Serving Older Adults with Behavioral Health Needs

Module 2: Behavioral Health Partners in Older Adult Behavioral Health

Presented by Oregon Health Authority, Health Systems Division and Portland State University Institute on Aging
Introductory Modules

1. The Everyday Experience of Aging

2. Behavioral Health Partners in Older Adult Behavioral Health

3. Aging Services Partners in Older Adult Behavioral Health
Clinical Modules

4. What’s Happening with Gladys?
5. Bill’s Search for Lois
6. Has Anyone Seen George?
7. We Have Another Call About Nell!
8. Behavioral Health Issues and Advance Care Planning
Module 2 Objectives

• **Describe aging population trends and risks for poor behavioral health in old age.**

• **Summarize how Oregon’s behavioral health services system works and how to access services.**

• **Explain how Older Adult Behavior Health Specialists can help aging services, behavioral health, and primary care bridge service gaps.**
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• **Explain how Older Adult Behavioral Health Specialists can help aging services, behavioral health, and primary care bridge service gaps.**
The numbers of “old old”—people over 80 or 85—that number is growing rapidly. And they’re the most complex cases, with both mental as well as physical illnesses.

And another significant change is the people with severe mental illnesses are living longer now. . . . and the same can be said for people with intellectual disability.

Tim Malone
Behavioral Health and Oregon’s Changing Demographics

The folks who have mental illness, they’re now having more cognitive dysfunction.

. . . They may be experiencing greater physical health issues.

Hazel Barrett
Demographics
Demographics

• About 20% of people age 55 years or older experience some type of behavioral health concern.

(Older adults and mental health: a time for reform. U.S. Department of Health and Human Services)
Demographics

• About 20% of people age 55 years or older experience some type of mental health concern.

  (Older adults and mental health: a time for reform. U.S. Department of Health and Human Services)

• By 2030, older adults with major psychiatric illnesses will more than double from about 7 million to 15 million.

  (American Association for Marriage and Family Therapy, 2015)
Need

Older adults in need of specialized behavioral health services:
Need

Older adults in need of specialized behavioral health services:
• Those with serious and persistent mental illness
Need

Older adults in need of specialized behavioral health services:
• Those with serious and persistent mental illness
• Those whose problems develop in later life, such as
  • Dementia (10% of older adults)
  • Alcohol and substance abuse (17%)
  • Anxiety (15%–52%) and depression (25% +)
Need

Older adults in need of specialized behavioral health services:

• Those with serious and persistent mental illness
• Those whose problems develop in later life, such as
  • Dementia
  • Alcohol and substance abuse
  • Anxiety and depression
• Those facing developmental challenges, such as
  • Role changes
  • Loss of friends and relatives
  • Declining functional abilities

(The State of Mental Health and Aging America)
Health and behavior health

- Physiological effects of aging
- Health conditions
- Poor health contributes to behavioral health disorders
- Behavioral health disorders contribute to poor health
Prevalence

• Most common conditions:
  • Anxiety disorders

(The State of Mental Health and Aging America)
Prevalence

• Most common conditions:
  • Anxiety disorders
  • Depressive disorders

(The State of Mental Health and Aging America)
Prevalence

• Most common conditions:
  • Anxiety disorders
  • Depressive disorders
  • Severe cognitive impairment

(The State of Mental Health and Aging America)
Prevalence

• Most common conditions:
  • Anxiety disorders
  • Depressive disorders
  • Severe cognitive impairment
  • Schizophrenia

(The State of Mental Health and Aging America)
Suicide

• Nationally, the suicide rate is highest for Non-Hispanic white males over the age 85.
• Rates of suicide are higher in Oregon than the U.S. for the past 30 years.
• Oregon ranks in the top 10.

What is most common?

Anxiety and depression. Those are the two.

Ceec Connelly

... They may have some symptoms, but don’t reach a full depression. I would say primarily depression and anxiety. Kind of situational, whatever is going on in their lives.

Peter Walsh
What is most common?

*The rate of suicide is very high for the elderly, and in fact grows as people get older, especially for Caucasian men. That’s a very high-risk population.*

*Margaret Thiele*
Lifetime Diagnosis of Anxiety Disorder

Percentage of adults aged 50 or older with a lifetime diagnosis of anxiety disorder.

- 0 - 9.38%
- 9.39 - 10.59%
- 10.60 - 12.06%
- 12.07 - 17.62%
- No data

Lifetime Diagnosis of Depression

Percentage of adults aged 50 or older with a lifetime diagnosis of depression.

- 0 - 14.22%
- 15.87 - 18.06%
- 14.23 - 15.86%
- 18.07 - 23.19%
- No data

Co-occurring disorders (COD)

- Person has
  - One or more substance abuse disorders
  - One or more psychiatric disorders
- Lifetime prevalence for those: 40% to 60%
- 20 times more likely to be hospitalized or use emergency services
- Increased rates of homelessness
- Vulnerable to housing insecurity
- Average length of life: 45 years
- 16% of Oregon inmates in jails and prisons
Trauma

- Acute, chronic, complex, system-induced
- Trauma is a primary condition in behavioral health conditions:
  - 90% of mental health clients (most have multiple experiences)
  - 97% of homeless women with severe mental illness
  - Majority in inpatient psychiatric treatment settings
Poor behavioral health—Implications for individuals

Physical health
- Functional disability
- Reduced physical health
- Increased chronic illness
- Slower recovery
- Negative effect on self-care activities
- Increased mortality

Social/emotional well-being
# Poor behavioral health—Implications for individuals

<table>
<thead>
<tr>
<th>Physical health</th>
<th>Social/emotional well-being</th>
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</thead>
<tbody>
<tr>
<td>• Functional disability</td>
<td>• Emotional distress</td>
</tr>
<tr>
<td>• Reduced physical health</td>
<td>• Lost potential, opportunity</td>
</tr>
<tr>
<td>• Increased chronic illness</td>
<td>• Pressure on social network</td>
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<tr>
<td>• Slower recovery</td>
<td>• Burden of care (time, financial strain)</td>
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<tr>
<td>• Negative effect on self-care activities</td>
<td>• Homelessness</td>
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<tr>
<td>• Increased mortality</td>
<td>• Decreased quality of life</td>
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(IOM, 2012)
Poor behavioral health—Social implications

• America spends more money than any other country on geriatric health care.
  • Older adults with serious mental illness are the most expensive group.

• Hidden costs
  • Expensive and extensive emergency department utilization
  • Longer hospital stays
  • More physician visits
  • Workforce strain (lack of providers; lack of training)

• Caregiver burden
Challenges

... the behaviors related to dementia ... The puzzle is solved by figuring out the underlying medical conditions.

... Personality disorders are quite refined by the time that someone is 80 years old. ... The confluence of a personality disorder with dementia. Very challenging.

Tim Malone
Illness like schizophrenia or bipolar, ones that are really difficult to manage throughout life. . . . As they live longer, their behaviors get a little more out of control. Dementia sometimes sets in, so you combine schizophrenia with dementia, and not having a family to support you—it can get a lot more complicated.

Kathy Ayers
Oregon’s Behavioral Health Service System
Oregon behavioral health strategic goals and strategies

- Promotion, prevention, treatment and recovery
- Recovery model—“People get better! People recover!”
- Care is consistent with Culturally and Linguistically Appropriate Services standards
- Health care disparities are addressed
- Behavioral health care is self-directed
- Families are supported and involved
- Diverse community outreach, engagement and collaboration
- Geography is a key factor in statewide planning
- Evidence-based practices, promising practices, and traditional culturally-based practices

(Oregon Health Authority, Addictions & Mental Health Division, 2015–2018)
Olmstead Decision, 1999

*Unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act.*

(Supreme Court, 1999)

(http://www.ada.gov/olmstead/olmstead_about.htm)
Implications of the Olmstead Decision

• Emphasis on self-determination
• Capacity
• Guardianship
• Housing

(Mental Health Law in Oregon, 4th edition, 2012)
Oregon behavioral health system

The Oregon Health Authority contracts with
• 36 Community Mental Health Programs
• 16 Coordinated Care Organizations
• 2 Oregon State Hospital campuses
• One state-run secure residential treatment facility
Oregon behavioral health system

Local services:

• Local Mental Health Authority (LMHA)
• Community Mental Health Programs (CMHP)
Community Mental Health Programs (CMHPs)

Core Services

• Available to all regardless of age and income
• 24/7 crisis services
• Screening, assessment, and referrals
• Civil commitment program
• Abuse investigations
• Care coordination for people with mental illness, intellectual/developmental disabilities, and substance use disorders
• PASRR (Pre-Admission Screening and Resident Review)
Additional CMHP services

- Manage referrals into and out of the State Hospital
- Work with CCOs
  - Manage referrals and oversee utilization review into and out of psychiatric units in local hospital
  - Authorize behavioral health outpatient treatment
- Forensics (jail diversion, psychiatric review board)
- Multidisciplinary Teams
- Housing services
  - Residential treatment homes/facilities
  - Adult foster homes
  - Supported housing
  - Supportive housing
  - Independent housing
- Trauma services
Trauma-informed care

• Philosophy and approach to services and supports
• Acknowledges and addresses the effects of trauma
Trauma Informed Oregon

Statewide collaborative goals:

• Disseminate and adopt best practices
• Establish an inclusive learning collaborative
• Develop the workforce to deliver trauma-sensitive care
• Coordinate and make information and resources accessible
• Establish statewide policies and guidelines that support sustained commitment to trauma-informed care and trauma-sensitive practice
Enhanced Care Services

• Partnership between Aging and People with Disability (APD)-licensed provider and Community Mental Health Program
Enhanced Care Services

• Partnership between APD-licensed provider and Community Mental Health Program
• Located in 11 counties
Enhanced Care Services

• Partnership between APD licensed provider and Community Mental Health Program

• Located in 11 counties

• Admission criteria:
  • Eligible for services through APD
  • Patient at or at-risk for admission to the state hospital
  • Multiple failed placements
  • Need for intensive level of mental health/behavioral supports
Civil commitment
Civil commitment

“A legal process in which a judge decides whether an individual who is allegedly mentally ill should be required to go to a psychiatric hospital or accept other mental health treatment for up to 180 days.”

(Mental Health Law in Oregon, 4th edition, 2012)
Civil commitment

- Hospital, non-hospital facility, or outpatient
- 180 days maximum
- May be a re-commitment process
- Legal rights can be limited in some circumstances:
  - Owning, buying or possessing firearms
  - Driver’s license

*(Mental Health Law in Oregon, 4th edition, 2012)*
Funding sources
Funding sources

• Medicare
  • Traditional
  • Medicare Advantage (HMO, PPOs)
• Oregon Health Plan (Medicaid)
• Dual Eligibles (Medicare and Medicaid)
• Veterans Affairs (TRICARE)
• Private Insurance
• CMHP indigent funding (small amount)
Medicare Part A—
Inpatient behavioral health services

General hospital
• No limit to number of benefit periods
  • Up to 90 days
  • 60 days’ reserve (lifetime)
• Benefit period ends with no hospital care for 60 consecutive days

Psychiatric hospital
• 190 days (lifetime)
Medicare Part A—
Inpatient behavioral health services

Hospital inpatient costs (2014):

- $1,216 deductible each benefit period
- Days 1–60 $0 coinsurance
- Days 61–90 $304 coinsurance per day
- Days 91 + $608 coinsurance up to 60 days (lifetime reserve)
- Beyond reserve All costs
Medicare Part B—Outpatient behavioral health services

• **Type of Providers**
  • Psychiatrist or other physician
  • Clinical psychologist
  • Licensed clinical social worker
  • Clinical nurse specialist
  • Nurse practitioner
  • Physician assistant
Medicare Part B—
Outpatient behavioral health services

• **Providers who accept assignment**
  • Agree to be paid directly by Medicare
  • Accept payment Medicare approves for the service
  • Agree not to bill patient/client for any more than Medicare deductible and co-insurance
Medicare Part B—
Outpatient behavioral health services

• **Types of services**
  • One-time “Welcome to Medicare”
  • Yearly wellness visit, including one depression screening
  • Individual or group psychotherapy (as allowed by state)
  • Family counseling to help with treatment
  • Testing to determine if getting services needed and treatment is helping
  • Psychiatric evaluation
  • Medication management
  • Diagnostic tests
  • Partial hospitalization
Medicare Advantage (Part C)—Behavioral health services

• Provides Medicare Part A, B, D (prescription drug coverage)
• May provide additional behavioral health services
Medicaid

• Oregon Health Plan
• Medicaid expansion: 138% of the poverty level
  • Additional 380,000 individuals qualified (2013)
• 16 Coordinated Care Organizations (CCO)
Oregon health care transformation

Priority #1: Integration of physical and behavioral health services

• Incentives to provide universal screening, intervention, and referral for common concerns (e.g., depression, substance misuse, developmental delays)

• Need to establish positive relationships with community behavioral health providers

(Øyemaja & Muench, 2014, Integrated Behavioral Health Alliance of Oregon)
Accessing behavioral health services

Since the Affordable Care Act, 95% of Oregonians have health care insurance.

Accessing behavioral health:
• Health care plan (member handbook, insurance card)
• Health care provider (integrated primary care)
• Referral from other provider
• Self or family referral
• Crisis service
Accessing behavioral health services

Variation

• Availability of providers, services
• Region (rural, urban)
• Age-specific services
• Public/private payment
• Location of services
  • Behavioral health clinic
  • Primary care clinic
  • In-home
Service gaps

- Misconceptions about aging

Service gaps

• Misconceptions about aging
• Fragmented system of behavioral health care
  • Services are offered in silos
  • Person-centered home and community-based care services
  • Workforce and Caregiver Capacity
  • Cultural Competence

(Older adults and mental health: a time for reform. U.S. Department of Health and Human Services
Service gaps

• Misconceptions about aging
• Fragmented system of behavioral health care
  • Services are offered in silos
  • Person-centered home and community-based care services are limited
  • Workforce and Caregiver Capacity is limited
  • Increasing cultural competence is needed
• Limited availability of good quality services
  • Workforce lacking knowledge of behavioral health and aging
  • Few age-appropriate services

Barriers to services

Few people specialize in older adults.

Transportation is a problem. The location of the services is really hard for people. They have to get there.

Kathy Ayers
Challenges

We’re siloed. We might try to connect, but everybody gets paid for speaking with a client, not speaking with [another] service provider . . .

Hazel Barrett
Challenges

Not enough willing providers . . . doctors wind up restricting their practice to a percentage of older adults . . . because a lot of these clients can be quite overwhelming.

Persons themselves don’t like asking for too much help. Another barrier is previous failed care.

Tim Malone
You hit frontier counties and the very sparsely populated areas when someone begins to need help. It is very difficult to procure the resources for them.

Ceec Connelly

There is still a stigma related to older adults seeking out mental health counseling.

Peter Walsh
What aging services staff should know

- Not to be afraid of mentally ill people
- Need referrals early
- It takes time to treat—no quick fixes
- We can offer more than one kind of therapy
- Mental health needs often are not predictable

- People are allowed to say “no” to mental health services and treatment
- Medications work differently for everyone
- Need constant reminders that coordinated care works (all of us)
- ACA can provide mental health services
Older Adult Behavioral Health Investment

• 25 Older Adult Behavioral Health Specialists throughout Oregon
• OABHS work closely with Community Stakeholders to:
  • Make sure older adults receive appropriate help
  • Remove barriers to care
  • Identify gaps in services
  • Develop strategies to improve community ability to address behavioral health needs
  • Build strong interagency networks to accomplish these objectives
  • Provide training, coaching and technical assistance to community partners
Older Adult Behavioral Health Specialist

Primary Functions

• **Systems integration**—Interagency/multi-system planning to
  • Increase coordination among agencies
  • Improve use of resources and expertise
  • Build better and more responsive infrastructure for clients
Older Adult Behavioral Health Specialist

Primary Functions

• Systems integration—Interagency/multi-system planning

• **Complex case consultation**
  • Provide technical assistance
  • Focus on individuals with cross-systems needs
  • Use/Create a multi-disciplinary team (MDT) approach
  • Identify solutions
Older Adult Behavioral Health Specialist

Primary Functions
  • Systems integration—Interagency/multi-system planning
  • Complex case consultation
  • Education and training
    • Workforce development
    • Community education
Clinical modules (Modules 4-8)
Clinical modules (Modules 4-8)

• *Serving Older Adults with Behavioral Health Needs* training program:
  • Anxiety (fear of falling)
  • Depression
  • Dementia (focusing on Parkinson’s disease)
  • Grief
  • Substance abuse
  • Suicidal behavior
  • Schizophrenia
  • Hoarding
  • Advance care planning
Behavioral Health Conditions

• Not covered in these modules:
  • Delirium*
  • Traumatic brain injury (TBI)
  • Post Traumatic Stress Disorder (PTSD)
  • Personality disorders
  • Bipolar disorders

*covered in the ADRC Tier 2 dementia training series,
https://www.youtube.com/embed/videoseries?list=PLsrX1nc_gB0rrYxDCtl2PpZQ0XBo-MHyP
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• Hazel Barrett, Adult Services Supervisor, Clackamas County Behavioral Health Division
• Kathryn E. Ayers, Clinical Director, Renew Consulting, Inc.
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