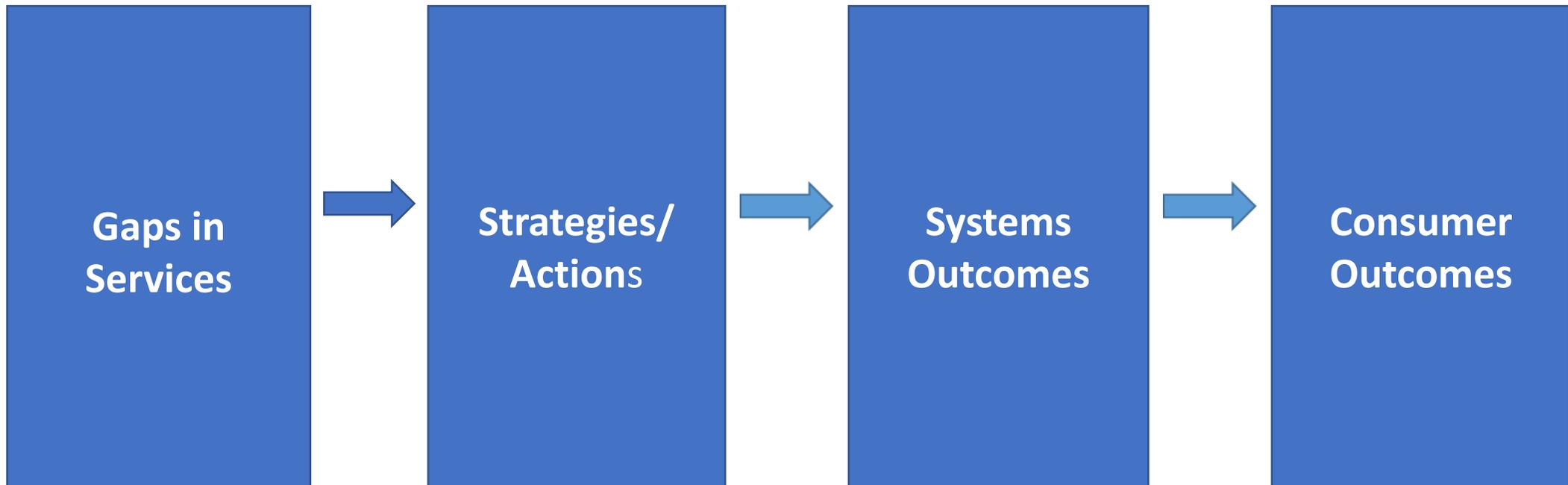
OLDER ADULT BEHAVIORAL HEALTH SPECIALISTS

- QUALIFIED MENTAL HEALTH PROFESSIONALS (QMHP)
- THESE ARE NOT DIRECT BILLABLE SERVICE POSITIONS
- MANY HAVE ACQUIRED ADDITIONAL CERTIFICATION SUCH AS MHFA, WISE CERTIFIED TRAINER, TEEPA SNOW PAC DEMENTIA TRAINERS, ASSIST TRAINED AND QPR TRAINED (SUICIDE PREVENTION)
- CONSIDER THEM SENIOR, EXPERIENCED STAFF
- ALLOCATION OF ONE FTE FOR EVERY 30,0000 OLDER ADULTS IN THE COUNTY'S POPULATION
- SOME AREAS HAVE BEEN REGIONALIZED
- MAJORITY OF CONTRACTS ARE WITH COMMUNITY MENTAL HEALTH PROGRAMS

What do the Specialists do?



Guiding logic model



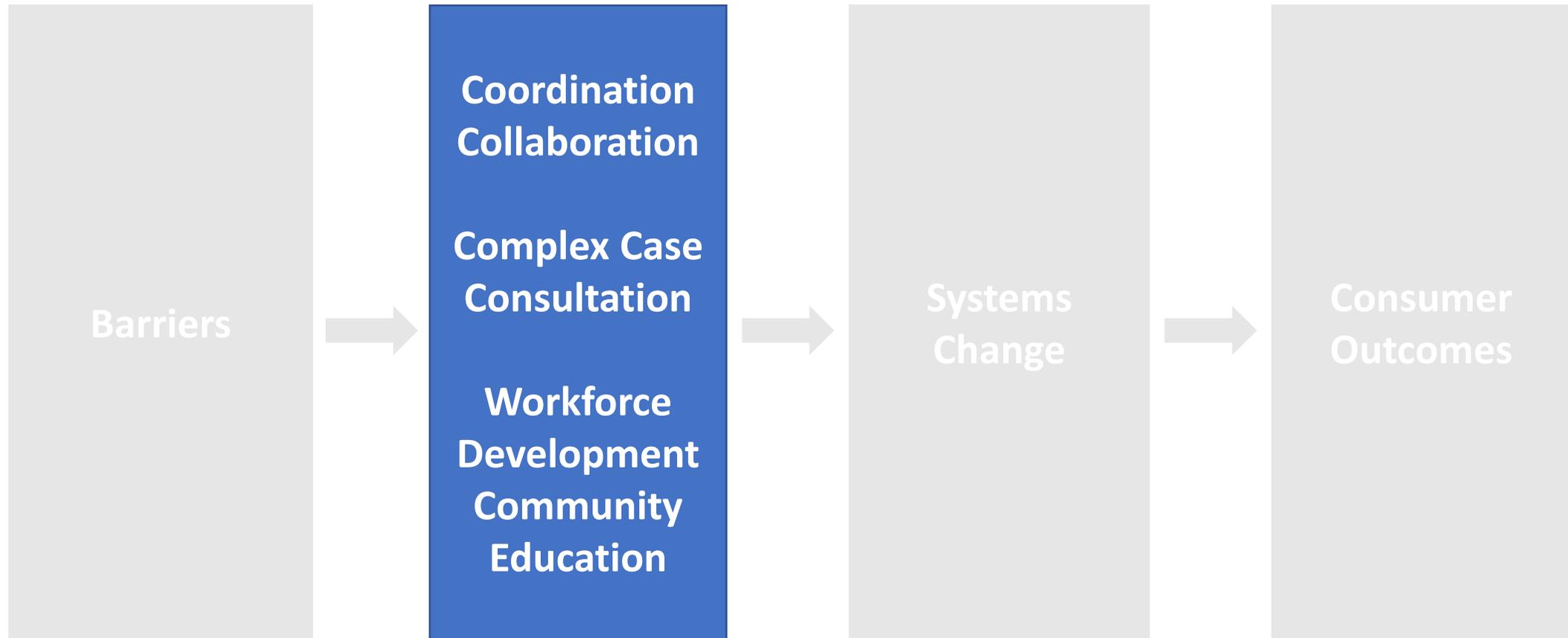
Consumer outcomes



Older adults and people with physical disabilities who have behavioral health needs:

- Are recognized as a priority population
- Have timely access to services that have demonstrated effectiveness
- Have their signs and symptoms recognized as BH needs
- Receive help from knowledgeable and skilled providers
- Seek help to better understand their signs and symptoms
- Have information and tools to promote mental health well-being
- Experience reduced lengths of stay
- Rarely experience evictions
- Experience successful resolution of issues through complex case consultation

Guiding logic model





Breaking Down Silos

- NO ONE SYSTEM CAN MEET THE COMPLEX NEEDS OF OLDER ADULTS THAT WE SERVE
- USING A MULTI-DISCIPLINARY LENS IS A BEST PRACTICE
- CROSS SECTOR/MULTI-SYSTEMS COLLABORATION AND INTEGRATION LEADS TO MORE RESPONSIVE CARE, PROVIDES FLEXIBILITY AND INCREASES THE SATISFACTION OF THE INDIVIDUALS AND FAMILIES WE SERVE.

Benefits of Collaboration

- RESPONSIVE SERVICE DELIVERY SYSTEM THAT IS PERSON CENTERED
- A FOCUS ON FUNCTION RATHER THAN DISEASE OR DIAGNOSIS
- REDUCED COSTS
- REDUCED REDUNDANCY
- RIGHT CARE AT THE RIGHT TIME
- REDUCED “FALLING THROUGH THE CRACKS”
- BETTER USE OF RESOURCES AND EXPERTISE
- BETTER INFRASTRUCTURE FOR SERVING OUR CLIENTS
- BETTER CASE FINDING – INCREASE IN REFERRALS



CONDUCT AN ANNUAL ONLINE STAKEHOLDER SURVEY



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- Collaboration and coordination is defined as any activity in relationship with community partners that is intended to or contributes to improvements to the local behavioral health system for older adults and adults with physical disabilities who have behavioral health needs
- In 2019 1,784 questionnaires were sent out and 456 responses received (26% response rate).



FINDINGS
FROM 2019
SURVEY

GAPS IN SERVICES HAVE BEEN IDENTIFIED

PARTICIPANTS REMAIN COMMITTED TO IMPROVING
BEHAVIORAL HEALTH SERVICES FOR OLDER ADULTS

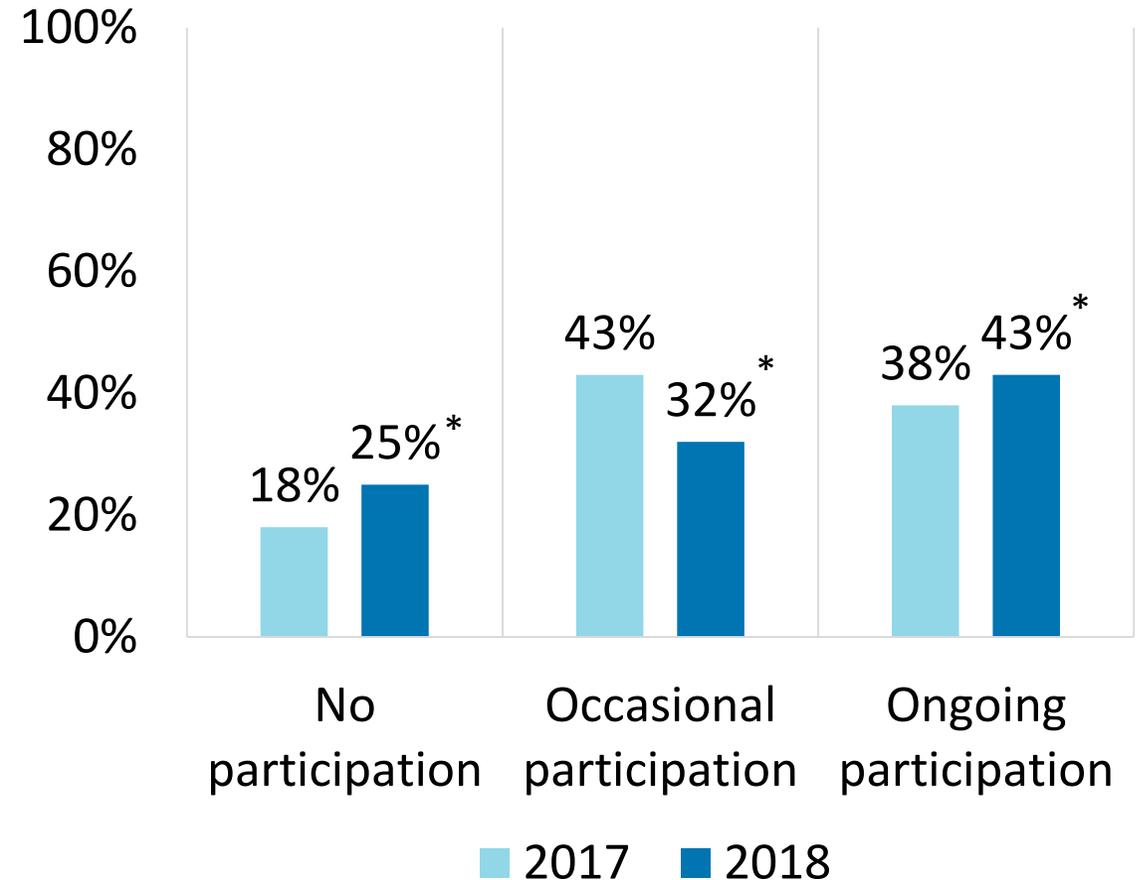
STRONG SUPPORT FOR TRAININGS INCORPORATING
KNOWLEDGE LEARNED INTO WORK AND SHARING
INFORMATION WITH CO-WORKERS

AFFORDABLE HOUSING REMAINED THE MOST
PREVALENT CHALLENGE FOLLOWED BY BEHAVIORAL
HEALTH SERVICES IN LONG TERM CARE SETTINGS

COMPLEX CASE CONSULTATIONS HAVE HAD SOME
SUCCESS

Coordination and Collaboration: Stakeholder Survey

- 75% participate at least occasionally
- Ongoing participation appears to have increased
 - Accompanied with a decline in occasional participation



Perceived Barriers to Improving Outcomes – Top 5 Stakeholder Survey

LACK OF...



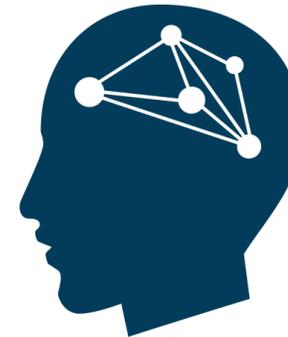
Affordable housing
94%



BH services in long-term care settings
80%



Credentialed providers willing to accept Medicare reimbursement for BH services
76%



BH programs specific to this population
75%

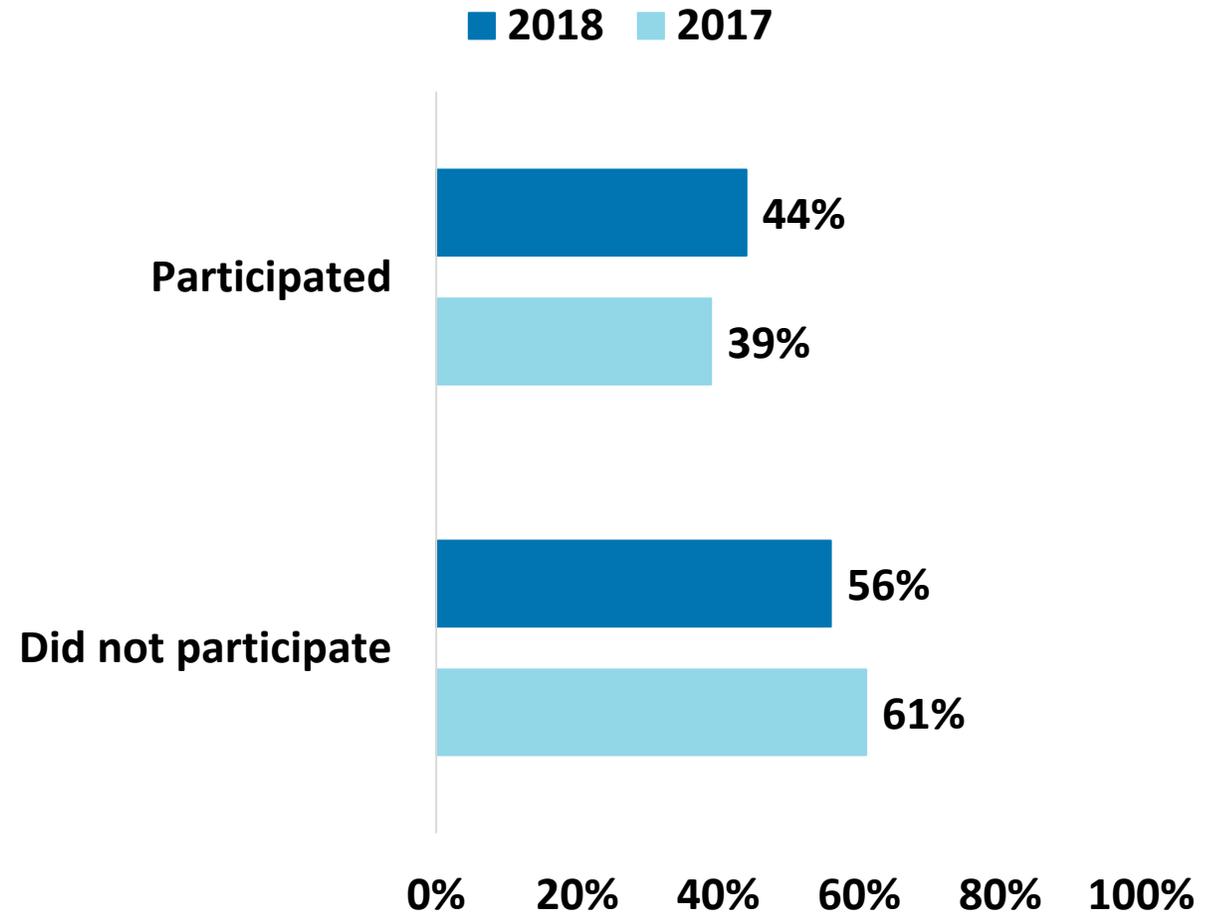


In-home services
74%

Complex Case Consultation

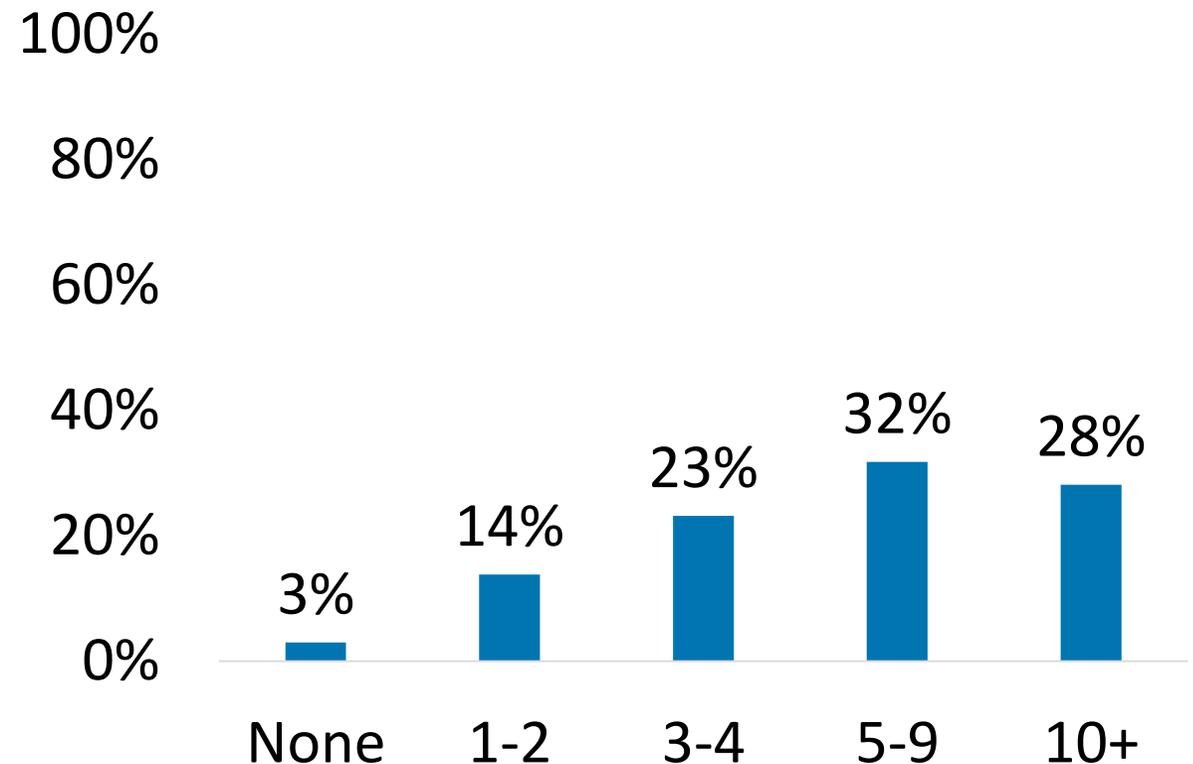
July 2016-September 2018
(Quarterly Reports)

- An average of 163 consultations each month
 - 2,123 unplanned
 - 2,244 regularly scheduled or planned
 - 41 unknown



Complex Case Consultation: Quarterly Reports

- On average, consumers had seven or more issues, including:
 - Neurological/cognitive
 - Physical/medical
 - Psychiatric/mental health
 - Social/individual
 - System



Complex Case Consultation: Frequently-Cited Issues (2018 Quarter 3)

- Neurological/Cognitive
 - Lack of capacity/competence for decision making (29%)
 - Dementia (21%)
- Physical/Medical
 - Complex and/or co-occurring medical conditions (45%)
 - ADL and other functional limitations (36%)
- Psychiatric/Mental Health
 - Mood disorders (e.g., depression, anxiety) (43%)
 - Serious mental illness (35%)
- Social/Individual
 - Homelessness (50%)
 - Isolation/loneliness (36%)
- System
 - System navigation (48%)
 - Understanding eligibility (33%)

Key highlights from these consultations:

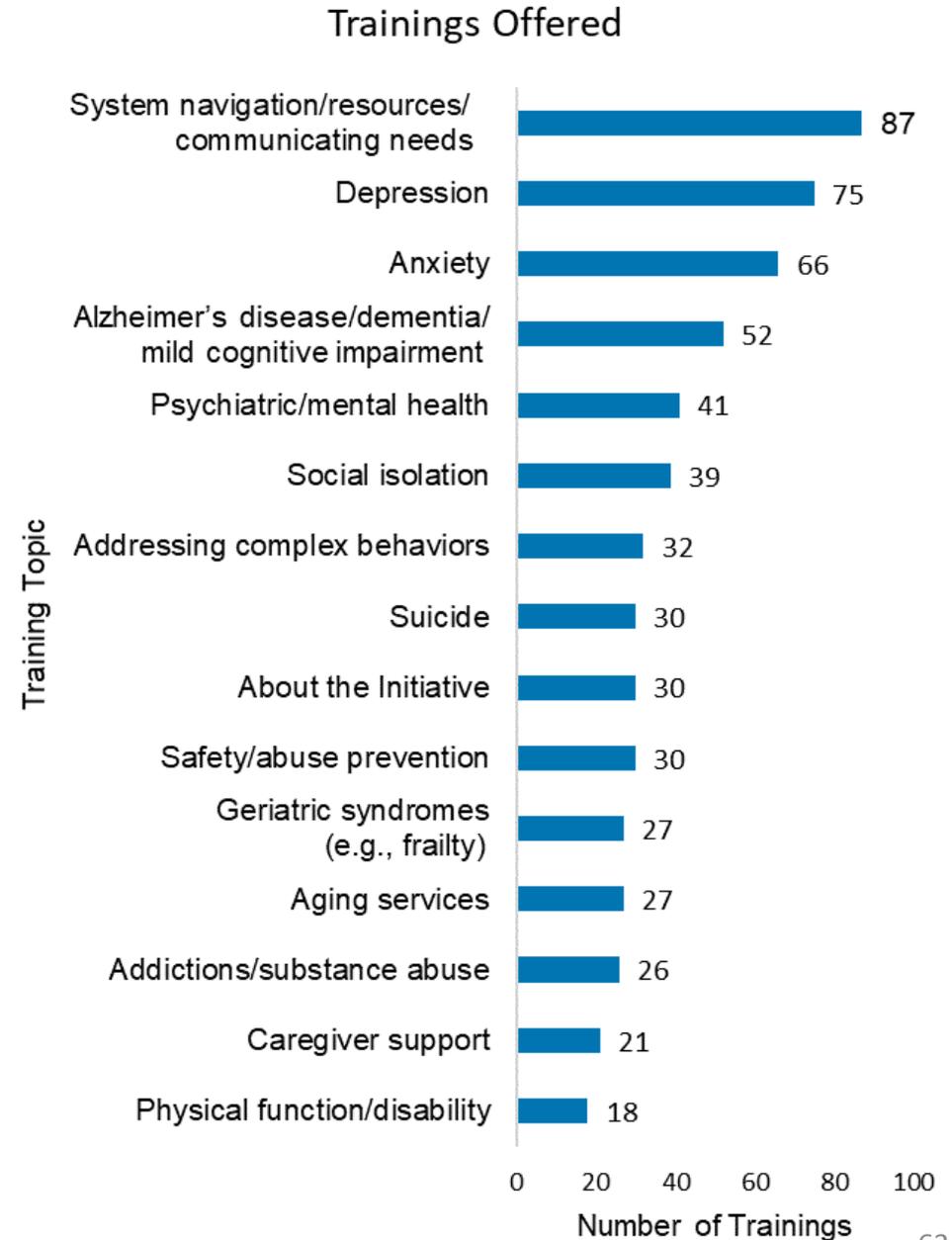
- Consumers were slightly more likely to be female (52%).
- Consumers were expectedly older than the Oregon population . The largest age group of consumers included people between ages 65 and 74 (34%), followed by those younger than age 60 (25%).
- Eleven percent of consumers with known veteran status were veterans, which is slightly higher than the Oregon average (10%).
- In 63 percent of cases, the meeting was the Specialist's first consultation about the consumer.
- Over half of consultations were planned (57%) and involved people from multiple organizations or departments or multidisciplinary teams (53%). A small portion (13%) of cases involved a team from a single organization only.

Workforce Development Community Education

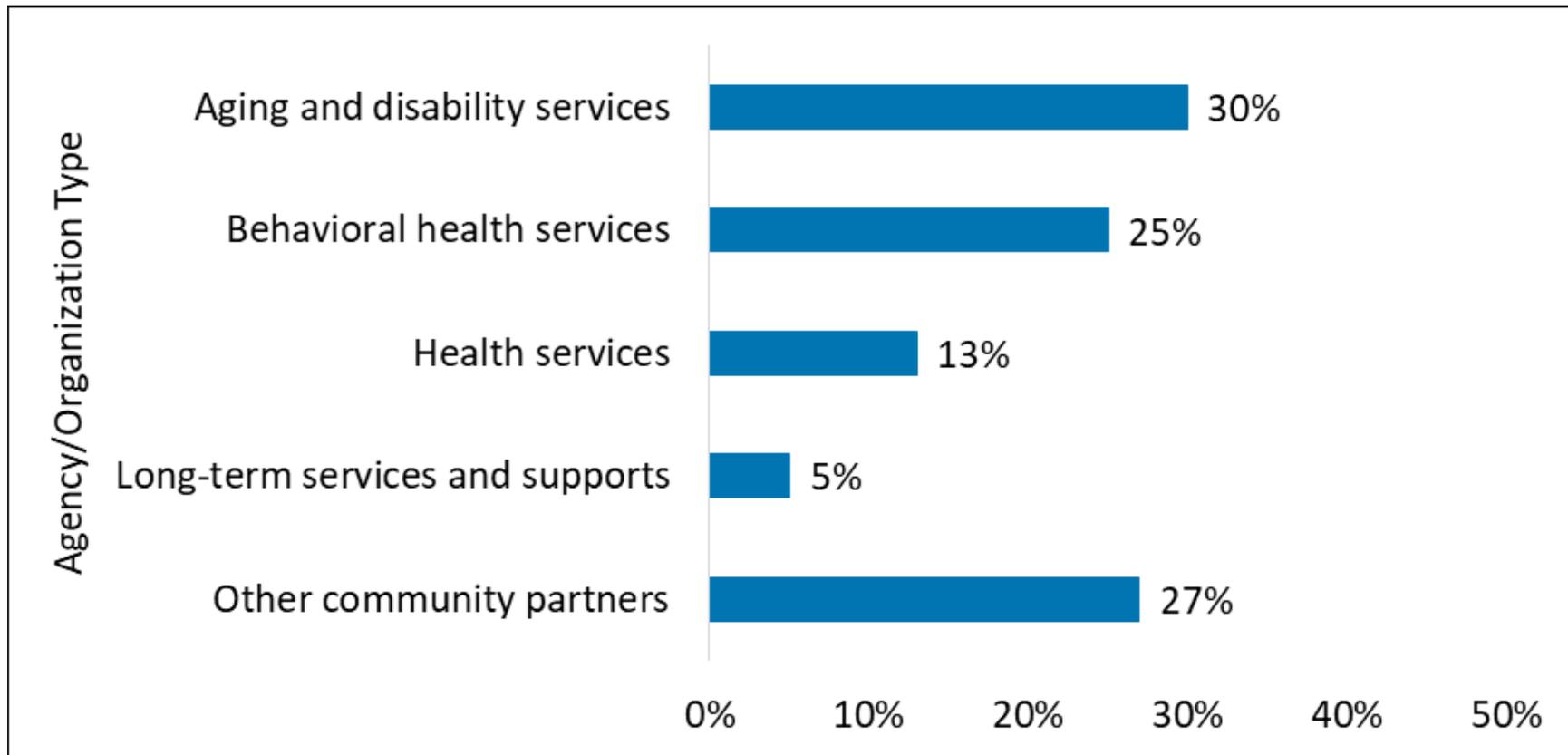
(Quarterly Reports)

- Between July 2016 and September 2018, Specialists...
 - Conducted an average of 38 workforce development or community education events each month.
 - 1000+ events in total
 - Attended by 26,000+ participants
- Training participants were from a variety of agencies and professions.
- Training topics covered a wide range of issues.

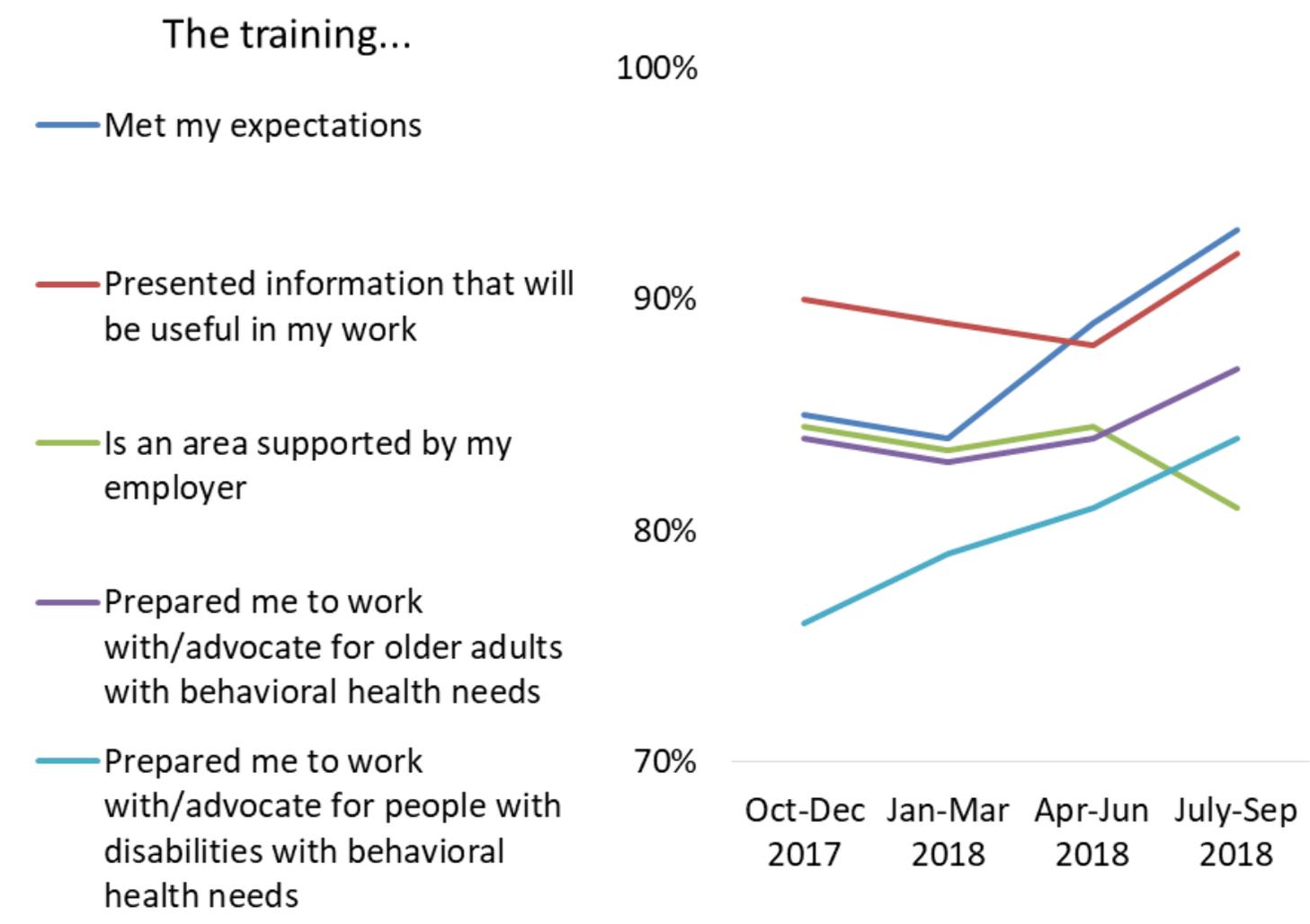
Trainings offered most frequently by Behavioral Health Specialists



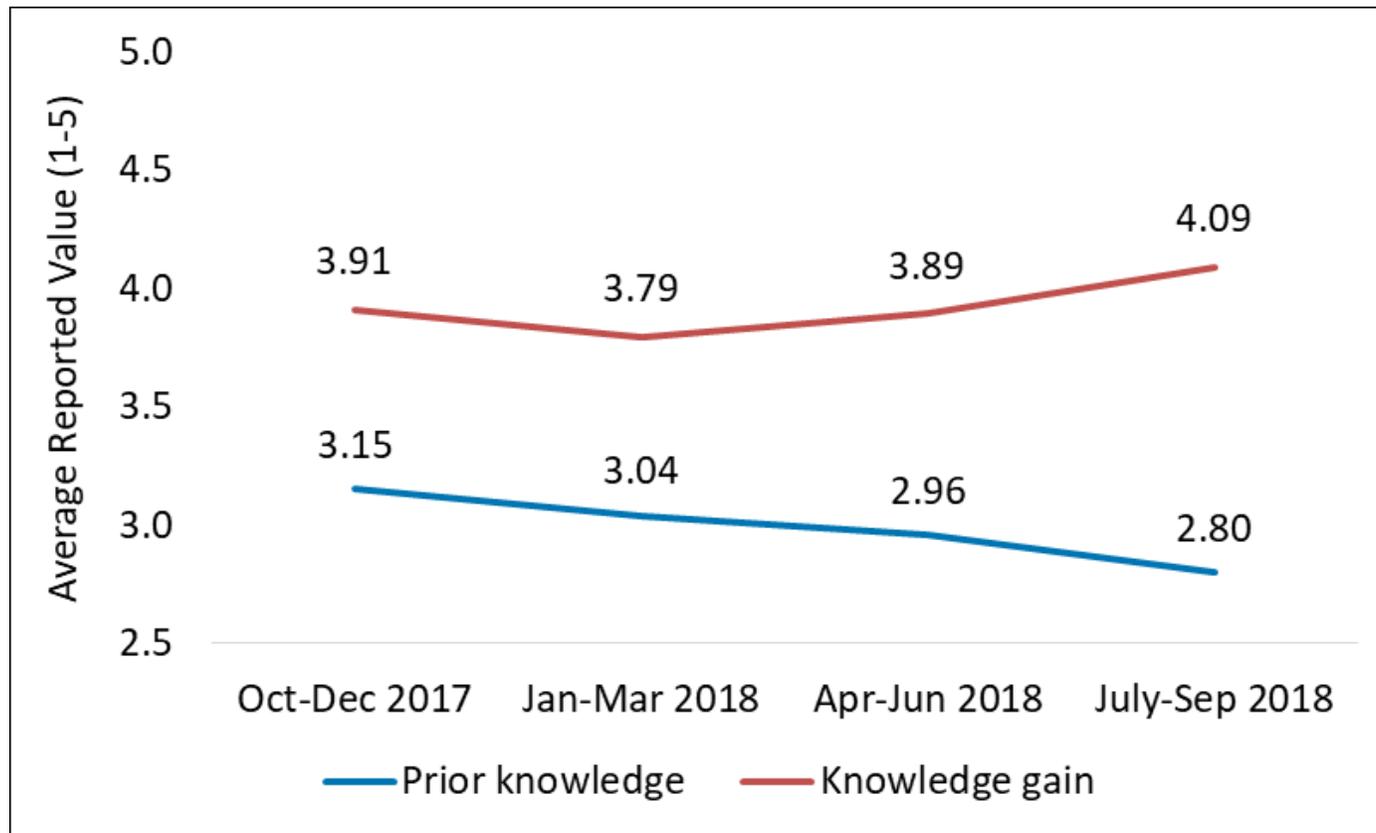
TRAINING PARTICIPANTS



IMPACT ON PRACTICE



KNOWLEDGE: PRE AND POST TRAINING



SPECIAL PROJECTS OF THE INITIATIVE

SOCIAL ISOLATION AND LONELINESS AS A RISK FACTOR FOR OLDER ADULTS:

CURRENTLY THREE PHONE LINE SERVICES TO MITIGATE SOCIAL ISOLATION AND PROMOTE HEALTH AND WELLNESS:

- ✓ The Friendship Line
- ✓ The Senior Loneliness Line
- ✓ Peer Warmline





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PROMOTING HEALTH AND WELLNESS AND CAREGIVER EDUCATION

- MENTAL HEALTH FIRST AID - SPECIALISTS IN SEVERAL COUNTIES ARE CERTIFIED AS OLDER ADULT MENTAL HEALTH FIRST AID TRAINERS.
- WISE (WELLNESS INITIATIVE FOR SENIOR EDUCATION) – MULTIPLE COUNTIES HAVE IMPLEMENTED THIS HEALTH PROMOTION PROGRAM THAT COVERS TOPICS SUCH AS AGING PROCESS, MEDICATION MANAGEMENT AND SIGNS OF ALCOHOL MISUSE.

PERSON CENTERED, STRENGTH BASED CROSS SYSTEM COORDINATION PILOT

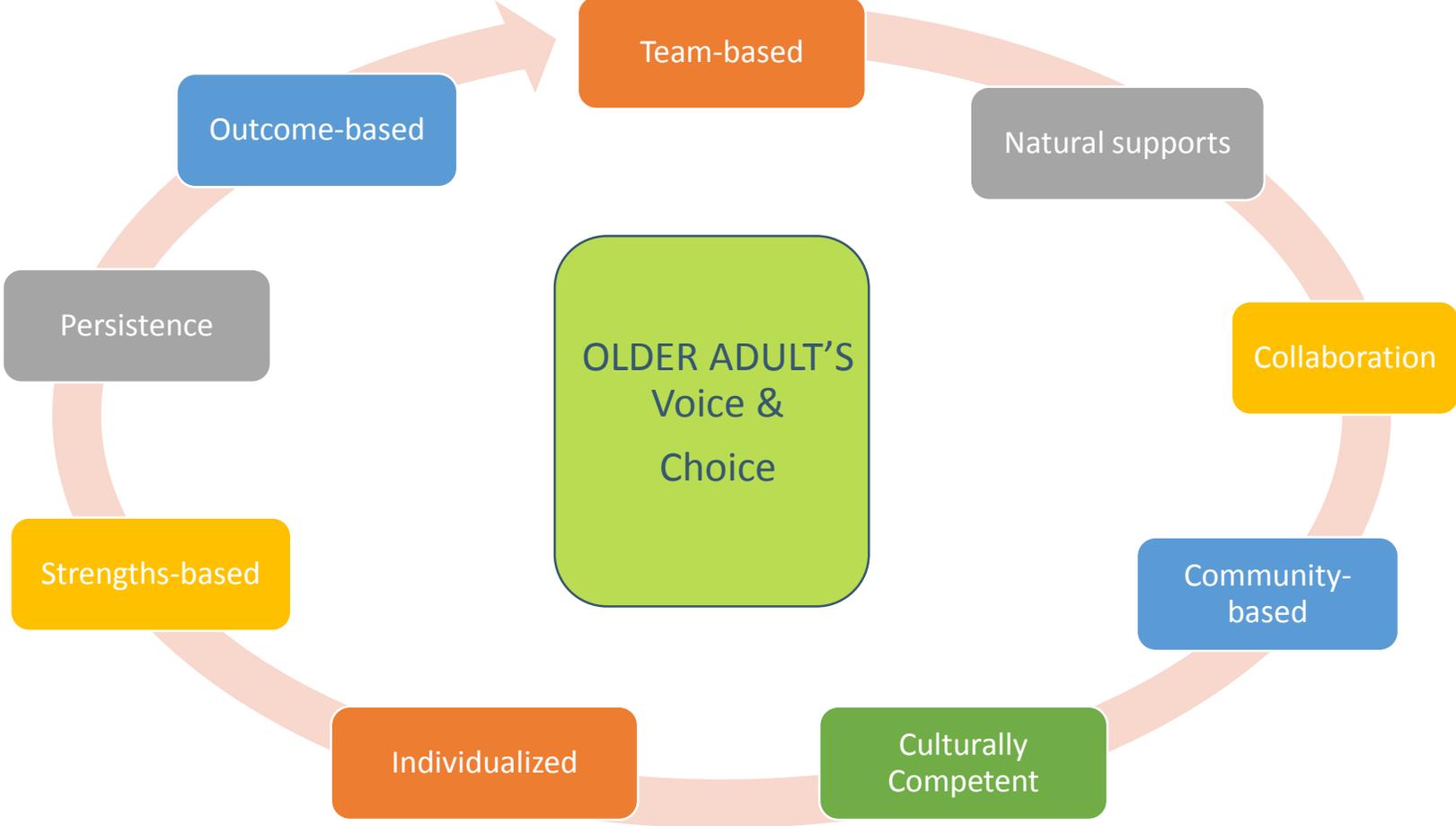
SYSTEM OF CARE MODELS

- System of care models initially implemented for youth with serious emotional disturbances that affected their function at school, home and community
- Definition for youth with special needs: A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families

VISION & PARTNERSHIP

- AGING AND PEOPLE WITH DISABILITIES
- OLDER ADULT BEHAVIORAL HEALTH INITIATIVE

Principles of Wraparound



IMPROVING ACCESS TO BH SERVICES FOR OLDER ADULTS

YOUNG AT HEART AGE SPECIFIC ALCOHOL AND DRUG TREATMENT PROGRAM FOR AGE 55 AND OLDER IN OUR MOST POPULOUS COUNTY

HOARDING DISORDER PREVENTION AND TREATMENT PROGRAM; HOARDING DISORDER TASK FORCE; BURIED IN TREASURE GROUPS

OLDER ADULT PEER DELIVERED SERVICES IN ONE COUNTY

TRAINING AGING SERVICES CASE MANAGERS TO BETTER RECOGNIZE MENTAL HEALTH SYMPTOMS AND MAKE APPROPRIATE REFERRALS



Recommendations to Improve Outcomes for Older Adults and People with Disabilities #1

INTEGRATE	Acknowledge	Use	Prioritize
INTEGRATE BEHAVIORAL HEALTH (OHA) AND AGING SERVICES (DHS) FOR LODER ADULTS WITH CROSS SYSTEM COMPLEX CARE NEEDS.	Acknowledge shared responsibilities for services by executing MOU's at the state and local levels	Use braided or blended funding and waivers so that each agency contributes to the needed array of services	Prioritize building bridges between local agency leaders and their staff to reduce state agency siloes and mitigate knowledge gaps.

Recommendations to Improve Outcomes for Older Adults and People with Disabilities #2

ELEVATE	Allocate	Support and invest in	Promote
ELEVATE OLDER ADULTS AS A PRIORITY POPULATION IN STATE SPONSORED BEHAVIORAL HEALTH INITIATIVES	Allocate funding for appropriate services	Support and invest in a knowledgeable and skilled workforce	Promote program development to enhance access to services and specialized housing

Recommendations to Improve Outcomes for Older Adults and People with Disabilities #3

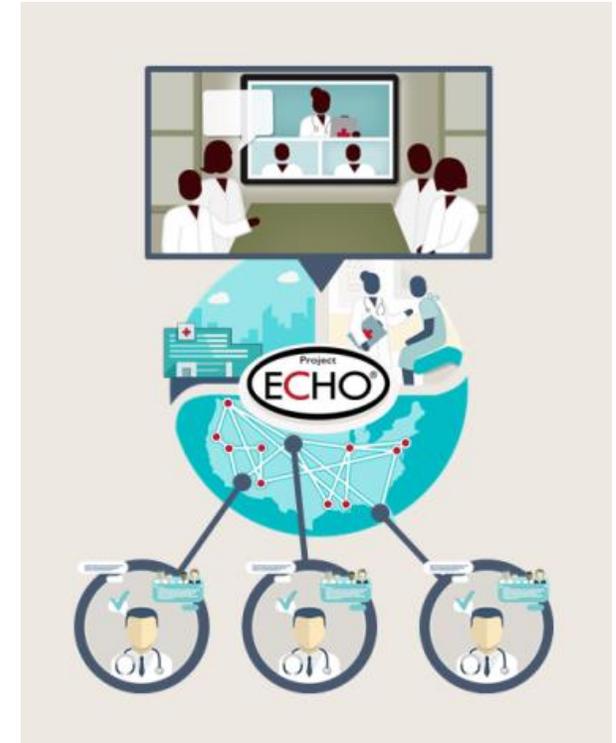
INCREASE	INCREASE MEDICARE LITERACY AND PROMOTE STRUCTURAL CHANGES IN MEDICARE
Allocate	Allocate funding for technical assistance for providers
Educate	Educate providers on behavioral health billing codes and alternative strategies
Advocate	Advocate for increased reimbursement rates and for a larger group of qualified licensed professionals who can provide mental health billable services

OTHER PROJECTS
TO IMPROVE THE
BEHAVIORAL
HEALTH
INFRASTRUCTURE

- **PROJECT ECHO BEHAVIORAL HEALTH GERIATRIC NURSING HOME CLINIC**
- BASED ON ECHO CLINIC FROM UNIVERSITY OF ROCHESTER – WORKED CLOSELY WITH DR.HASSELBERG
- FUNDED BY CMS THROUGH THE CIVIL PENALTY FUND.
- JUST COMPLETED FIRST COHORT OF 20 NF.
- EXCITED THAT CMS HAS APPROVED OUR PROPOSAL FOR FUNDING FOR OUR SECOND CLINIC WITH 15 NF TO START EARLY NEXT YEAR.
- WILL ALSO PILOT A COMMUNITY OF PRACTICE MODEL.

The Project ECHO® Model Principles

1. Use Technology (multipoint videoconferencing and Internet) to leverage scarce resources
2. Sharing “best practices” to reduce disparities
3. Case-based learning to master complexity
4. Program evaluation and data tracking



Nursing Facility Behavioral Health ECHO Overall Program Goals

- **The overall project purpose is to develop more knowledgeable and skilled nursing facility staff who are better equipped to deliver person-centered care to address their nursing facility residents' mental health concerns and behavioral issues.**

Intermediate Goals

Staff will increase their skills to:

- Quickly detect and effectively treat mental health and behavioral care needs
- Employ person-centered interventions
- Recognize unsafe psychiatric medication prescribing
- Perform assessments and create high quality care plans

Resident care outcomes:

- Improved resident satisfaction
- Increased resident placement stability

Long-term goals

- Reduction in emergency hospital transfers for behavioral crisis
- Reductions in denial of right to return-readmit-involuntary transfer
- Increased willingness by facilities to admit individuals with mental health and behavioral care needs
- Increased staff confidence and satisfaction in providing behavioral care

Meet the Specialist Team



Faculty Lead,
Geriatric
Psychiatrist,
Maureen Nash,
MD



Occupational Therapist:
Sarah Foidel, OTD, OTR/L



Licensed Clinical Social
Worker: Janet Holboke,
MSW, LCSW



Nurse Expert:
Joanne Rader,
RN, MN



Gerontologist and
Psychiatric Nurse
Practitioner: Susan S Rose,
PhD, PMHNP

Curriculum Topics

- **Building Knowledge in Treating Different Conditions**
 - Behavioral Interventions with People with Dementia
 - Types of Dementia
 - Personality Disorders in LTC
 - **Depression-Pharmacological and Non-Pharmacological approaches**
 - **Anxiety**
 - **Parkinson's Disease**
 - Chronic Neurological Issues with Psychiatric Overlays
 - Substance Use Disorder
 - Pain and Palliative Care
 - **Drug/Drug Interactions and Polypharmacy**
- **Behavioral Interventions, Communication, and Skill Building**
 - Behavioral Interventions
 - **Working with Challenging Families**
 - Maximizing Independence in Self-Care
 - Sleep
 - Sexuality
 - Beyond Bingo: Increasing Participation in Activities
 - Communicating with Residents
 - Staff to Staff Communications (huddles)
 - Loving the Unlovable
 - **Creating Purpose**

Case Themes

- Polypharmacy
 - Verbal/ physical aggression toward staff
 - Repetitive calling out
 - Self-destructive behaviors
 - Intoxication
 - Hoarding
 - Delusions
 - Sexually-inappropriate behaviors
- Pain
 - Mood fluctuations
 - Resistance/refusal of care
 - Accusations against staff
 - Increase in behaviors related to dementia including intrusiveness, resistance to care, medication and delusional beliefs

Preliminary Post-Program Feedback

- **Overall most helpful information learned:**
- “Behavioral interventions”
- “Different approaches on modifying physically aggressive behaviors”
- “Drug-drug interactions”
- “I loved when it got more in-depth about medications...”
- “I appreciate the summary education notes I use the information & share with co-workers”

QUALITY IMPROVEMENT MODULE : *Addressing Geriatric Opioid Prescribing and Opioid Misuse: Prevent Opioid Related Harms in Older Adults in Oregon*

- FUNDED THROUGH THE STR GRANT
- WORKING WITH PACIFIC UNIVERSITY SCHOOL OF HEALTH PROFESSIONALS TO DEVELOP A THREE STAGE QI MODULE FOR IDENTIFIED PRIMARY CARE PROVIDERS AND PHARMACISTS
- STAGE ONE –PERFORMANCE MEASUREMENT
- STAGE - NTERACTIVE ONE DAY SEMINAR WITH EXPERTS- INTERVENTION/IMPROVEMENT PLAN
- STAGE THREE – RE-MEASUREMENT AFTER 3 – 6 MONTHS (TO SEE IF PRACTICE CHANGE OCCURRED)

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GOALS FOR THE PROJECT

Stop

Stop improper prescribing

Enhance

Enhance diagnosis of opioid use disorder (expand screening, diagnosis and treatment of opioid use disorders)

Encourage

Encourage non-opioid pain treatments (increase the use of evidence-based practices for acute and chronic pain)

OLDER ADULTS AND OPIOID CRISIS

- CREATING A FACT SHEET FOR NURSING FACILITIES ON OPIOID USE DISORDER AND MEDICATION ASSISTED TREATMENT(MAT)
- CREATING AN EDUCATION AND AWARENESS PAMPHLET FOR OLDER ADULTS ON THE RISK OF OPIOID MISUSE AND CO- PRESCRIPTION OF BENZOS



UPSKILLING THE WORKFORCE

MENTAL HEALTH FIRST AID TO TRAIN STATE IN-HOME CARE WORKERS

COLLABORATED ON WRITING A PROPOSAL WITH A COMMUNITY PARTNER TO BRING BRIEF VIDEO TRAININGS ON MENTAL HEALTH TOPICS FOR FRONTLINE NURSING HOME STAFF – FUNDING SOURCE CIVIL PENALTY FUND

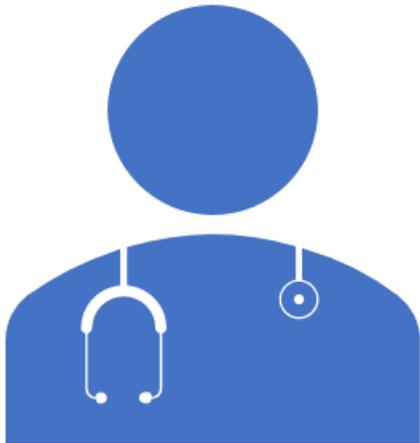
3 OLDER ADULT SPECIALISTS HAVE DEVELOPED A MENTAL HEALTH CURRICULUM FOR ADULT CARE HOME PROVIDERS

CRISIS INTERVENTION TRAINING FOR LAW ENFORCEMENT INCLUDES CLASS ON THE MENTAL HEALTH NEEDS OF OLDER ADULTS INCLUDING DEMENTIA

DEESCALATION TRAINING FOR AGING SERVICES PROVIDERS AND NURSING HOME STAFF

ASSIST AND QPR TRAINING FOR AGING SERVICES CASE MANAGERS, MEALS ON WHEELS VOLUNTEERS AND PRIMARY CARE STAFF

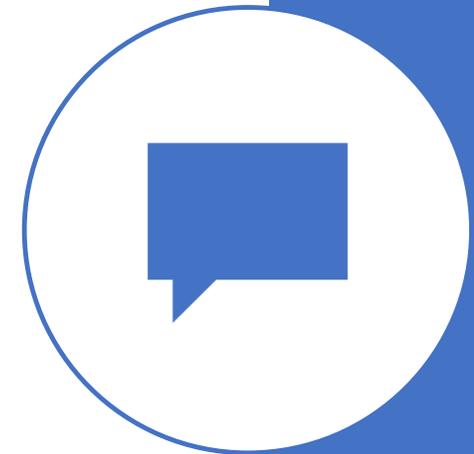
EXISTING PROGRAMS THROUGH OREGON HEALTH AUTHORITY – ENHANCED CARE SERVICES SERVES INDIVIDUALS WITH COMPLEX MEDICAL, PHYSICAL AND MENTAL HEALTH NEEDS AND IS A JOINT PROGRAM OF AGING SERVICES AND OHA BEHAVIORAL HEALTH



- **ENHANCED CARE FACILITIES** - Dedicated APD facilities or units within APD facilities where individuals can receive Enhanced Care Services. Mental health supports are provided on-site 7 days a week for a minimum of 4 hours per day. These include Residential Care Facilities and Nursing Facilities.
- **ENHANCED CARE OUTREACH** - Intensive mental health treatment services provided to individuals residing in an APD licensed setting. Based on individual needs, services are typically community based but can include clinic based.

ANNUAL GERIATRIC BEHAVIORAL HEALTH CONFERENCE – OHA INVESTS IN WORKFORCE DEVELOPMENT!

- THIS YEAR'S THEME : ASSESSMENT AND RISK IN COMPLEX CASES
- FREE , CEU'S PROVIDED
- TARGET AUDIENCE:
- PASRR LEVEL II CLINICIANS, OLDER ADULT BH SPECIALISTS, ENHANCED CARE STAFF, AGING SERVICES PARTNERS



PROGRAM EVALUATION OF THE OLDER ADULT BEHAVIORAL HEALTH INITIATIVE

- OHA INVESTS IN PROGRAM EVALUATION OF THE INITIATIVE THROUGH A CONTRACT WITH PORTLAND STATE UNIVERSITY'S INSTITUTE ON AGING SINCE 2015.
- <https://www.pdx.edu/ioa/older-adults-with-behavioral-health-needs>



OTHER MENTAL HEALTH PROGRAMS OFFERED BY AGING AND PEOPLE WITH DISABILITIES



This Photo by Unknown Author is licensed under [CC BY](#)

- A RANGE OF EVIDENCE BASED PROGRAMS OFFERED THROUGH THE ADRC AND OR CENTERS FOR LIVING:
 - ✓ PEARLS
 - ✓ WISE
 - ✓ HEALTH IDEAS
 - ✓ HEALING PATHWAYS
 - ✓ HOPE PEER DEPRESSION PROGRAM

What will Maryland do next??

- NO ONE SYSTEM CAN MEET THE COMPLEX NEEDS OF OLDER ADULTS WITH MENTAL HEALTH NEEDS
- USING A MULTI-DISCIPLINARY LENS IS A BEST PRACTICE
- CROSS SECTOR/MULTI- SYSTEMS COLLABORATION AND INTEGRATION LEADS TO MORE RESPONSIVE CARE, PROVIDES FLEXIBILITY AND INCREASES THE SATISFACTION OF THE INDIVIDUALS AND FAMILIES WE SERVE.
- BREAKING DOWN ORGANIZATIONAL, FINANCIAL AND POLICY SILOS IS IMPERATIVE



RESOURCES

- <https://store.samhsa.gov/product/Older-Adults-Living-with-Serious-Mental-Illness-The-State-of-the-Behavioral-Health-Workforce/PEP19-OLDERADULTS-SMI>
- <https://mhttcnetwork.org/centers/northwest-mhttc/integrated-care-older-adults-serious-mental-illness-and-medical-comorbidity>
- [https://www.nasmhpd.org/sites/default/files/TAC.Paper.8.Older Adults Peer Support-Finding a Funding Source.pdf](https://www.nasmhpd.org/sites/default/files/TAC.Paper.8.Older%20Adults%20Peer%20Support-Finding%20a%20Funding%20Source.pdf)
- <https://nasmhpd.org/content/ta-coalition-assessment-working-paper-weaving-community-safety-net-prevent-older-adult>
- **Functional Adaptation Skills Training (FAST): A randomized trial of a psychosocial intervention for middle-aged and older patients with chronic psychotic disorders , Szh Research Vol 86, issue 1-3, sept 2006, 291-299**

RESOURCES

- Improving the system of care for older adults with mental illness in the US – Bartels, S.J , Am Jr Geriatric Psychiatry Sept/Oct 2003:11,5;
- Bartels, S.J , Commentary : The Forgotten Older Adult with Serious Mental Illness The Final Challenge in Achieving the Promise of Olmstead, Jr of Aging & Soc Pol,23:3,244-257
- Last –in-line: Barriers to Community Integration for Older Adults with Mental Illness, Bazelon Center for Mental Health Law 2003
- <https://www.pewsocialtrends.org/2010/12/20/baby-boomers-approach-65-glumly/>

WHAT WILL
YOU DO?

THANK YOU!

NIRMALA DHAR

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