Building Community Capacity for Older Adult Behavioral Health

December 2015

I. Executive Summary

Almost one in five older adults in Massachusetts suffers from mental illness and/or substance use. A variety of barriers can prevent many older adults from seeking and accessing behavioral health treatment, including stigma around behavioral health problems; racial and cultural disparities in treatment; limited mobility; lack of transportation; financial and insurance issues; lack of social support; and inadequate coordination across providers. The population of homebound older adults is even less likely to be receiving treatment because of its isolated status. Homebound and isolated elders with behavioral health conditions face high health care costs along with risk of hospitalization, nursing home stays, and housing loss.

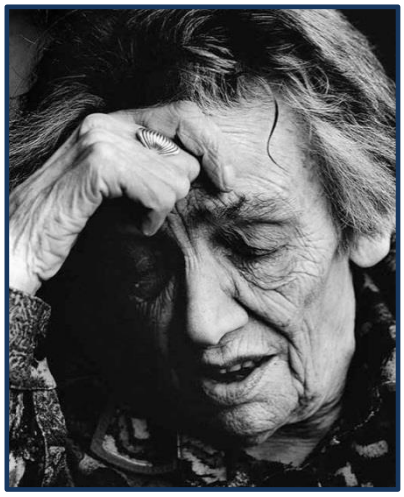
Over 18 months, we aim to target four pilot sites across Massachusetts with a total of 400 homebound and/or isolated adults aged 60 and over who have mental health conditions and/or substance abuse disorders. We propose the following innovative and cost-effective approaches to increase access to and acceptance of treatment, and to reduce the risk of hospitalization, nursing home stays, and/or housing loss in this population:

1. Create and sustain community networks that can identify elders who are at risk and connect them with appropriate, integrated treatment;
2. Build older adults peer specialist support systems to reduce stigma and isolation and strengthen the capacity of the workforce;
3. Implement telehealth solutions to increase access to home-based care.

To carry out this initiative, a total of $2 million is needed for staffing, training, telehealth solutions, and evaluation. Throughout the pilot, strategies for scaling and sustaining the program will be developed and tailored based on ongoing evaluation outcomes.

II. Background

Although estimates of the prevalence of behavioral health conditions among older adults vary, data from Massachusetts indicates that 19.4% of adults 65 and over experience mental illness or substance use disorders, the most common of which are major depression, other depression, and alcohol abuse or dependence.[1] Homebound elders are particularly vulnerable to depression, and their homebound status often prevents them from receiving treatment.[2] In Massachusetts, 9.2% of adults age 60 and over engage in excessive drinking,[3] and growing numbers of older adults misuse prescription medications with abuse potential.[4] As individuals age, substances can have a stronger affect,[5] and unhealthy substance use can have implications for balance and coordination, as well as cognition.[6] Furthermore, community-dwelling older adults with mental health or substance use disorders in Massachusetts show high levels of comorbidity with chronic physical conditions, including hypertension, congestive heart failure, diabetes mellitus, cancer, and others.[7] Elders with behavioral health conditions typically have both high health care costs and low quality of care; [8] these individuals may also have greater hospitalization and emergency department utilization, and higher rates of housing loss and nursing home stays.



In many cases, elders with behavioral health conditions face barriers to seeking and accessing treatment, including limited mobility or homebound status; limited income or insurance coverage; lack of transportation; stigma around mental health treatment; lack of coordination among providers; and inadequate services and social support.[9] Although older adults are more likely to seek mental health treatment in primary care settings, primary care providers detect and adequately treat only 40-50% of elders with behavioral health conditions in their care.[10] Among traditional mental health providers, a

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[1] Lin, W.C., Zhang, Y., Leung, G.Y., & Clark, R.E. (2011). Twelve-month Diagnosed Prevalence of Behavioral Health Disorders among Elderly Medicare and Medicaid Members. *American Journal of Geriatric Psychiatry*, 19(11), 970-979.

[2] Choi, N.G., Sirey, J., & Bruce, M.L. (2013). Depression in homebound older adults: Recent advances in screening and psychosocial interventions. *Current Translational Geriatrics & Experimental Gerontology Report,* 2(1), 16-23.

[3] Dugan, Elizabeth; Porell, Frank; Silverstein, Nina; Palombo, Ruth; and Mann, Stacey, "Massachusetts Healthy Aging Data Report: Community Profiles" (2014). *Gerontology Institute Publications.* Paper 97.
http://scholarworks.umb.edu/gerontologyinstitute_pubs/97

[4] Blow, F.C., & Barry, K.L. (2012). Alcohol and substance misuse in older adults. *Current Psychiatry Reports.* 14(4), 310-319.

[5] Turnheim, K. (2003). When drug therapy gets old: pharmacokinetics and pharmacodynamics in the elderly. *Experimental Gerontology,* 38, 843-853.

[6] Friedman, M.B., & Williams, K.A. (2015). Substance abuse and misuse in older adults. *Behavioral Health News,* (Winter 2015). Retrieved from: http://www.mhaofnyc.org/wp-content/uploads/2014/11/Substance-Abuse-BHN-Winter15.pdf

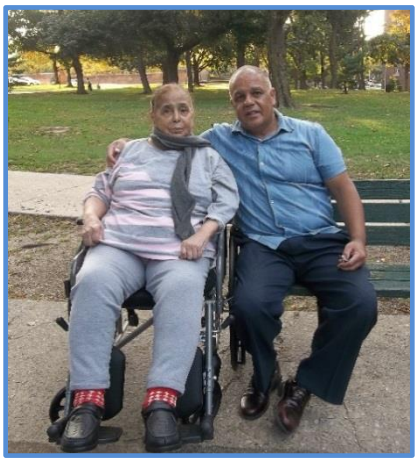
[7] Lin, W.C., Zhang, J., Leung, G.Y., & Clark, R.E. (2011). Chronic physical conditions in older adults with mental illness and/or substance use disorders. *Journal of the American Geriatrics Society,* 59(10), 1913–1921.

[8] Lin, W.C., Zhang, J., Leung, G.Y., & Clark, R.E. (2011). Chronic physical conditions in older adults with mental illness and/or substance use disorders. *Journal of the American Geriatrics Society,* 59(10), 1913–1921.

[9] Bartels, S.J., Blow, F.C., Brockmann, L.M., & Van Citters, A.D. (2005). *Substance abuse and mental health care among older Americans: The state of the knowledge and future directions*. Rockville, MD: WESTAT.

[10] Speer, D., & Schneider, M. (2003). Mental Health Needs of Older Adults and Primary Care: Opportunity for Interdisciplinary Geriatric Team Practice. *Clinical Psychology: Science And Practice*, *10*(1), 85-101.

lack of geriatric training often prevents older adults from receiving adequate care.[11] Furthermore, the number of providers who have expertise in both behavioral health and aging does not meet the demand for these services; according to the American Association for Geriatric Psychiatry, it is estimated that 4,000-5,000 geriatric psychiatrists who provide patient care are needed.[12] Similarly, many providers have expertise in either mental health or substance abuse treatment, but not both.[13]



Access to appropriate treatment becomes further complicated for the growing population of older adults who do not speak English and/or have cultural beliefs that impact their health but may not be recognized by providers. In addition, significant racial disparities in geriatric mental health care exist; for example, Latino and Asian elders are less likely to receive mental health services than other groups.[14]

The evidence points to a critical need to improve access, coordination, and cultural proficiency of behavioral health care for older adults in Massachusetts, in order to improve health outcomes and reduce costs. By investing in more robust community-based mental health initiatives that identify and effectively develop culturally competent treatment plans, we can prevent hospitalizations, nursing home stays, and housing loss; we can support more of these consumers in their home and community as they age, and improve their quality of life. We also seek to promote seamless, coordinated care across transitions and providers, including acute care, post-acute care and long-term services and support (LTSS) providers; physical and behavioral health care, and aging services providers; housing supports, councils on aging, elder and mental health advocates and consumers, and other key community partners.

We propose a collaboration led by the Department of Mental Health (DMH), the Executive Office of Elder Affairs (EOEA), and the Department of Public Health (DPH) that will lead community-based initiatives with the philosophy of "meeting people where they are" by:

- Leveraging **traditional community supports**, including primary care and other health care providers, local aging and behavioral health providers; and simultaneously developing partnerships with **non-traditional community partners** such as first responders, postal workers, clergy, community cultural center staff, community health workers, meals on wheels staff, and others who are likely to have contact with homebound elders. This approach will be modeled after a nationally-recognized

[11] Bartels, S., Dums, A., Oxman, T., Schneider, L., Areán, P., Alexopoulos, G., & Jeste, D. (2003). Evidence-based practices in geriatric mental health care: an overview of systematic reviews and meta-analyses. *Psychiatric Clinics Of North America*, *26*(4), 971-990.
[12] Careers in Geriatric Psychiatry. (n.d.). In *American Association for Geriatric Psychiatry*. Retrieved from http://www.aagponline.org/index.php?src=gendocs&ref=CareersGeriatricPsychiatry&category=Main
[13] National Research Council. (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: The National Academies Press.
[14] Biegel, D.E., Farkas, K.J., & Song, L. (1997). Barriers to the use of mental health services by African-American and Hispanic elderly persons. *Journal of Gerontological Social Work*, 29(1), 23-44.

evidence-based program that has been successfully implemented in other states. The composition of non-traditional community partners will be individualized to each community based on its particular strengths and needs. For example, partnerships with local boards of health might be a key strategy in Prevention and Wellness Trust Fund communities. By building strong community coalitions, we expect case finding and referrals for services to increase.

- Leveraging the role of **trained older adult peer specialists** ("bridgers"), modeled after successful programs such as the University of Pennsylvania's Certified Older Adult Peer Specialist (COAPS), whose goal is to prepare a peer workforce to meet the needs of older adults with behavioral health conditions. We define peers as self-identified current or former consumers of behavioral health services who receive training and certification to offer support and assistance to others with behavioral health needs. Given the deficit of professional providers of geriatric behavioral health services, peers represent a cost-effective approach that shows promising outcomes and may moderate the barriers of stigma and isolation.[15] In Massachusetts, DMH has begun building an older adult peer specialist support system by supporting two older adult peer specialists who work closely with local Aging Service Access Points (ASAPs) and local behavioral health providers to help older adults connect with their community and local resources. In addition, 17 peer specialists aged 55 and over graduated from COAPS training in April 2015. This pilot would train additional peer specialists, including individuals with diverse cultural and linguistic backgrounds. This part of the initiative would therefore: 1) expand the reach and sustainability of existing programs in Massachusetts; and 2) add new strategies for reaching elders with mental health and substance use issues who may not currently receive services.
- Leveraging the role of **telehealth technology** to allow behavioral health clinicians for whom it is currently cost-prohibitive to conduct regular home visits, such as psychologists, clinical nurse specialists, psychiatrists, or substance abuse treatment providers, to provide treatment to homebound and isolated elders. Telehealth technology would also facilitate the inclusion of interpreter services as needed.

III. Project Implementation

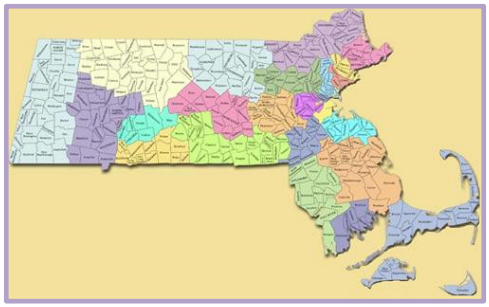
Objectives:

1. Create and sustain **community networks** that can identify older adults who are at risk of mental health/substance use conditions, and connect them with appropriate services and supports through systematic and reliable approaches such as a *No Wrong Door*, or collaboration across health, mental health, and aging services.
2. Develop **older adult peer specialist support systems** by training older adult mental health/substance abuse consumers to provide information, coaching, and in-home one-on-one support to their peers who also have mental health/substance abuse conditions.

[15] Zubritsky, C., Keogh, B., Boyer, B., Mastrine, G., Keppen, S., Wills, J., Rhodes, M., & Kravatz, Y. (2013). *Certified Older Adult Peer Specialists (COAPS) Initiative* [PowerPoint slides]. Retrieved from http://www.parecovery.org/documents/COAPS_Initiative_2013.pdf

3. Implement **telehealth technology** that will allow behavioral health clinicians to provide treatment to homebound and isolated elders remotely.

Pilot Communities:
We have identified four potential regions for the pilot: Greater Lynn, Bristol County, Worcester, and Franklin County. We selected these regions for three reasons:



1. To have a pilot site in the northeastern, southeastern, central, and western parts of Massachusetts; each region would therefore have a lead community that could help with further dissemination of the strategies proposed here over time.
2. To ensure that we reach culturally and linguistically diverse communities, low-income populations, and rural communities. This initiative would help sustain and build on existing services.
3. To incorporate communities with different capacities and needs, including communities with more established geriatric mental health service delivery systems and communities that require more development of new infrastructures. Greater Lynn Senior Services (GLSS) currently has a mobile mental health program with four behavioral health clinicians, and the program was awarded the Geriatric Mental Health Foundation/American Association for Geriatric Psychiatry's *Deirdre Johnston Award for Excellence and Innovation in Geriatric Mental Health Outreach Services*. In addition, Element Care PACE, which has a site in Lynn, has integrated behavioral health into their services to enhance coordination and improve clinical outcomes. Community Counseling of Bristol County (CCBC), in partnership with Bristol Elder Services, is an EOEA Elder Suicide Prevention Program site, and their Elder Mobile Outreach Team (EMOT) provides outreach, mobile treatment, and care coordination for elders in the community who are experiencing mental health and substance abuse issues. In addition, Bristol Elder Services has an older adult peer specialist ("bridger") and could therefore provide guidance on initiating peer specialist supports in other regions. Elder Services of Worcester Area (ESWA), in partnership with provider Community Health Link (CHL), is an EOEA Elder Suicide Prevention Program site and currently has one full time and one part time clinician. Originally funded under the RFR-ELD-2007-01 initiative for mental health services to elders, since FY 08 the Program continues through funding from DPH to provide home and community-based mental health counseling and mental training to outreach staff. In western Massachusetts, Franklin County Home Care Corporation has been developing behavioral health collaborations, including addressing hoarding needs and providing input into the Home Care Aide Council's revised supportive home care aide mental health curriculum, but Franklin County has not received funding for specific mental health programs.

This initiative would develop new capacity in all four regions by enhancing integration across community networks, adding peer supports, and developing telehealth technology to increase access to services.

Methods:
We will develop and pilot a scalable program to promote prevention, enhance identification and outreach, and expand mobile service delivery options for older people with depression, anxiety, isolation, self-neglect, suicidality, unhealthy alcohol or drug use and other common mental health and substance use conditions. This builds on previous grant-funded efforts to train options counselors, COA staff, supportive home care aides, and other community-based providers to recognize signs/symptoms of mental health disorders in older adults and refer as needed. First, all options counselors working at Aging & Disability Resource Consortia (ADRCs) are required to complete an online course on mental health developed by the Boston University Center for Aging & Disability Education & Research (BU CADER) that focuses on enhancing their knowledge, skills, and professional values and ethics. To date, over 225 options counselors have completed this training. Second, BU CADER provided geriatric mental health training to Council on Aging staff in two regions of Massachusetts in 2014 through a grant from the DPH. However, due to limited funds, this has not been expanded more broadly to other regions of the state. Third, the Home Care Aide Council is currently piloting an updated 12 hour mental health curriculum to include best practices for mental health trainings as well as insights from providers, including direct service and supervisory staff. This revised curriculum will enhance the 87 hour training that supportive home care aides receive.

Despite these efforts, access to geriatric mental health care remains inconsistent across Massachusetts, and many professional and non-traditional service providers who have contact with homebound and isolated elders could benefit from basic or additional geriatric mental health training. For example, some ASAPs and COAs provide basic training for drivers who come into contact with homebound and isolated elders to detect and report indicators of behavioral health issues, such as changes in behavior, demeanor, or dress. Expanding these efforts and other similar efforts can help ensure that isolated individuals receive the services they need. Additionally, Protective Services workers often encounter individuals with behavioral health conditions, such as in cases of self-neglect. Although Protective Services workers have the training to recognize individuals with behavioral health conditions, they may benefit from additional community-based options to connect these individuals with appropriate services. We believe that the strategies proposed here (better integrated community networks, older adult peer specialists, and telehealth technology) will further increase home and community-based service utilization and further reduce the risk of institutionalization or homelessness.

The four community-based components of the program will include:

1. **Outreach and Training – Traditional.** Training traditional providers to ensure expertise in geriatric mental health, including primary care and other health care providers such as pharmacists, local aging and behavioral health providers, staff from councils on aging, and home care/home health aides to recognize older adults who may benefit from mobile mental health/substance abuse services and to promote coordinated care across providers and settings;

2. **Outreach and Training – Non-traditional.** Training non-traditional community partners, such as first responders, postal workers, and meals-on-wheels volunteers, to recognize the signs of behavioral health conditions in older adults and refer them for services;
3. **Mobile Service Delivery – Older Adult Peer Specialists.** Training older adults with a history of mental health/substance abuse conditions to act as peer specialists, providing in-home guidance and support;
4. **Mobile Service Delivery – Telehealth**. Telehealth technology will enable behavioral health providers, aging providers, and possibly peer specialists to connect with homebound elders remotely to engage in coaching and support.

Each local entity may partner with other agencies, or independently initiate appropriate referrals and service coordination with local mental health providers, including arranging in-home or telehealth visits when needed. A longitudinal, person-directed care plan will be maintained and shared among all providers. Throughout the pilot initiative, strategies for scaling and sustaining the program will be developed and tailored based on ongoing evaluation outcomes.

Statewide Consortium and Local Steering Committees:

DMH, EOEA, and DPH will also convene a consortium of public and private entities and local experts to address ongoing behavioral health issues in this older adult population, to develop a statewide strategy for integration of mental and physical health and to consider sustainability of any successful pilots (see MMPI report on barriers to integration of behavioral and physical health[16] and report from EOEA, DMH, DPH, and Massachusetts Association of Older Americans (MAOA) on a summit on behavioral health needs among the coming wave of older adults[17]). The consortium may include, but is not limited to, the following: DMH, EOEA, DPH (including BSAS), consumers (particularly those with behavioral health conditions), Department of Transitional Assistance (DTA), Massachusetts Rehabilitation Commission (MRC), Department of Developmental Services (DDS), Senior Care Options (SCO), Program of All-inclusive Care for the Elderly (PACE), LeadingAge Massachusetts, Massachusetts Senior Care Association, MAOA, Mass Home Care, Home Care Aide Council, Boston Health Care for the Homeless Program (BHCHP), MassHealth, Massachusetts League for Community Health Centers (The League), Department of Veterans' Services, Councils on Aging (COAs), Massachusetts Hospital Association (MHA), Massachusetts Association of Behavioral Health Systems (MABHS), American Psychiatric Association (APA), American Psychological Association (APA), Massachusetts Organization for Addiction Recovery (MOAR), Association for Behavioral Healthcare (ABH), Massachusetts Behavioral Health Partnership (MBHP), Massachusetts Medical Society (MMS), National Community Pharmacists Association (NCPA), National Association of Social Workers (NASW) - Massachusetts Chapter, Gerontological Advanced Practice Nurse Association (GAPNA), Association for Behavioral Healthcare (ABH), National Alliance on Mental Illness (NAMI),

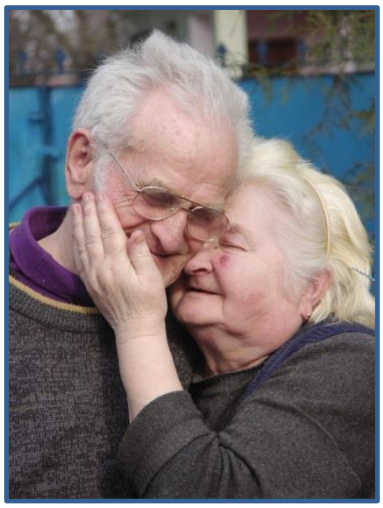
[16] Houy, M., & Bailit, M. *Barriers to Behavioral and Physical Health Integration in Massachusetts,* Massachusetts Medicaid Policy Institute, Blue Cross Blue Shield Foundation, June 2015.

[17] Massachusetts Department of Public Health, Massachusetts Department of Mental Health, Massachusetts Executive Office of Elder Affairs, & Massachusetts Association of Older Americans, Inc. *Summit on Older Adults: Behavioral Health Issues and the Coming Wave*. Massachusetts: Author.

Massachusetts Association for Mental Health (MAMH), and Mass Aging and Mental Health Coalition (MAMHC). Some of these organizations may play larger roles in the consortium, but outreach will be conducted to all.

In addition to the statewide consortium that will provide leadership on evidence-based programs and resources, local steering committees in each pilot community with a self-identified lead agency, will oversee and advise on program implementation in that particular community.

IV. Outcomes and Evaluation



Client Outcomes:

1. Increased acceptance of mental/behavioral health services through increased access to mobile and in-home services, including older adult peer specialist supports;
2. Improved self-reported well-being and self-rated quality of life;
3. Improved scores on standardized measures, such as the nine item depression scale of the Patient Health Questionnaire (PHQ-9).

System Outcomes:

1. Increased number of individuals served through mobile mental health services and older adult peer specialist supports;
2. Increased community capacity to serve homebound/isolated elders with mental health/substance abuse treatment needs;
3. Increased collaboration among aging, public health, health system, and mental health services networks.

Evaluation:

Using data available in Senior Information Management System (SIMS), the MassHealth Data Warehouse, and other sources, we will engage an entity familiar with evaluation of government programs. The evaluation will contribute to the evidence base on the effectiveness of this type of local, multi-agency behavioral health intervention in helping older adults remain in the community.

V. Budget

Over 18 months, we aim to target a total of 400 (100 per site) homebound and/or isolated adults aged 60 and over who have mental health conditions and/or substance abuse disorders, which put them at risk of hospitalization, nursing home stays, and/or housing loss.

Budget Item		Explanation	Amount	Sub-total
Staffing	**Project manager at DMH or EOEA**	Oversight and coordination of initiative, including plan for scaling project based on evaluation outcomes	$80,000	$1,380,000
	Wraparound services	Linguistic and cultural support, including interpreters; housing support; and legal support for each pilot site	$25,000 per site x4 =$100,000	
	Behavioral health clinicians (LICSWs or LMHCs)	Based on the number of behavioral health clinicians in Greater Lynn (4 at GLSS): • Bristol County: 4 behavioral health clinicians with benefits and travel costs • Worcester: 2 additional behavioral health clinicians with benefits and travel costs • Franklin County: 4 behavioral health clinicians with benefits and travel costs	$80,000 x 10 = $800,000	
	Older adult peer specialists	2 per site (based on current cost of existing DMH/EOEA Elder Peer Bridgers)	$50,000 x8 = $400,000	
Training	**Training consultation with evidence-based program**	Best practices; clinician training; marketing materials; additional consultation hours as needed	$16,000	$108,000
	Traditional providers	Per site, approximately 30 (120 total) primary care and other health care providers; local aging and behavioral health providers; councils on aging staff	$300 per person x120 = $36,000	
	Non-traditional providers	Per site, approximately 30 (120 total) first responders, postal	$300 per person x120	

		workers, meals-on-wheels volunteers, and others (based on community strengths and needs)	= $36,000	
	Older adult peer specialists	• Three day training for current Certified Older Adult Peer Specialists (COAPS) with University of Pennsylvania = $10,000 • Holding a COAPS facilitator training class in Massachusetts for graduates who demonstrate the skill and interest to become facilitators, allowing us to sustain Massachusetts' work force needs going forward = $10,000	$20,000	
Telehealth solutions		Contracting with a telehealth provider, including: • Leasing devices • Wi-Fi and/or cellular network costs • Technical training and support	$65 per month per device (including Wi-Fi___33/ network access) x12 months x400 consumers =$312,000 $25,000 per site for training and support x4 =$100,000	$412,000
Evaluation		Contract with an outside academic/research institution to evaluate the project	$100,000	$100,000
TOTAL				**$2,000,000**