
# INTEGRATING OLDER ADULT BEHAVIORAL HEALTH INTO LONG-TERM CARE REBALANCING

## Opportunities and Recommendations for Funders: Public Health Agencies and Managed Care Organizations

A Project of the National Coalition on Mental Health and Aging

January 2017

## About the National Coalition on Mental Health and Aging

The National Coalition on Mental Health and Aging (NCMHA) is comprised of over 80 members representing professional, consumer and government organizations with expertise in mental health and aging issues as well as state and local mental health and aging coalitions. NCMHA provides opportunities for organizations to work together towards improving the availability and quality of mental health preventive and treatment services to older Americans and their families through education, research and increased public awareness.

***The publication of this report is generously supported by the Retirement Research Foundation.***



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## EXECUTIVE SUMMARY

Through various Patient and Protection and Affordable Care Act (ACA) provisions that promote long-term care rebalancing, many states are focused on moving their Medicaid funded long-term care services and supports (LTSS) systems away from a dependency on institutional care and toward a community based system of care. **However, most of the rebalancing efforts across the country have paid very little attention to the behavioral health needs of individuals in transition, including older adults, despite the fact that inadequately addressed mental and behavioral challenges are major drivers of premature, and perhaps unnecessary, placement in institutional settings.** Nearly 50% of individuals receiving long-term care have a mental disorder other than dementia; these disorders frequently co-occur with dementia and/or physical disabilities. Mental disorders are associated with poorer health outcomes, increased functional impairment, and decreased adherence to treatment. **Thus, to effectively reduce institutionalization, costs of care, and improve health and functioning, state long-term care rebalancing efforts must address the behavioral health needs of older people at risk of placement or being transitioned from institutions and of family caregivers who are often under tremendous stress and at high risk of mental health challenges.**

Two major incentives for states to support the integration of behavioral health into community-based long-term services and supports for older adults are 1) the Olmstead decision, which requires that states provide community-based services to persons with disabilities, including older adults and 2) the financial savings to be achieved with the delivery of services in the community as opposed to care delivered in institutional settings.

The report identifies state long-term care re-balancing opportunities for embedding older adult behavioral health supports and services, while also highlighting state initiatives and projects within re-balancing that are addressing the needs of this population.

A series of recommendations for funders of older adult services and supports, including public agencies and managed care organizations, on how to best to support the needs of older adults with behavioral health needs in state long-term care rebalancing efforts are outlined including recommendations pertaining to:

- State Planning
- Role of Managed Care
- Workforce Issues
- Transition Support and Integrated Care
- Financing and Sustainability

Despite the fact that unaddressed behavioral health issues among older adults are major drivers of institutionalization, many long-term care rebalancing efforts fail to adequately integrate behavioral health services and supports. The various long-term care rebalancing initiatives being implemented around the country offer opportunities for states to foster integrated service delivery, and there are numerous examples of states and communities making headway in this area. Despite challenges with fostering adequate service delivery for this population, there are achievable recommendations, which leverage existing services and supports that states can implement to promote older adult behavioral health thus improving their lives and tenure in the community.

## INTRODUCTION

### *Background*

Through various Patient and Protection and Affordable Care Act (ACA) provisions that promote long-term care rebalancing, many states are focused on moving their Medicaid funded long-term care services and supports (LTSS) systems away from a dependency on institutional care and toward a system that embraces consumer choice to receive care in the community. In addition to providing the infrastructure support needed to overcome barriers to delivering community-based care, many of the long-term care rebalancing provisions are focused on ensuring the availability of quality community-based services, particularly assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), to help support tenure in the community. **However, most of the rebalancing efforts across the country have paid very little attention to the behavioral health needs of individuals in transition, including older adults, despite the fact that inadequately addressed mental and behavioral challenges are major drivers of premature, and perhaps unnecessary, placement in institutional settings.**

### *Purpose*

The purpose of this project was to identify state long-term care re-balancing opportunities for embedding older adult behavioral health supports and services, while also highlighting state initiatives and projects within re-balancing that are addressing the needs of this population. The project also sought to provide recommendations for funders of older adult services and supports, including public agencies and managed care organizations, on how to best to support the needs of this population.

### *Methods*

The National Coalition on Mental Health and Aging convened a learning community of representatives from select state mental health and aging coalitions across the country that are involved with long-term care rebalancing efforts in their states. The purpose of the learning community was to:

- Conduct a needs assessment to identify each state's current long-term care rebalancing initiatives and each state coalition's current efforts and challenges in meeting older adult behavioral health issues in long-term care.

- Establish a structure and process to mutually learn about initiatives and projects to effectively meet older adult behavioral health need, strategize on behavioral health long-term care rebalancing issues, support communication and idea sharing across states, and collaboratively develop recommendations for change.

## OLDER ADULT BEHAVIORAL HEALTH NEEDS IN LONG-TERM CARE

Older adults are the fasting growing segment of the US population. As a result of their expansive growth, over the next two decades the number of older adults with mental and/or substance disorders will nearly double from about 8 million people to about 14 million people. Older adults are often not recognized as a high risk population, despite the fact that 20% of older adults have diagnosable mental and/or substance abuse conditions in any given year and that prevalence increases with age[1]. By the age of 85, it is estimated that at least 50% of older adults have a behavioral health issue, including dementia, which frequently co-occurs with other behavioral health conditions, particularly depression and anxiety[2]. Unfortunately, these conditions are frequently untreated among older adults with less than a third of the population in need of mental health services receiving care[3].

Among people needing long-term care, over 55% are over the age of 65. Nearly 50% of individuals receiving long-term care have a mental disorder other than dementia; these disorders frequently co-occur with dementia and/or physical disabilities. As individuals transition from community-based long-term care to institutional care, the prevalence of mental health problems increases[4]. Over 50% of nursing home residents have mental disorders[5,6] and between 10 and 15% of people who are in nursing homes are placed there primarily because they have mental health conditions. In fact, mental disorders of older adults and/or their family caregivers are major reasons for premature and often unnecessary institutional placement[7,8,9,10].

Mental disorders are associated with poorer health outcomes, increased functional impairment, and decreased adherence to treatment. While little is known about how mental disorders affects long-term care costs, mental disorders have a terrible impact on overall costs of physical health care. Older adults with depression and chronic physical conditions, for instance, have roughly 50% higher health care costs than non-depressed older adults[11]. **Thus, to effectively reduce**

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[1] U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general*. Rockville, MD: Author.
[2] Byers, A.L., Yaffe, K., Covinsky, K.E., Friedman, M.B., & Bruce, M.L. (2010). High occurrence of mood and anxiety disorders among older adults: The national comorbidity survey replication. *Archives of General Psychiatry*, *67*(5), 489-496. Jeste, D.V., et al. (1999). Consensus statement on the upcoming crisis in geriatric mental health: Research agenda for the next 2 decades. *Archives of General Psychiatry*, *56*(9), 848-853.
[3] 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.
[4] Hybels, C.F. & Blazer, D.G. (2003). Epidemiology of late-life mental disorders. *Clinics in Geriatric Medicine*, 19, 663-696.
[5] Center for Medicare and Medicaid Services (2013). *CMS OSCAR data current surveys: Medical condition-mental status*. Retrieved from http://www.ahcancal.org/research_data/oscar_data/NursingFacilityPatientCharacteristics/LTC%20STATS_HSNF_PATIENT_2013Q2_FINAL.pdf
[6] Mechanic, D. & McAlpine, D. (2000). Use of nursing homes in the care of persons with severe mental illness: 1985 to 1995. *American Psychiatric Association*, 51, 354-358.
[7] Dorenlot P., Harboun M., Bige V., Henrard J.C., Ankri J. (2005). Major depression as a risk factor for early institutionalization of dementia patients living in the community. *International Journal of Geriatric Psychiatry*, 5, 471-478.
[8] Gaugler, J., Leitsch, S.A., Zarit, S.H., & Pearlin, L.I. (2000). Caregiver involvement following institutionalization. *Research on Aging*, 22, 337-359.
[9] Buhr, G., Kuchighatla, M., & Clipp, E. (2006). Caregivers' reasons for nursing home placement: Clues for improving discussions with families prior to the transition. *The Gerontologist*, 46, 52-61.
[10] Chan, D., Kasper, J.D. Black, B.S., & Rabins, P.V. (2003). Presence of behavioral and psychological symptoms predicts nursing home placement in community-dwelling elders with cognitive impairment in univariate but not multivariate analysis. *The Journals of Gerontology*, *58A* (6), 548-554.
[11] Unutzer, J. (1997). Depressive symptoms and the cost of health services in HMO patients aged 65 years and older. *JAMA* 277, 20.

**institutionalization, costs of care, and improve health and functioning, state long-term care rebalancing efforts must address the behavioral health needs of older people at risk of placement or being transitioned from institutions and of family caregivers who are often under tremendous stress and at high risk of mental health challenges.**

## IMPERATIVE FOR CHANGE

There are two major incentives for states to support the integration of behavioral health into community-based long-term services and supports for older adults. First, the Olmstead decision requires that states provide community-based services to persons with disabilities, including older adults. Second, there is financial savings to be achieved with the delivery of services in the community as opposed to care delivered in institutional settings.

### *Olmstead Decision*

In its 1999 Olmstead v. L.C. decision, the U.S. Supreme Court ruled that states, in accordance with the Americans with Disabilities Act (ADA), have an obligation to provide services to individuals with disabilities in the most integrated setting appropriate to their needs – most often in the community. Since the ruling some states and local governments have begun providing more integrated community alternatives to individuals in or at risk of institutional placement. Yet many people, including older adults with behavioral health challenges, who could and want to live and receive services in integrated community settings are still waiting for the promise of *Olmstead* to be fulfilled. In 2009 President Obama launched "The Year of Community Living" and directed federal agencies to vigorously enforce the civil rights of Americans with disabilities. This has resulted in significant Department of Justice enforcement efforts around the country over the past few years forcing states to make necessary modifications to support community integration for a variety of populations.

The Olmstead ruling demonstrates the legal obligation for states to develop, implement, and fund community-based models of care for older adults with mental health and substance use conditions. Some states have leveraged long-term care rebalancing opportunities to transition individuals, including older adults, from institutions into the community, thus achieving compliance with the Olmstead mandate for this population. However, many states could do more to comply with Olmstead, particularly because states operate Medicaid under broad federal guidelines deciding financial and functional eligibility criteria for LTSS and the range of HCBS that beneficiaries can receive[12]. State can use that flexibility to provide greater opportunity for older adults with behavioral health needs to live in the community.

### *Financial Savings*

One of the main drivers of long-term care rebalancing is the achieved cost containment with the delivery of community-based services and supports as opposed to institutional care. Numerous studies have evaluated the cost effectiveness of home and community-based supported Medicaid services and other efforts to move more resources toward community rather than institutional

[12] Tilly, J. (2016). Promoting community living for older adults who need long-term services and support. Washington, D.C. Center for Policy and Evaluation, Administration for Community Living.

based settings. The studies consistently demonstrate evidence of cost control and a slower rate of growth as states have expanded community-based care.[13]

While most studies of integrated care do not focus on long-term care services, integrated service delivery models that bring together behavioral health and primary care services have shown to result in significant cost savings by adequately addressing behavioral health needs, reducing unnecessary utilization of more expensive health care services, increasing coordination and communication between providers, and improving self-management of chronic health conditions[14]. These integrated care programs have been shown to be cost-effective for a variety of mental health conditions, in diverse settings, in different patient populations, using different payment mechanisms. The implication is that integrated physical and behavioral health services within community-based long-term care is a cost-effective approach to care delivery for an older population.

## LONG-TERM CARE REBALANCING INITIATIVES AND BEHAVIORAL HEALTH

The Affordable Care Act (ACA) has provided states a number of programmatic and financial opportunities to promote long-term care rebalancing. As a result, many states are capitalizing on these opportunities to move their Medicaid funded long-term care services and supports (LTSS) systems away from institutional care and toward a system that embraces consumer choice to receive care in the community. In 2014, over half (53%) of national Medicaid LTSS spending went for home and community-based services (HCBS), the remainder was spent on institutional care. However, these figures vary considerably by state with 24 states having HCBS spending below 50%[15]. Comparing populations, older adults are more likely than younger adults to receive care in institutions. In 2011, nearly half (49%) of older adults received care in the community as compared to 80% of younger adults[16]. There is significant potential for many states to increase their proportion of Medicaid spending on community-based long-term care and to expand that care to older adult beneficiaries.

Many of the long-term care rebalancing provisions are focused on providing the infrastructure support needed to overcome barriers to delivering community-based care and ensuring the availability of quality services, particularly assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), to help support tenure in the community. However, many of the rebalancing efforts across the country are not paying adequate attention to

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[13] Fox-Grage, W., & Walls, J. (2013). *State studies find home and community-based services to be cost-effective*. Washington, D.C.: AARP Public Policy Institute.

[14] Blount, A., Schoenbaum, M., Kathol, R., Rollman, B. L., Thomas, M., O'Donohue, W., & Peek, C. J. (2007). The economics of behavioral health services in medical settings: A summary of the evidence. *Professional Psychology: Research and Practice*, *38*(3), 290-297.

Chiles, J. A., Lambert, M. J. and Hatch, A. L. (1999). The impact of psychological interventions on medical cost offset: a meta-analytic review. *Clinical Psychology: Science and Practice*. *6*(2), 204-220.

Melek,S., Halford, M., & Perlman, D. (2012). *Depression treatment: the impact of treatment persistence on total healthcare costs*. Denver, C.O. Milliman research report.

Woltmann, E., Grogan-Kaylor, A., Perron, B. E., Georges, H., Kilbourne, A. M., & Bauer, M. S. (2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. *American Journal of Psychiatry*, 169, 790-804.

[15] Eiken, S., Sredl, K., Burwell, B., Saucier, P. (2016). *Medicaid expenditures for long-term services and supports (LTSS) in FY2014: Managed LTSS reached 15 percent of LTSS spending*. Truven Health Analytics.

[16] Truven Health Analytics. (2016). *Truven health expert series: Updates on Medicaid home and community-based services*. Retrieved from http://truvenhealth.com/your-healthcare-focus/government/government-expert-series

the behavioral health needs of individuals in transition and their impact on overall well-being, health care costs, and institutional placement. A 2011 report from the Hilltop Institute, *Rebalancing Long-Term Services and Supports: Progress to Date and a Research Agenda for the Future*, noted the need to integrate behavioral health services into LTSS delivery and financing models to better serve individuals in the community as one of the top challenges for states in rebalancing.

***Managed Long-term Services and Supports (MLTSS)***

Managed Long-term Services and Supports (MLTSS) refers to the delivery of long-term services and supports through capitated Medicaid managed care programs. Many states are using MLTSS as a mechanism to expand home and community-based services, foster greater community inclusion, enhance quality, and increase efficiency. Over 20 states have MLTSS programs with great variability among them. They include programs that make capitated payments to contractors primarily for LTSS, programs that make capitated payments to contractors for all or most Medicaid services, and fully integrated Medicare-Medicaid programs that include all Medicaid and Medicare services. Several have proposed large new MLTSS initiatives as part of Section 1115 Medicaid demonstrations or Medicare-Medicaid Financial Alignment demonstrations. As part of the alignment initiative, CMS is testing capitated and/or managed-fee-for service models with states to better align the financing of these two programs and integrate primary, acute, behavioral health and long-term services and supports for their dual eligible beneficiaries.

MLTSS encompasses the broad range of paid and unpaid medical and personal care assistance that people may need when they experience difficulty completing self-care tasks. This includes providing assistance with activities of daily living and instrumental activities of daily living and typically includes care management, respite, day programs, home health aide services, personal care services, transportation, nursing home care as well as assistance provided by an informal caregiver. While most MLTSS programs incorporate mental health and addiction services, the services are often not geared towards recognizing and serving the unique needs of older individuals.

***BIP: State Spotlights***

***SAMHSA*** in partnership with ACL developed and implemented an older adult behavioral health training to help ADRC staff better meet the needs of older adults with behavioral health issues. Eight states participated in the training: Connecticut, Maryland, Massachusetts, New Hampshire, Oregon, Vermont, Washington, and Wisconsin. Training materials can be accessed here (insert link).

***Connecticut*** has incorporated Screening Brief Intervention Referral Treatment (SBIRT) into ADRC assessment and training for staff.

***Illinois's*** BIP funded Nursing Home Deflection demonstration project integrates behavioral health care. The project includes assessments and short term counseling for older adults who do not have a serious mental illness and are not eligible for Medicaid.

***Balancing Incentive Program (BIP)***

The Balancing Incentive Program (BIP), created by the ACA, provided financial incentives to States to increase access to non-institutional long-term services and supports (LTSS). The aim was to support the integration mandate of the Americans with Disabilities Act (ADA), as required by the Olmstead decision. BIP authorized state grants to serve more people in home and community-based settings from October 1, 2011 to September 30, 2015. BIP helped states transform their long-term care systems by:

- Establishing No Wrong Door Systems for people to obtain information on Medicaid LTSS
- Utilizing core standardized assessment instruments to streamline access to LTSS
- Implementing conflict-free case management

Many states have leveraged their existing Aging and Disability Resource Centers (ADRCs) to establish a No Wrong Door (NWD) System. ADRCs serve as single points of entry into the long-term supports and services system for older adults and people with disabilities. ADRCs provide information on the broad range of programs and services, help people understand the various long-term care options available to them, help people apply for programs and benefits, and serve as the access point for publicly-funded long-term care. ADRCs are required to serve all target populations, including people with mental health and substance use conditions and their families. Therefore, ADRC staff are expected to have knowledge and skills to effectively serve people with behavioral health challenges including basic information about behavioral health conditions, identify someone with a behavioral health issue, communicate effectively and refer to appropriate resources. However, not all ADRC staff have been appropriately trained in how to identify, engage, and support individuals with behavioral health issues.

***Community First Choice Option***

The Community First Choice (CFC) Option allowed States to provide home and community-based attendant services and supports to Medicaid enrollees who require institutional level of care under their State Plan. Covered services include attendant services and supports intended to support enrollee say and control over the services they receive. CFC covered:

- Assistance with activities of daily living (ADLs), instrumental activities of daily living (IADL's) and health-related tasks through hands-on assistance, supervision, and/ or cuing
- The acquisition, maintenance, and enhancement of skills necessary to accomplish ADLs, instrumental activities of daily living IADLs, and health-related task
- Backup systems or mechanisms to ensure continuity of services and support
- Support system activities (such as needs assessment, assessment counseling, risk assessment and management, and person-centered service planning)
- Voluntary training on selecting, managing, and dismissing attendants

Of individuals served through CFC, in all but one state, at least half of the population receiving CFC was over 65 years old. There was also high prevalence of mental health conditions, chronic illness, and functional impairment among enrollees served through CFC. While many individuals

being served had behavioral health issues, there was no coverage of mental health supports to either support their transition or retention in the community[17].

### *1915(i) Home and Community-Based Services State Plan Option*

The 1915(i) Home and Community-Based Services (HCBS) State Plan Option gives states the option to provide home and community-based services as a state plan service, therefore, without having to obtain a waiver from the federal government. The Affordable Care Act expanded coverable services under 1915(i) to include any of the HCBS permitted under section 1915(c) HCBS waivers, certain services for individuals with behavioral health disorders, and other services requested by a state and approved by the federal government. In addition, the changes support ensuring the quality of HCBS, require states to offer the benefit statewide and enable states to target 1915(i) State Plan HCBS to particular groups of participants but not limit the number of participants who may receive the benefit. The 1915(i) HCBS State Plan Option has afforded states new opportunities to better meet the mental health challenges of older adults, but there are not specific state initiatives targeting the needs of this population.

### *Money Follows the Person*

The Money Follows the Person (MFP) Rebalancing Demonstration Grant, which was strengthened and expanded through the Affordable Care ACT, helped states rebalance their Medicaid long-term care systems transitioning individuals with chronic conditions and disabilities from institutions back into the community. The goals of the program were to:

- Increase the use of HCBS and reduce the use of institutional services
- Eliminate barriers in law, Medicaid plans, and budgets that restrict the use of Medicaid funds to allow people to get long-term care in the community
- Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions
- Implement procedures to provide quality assurance and improvement of HCBS

Importantly, the MFP demonstrations gave states the flexibility to test new service innovations to help meet participant's needs in the community[18]. The Mathematica Policy Research, *National Evaluation of the MFP Demonstration,* reviewed state MFP demonstrations that are implementing a variety of innovative approaches to enhance the stabilization of care and support for MFP recipients transitioning into the community. States have focused on pre-transition and short-term services, expanding scope of transition coordination, or investing in services available after discharge, some of which focus on behavioral health[19].

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[17] Burwell, S.M. (2015). *Report to Congress: Community First Choice as required by the Patient Protection and Affordable Care Act of 2010*. Washington, DC.: Department of Health and Human Services.
[18] Denny-Brown, N., Hagen, B., Bradnan, C., & Williams, S. (2015). *The right supports at the right time: How money follows the person programs are supporting diverse populations in the community*. Cambridge, M.A.: Mathematica Policy Research. Peebles, V & Kehn, M. (2014). *Innovations in home and community-based services: Highlights from a review of services available to money follows the person participants*. Cambridge, M.A.: Mathematica Policy Research.
[19] Irvin, C.V. (2-15). *Money follows the person 2014 annual evaluation report*. Cambridge, M.A.: Mathematica Policy Research.

While some states are focusing on the mental well-being of older MFP recipients, states with MFP demonstrations could be doing far more to target behavioral health services for this population. A Mathematica Policy Research annual review of the MFP shows that the most common reason for re-institutionalization is deterioration in physical or mental health status,

***MFP: State Spotlights***

***Ohio's*** MFP demonstration trained behavioral health specialists to serve as transition coordinators, which were available for all individuals with behavioral health needs and were extended 90 days past transition. The specialists are assigned to MFP participants who are already obtaining services in the behavioral health system, ensuring continuity of care and increasing the likelihood that participants will remain engaged with service providers post transition. Ohio MFP also provides counseling services to MFP participants, their guardian, caregiver, or family member to help support a stable and supportive environment for the individual transitioning.

***Washington's*** MFP demonstration provided transitional mental health services to address mental health needs during the transition process, which was available to any MFP participant with an identified mental health need in their care plan.

***Illinois's*** demonstration program focused on individuals with a primary diagnosis of mental illness, although not focused on older individuals. They provided transition staff with training to increase their competence in serving individuals with complex mental and physical conditions. Additionally, appropriate MFP participants were linked with an assertive community treatment-team to ensure continuity of care post-transition.

The ***Georgia*** MFP Pilot engaged behavioral health experts in planning for transition which assisted the transition coordinator in linking individuals to behavioral health services. Recommendations were made that prior to transition a thorough behavioral health assessment be provided by the community-based mental health provider for all persons with a behavioral health diagnosis and/or taking psychotropic medications in order to better understand the persons support service needs and to engage the individual in their new community-based behavioral health services. The challenge that Georgia had was community behavioral health providers have limited staffing and reimbursement capacity which would allow them to provide a behavioral health assessment in the skilled nursing facility prior to discharge ensuring a successful transition. Georgia's Area Agencies on Aging and public mental health providers are working closely to improve collaboration across systems in an effort to improve the care of older adults with behavioral health disorders living in the community.

***Maryland***'s MFP formed a Behavioral Health Workgroup that developed a set of key recommendations for addressing the behavioral health needs of MFP recipients. One of the recommendations that was adopted was to hire regional behavioral health specialists who would have geriatric expertise and would support both better care in nursing homes and appropriate transition into the community.

with older adults making up the majority (53%) of re-institutionalizations[20]. States should do more to focus on the behavioral health needs of older adults who have transitioned as a way to decrease the risk of re-institutionalization.

[20]Morris, E. et al. (2016). *Money follows the person demonstration: Overview of state grantee progress, January to December 2015*. Cambridge, M.A.: Mathematica Policy Research.

## CHALLENGES AND RECOMMENDATIONS FOR CHANGE

As noted, state long-term care rebalancing efforts barely recognize the importance of older adult mental and behavioral health services. To address this shortcoming, below is a series of recommendations for improving attention, funding, and supports for this population starting with key values and principles for effectively serving older adults with behavioral health needs.

### *Values and Principles for Supporting Older Adults with Behavioral Health Challenges*

While there is not a separate system of care for serving the older population, it is imperative that states incorporate the below values and principles in establishing services and supports for older adults with behavioral health conditions. These overarching values and principles are key to developing an appropriate service delivery system that is responsive to an older population's unique needs and challenges.

**Core Values**

- **Person-centered:** Afford older adults the opportunity to decide where and with whom they live, to have control over the services they receive, and who provides the services.

- **Generationally, culturally, and linguistically competent:** Provide accessible information and services that take into account generational, cultural, and linguistic needs of the older adults served and eliminate disparities in care.

- **Community-based**: Services should be provided in the community and support the tenure of older adults to remain in the community as they age.

**Principles**

- Ensure availability and access to a broad, flexible array of effective, community-based services and supports for older adults.

- Provide individualized services in accordance with the unique potential and needs of each older adult.

- Ensure that services and supports include evidence-based and promising practices to ensure the effectiveness of services and improve outcomes for older adults.

- Deliver services and supports within the most integrated setting that is clinically appropriate.

- Ensure that older adults and their caregivers are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for older people.

- Ensure that physical and behavioral health services are integrated, where possible, and coordinated across multiple service delivery systems.

- Provide generationally appropriate services and supports that promote optimal outcomes for older adults in their homes and community settings.

- Emphasize mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes for older adults.

- Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of desired outcomes

***State Planning***

While there are sporadic programs and projects that focus on older adult behavioral health in long-term care, there has been no systemic effort by states to integrate mental health and substance use care for older individuals in long-term rebalancing efforts. This is represented by limited attention to these issues in state plans, lack of expert representation on planning and advisory committees, and absence of funding for integrated services.

***State Planning: State Spotlight***

The ***Indiana*** Division of Aging State Plan 2015-2018 includes addressing behavioral health issues among older adults specifically "elevating awareness of older adults who are at risk for mental health and substance abuse issues".

***Recommendations:***

- Recast long-term care re-balancing initiatives to recognize the importance of mental health

- Incorporate the mental health and substance use needs of older adults and plans for addressing them in relevant state plans

- Include older adult behavioral health representatives on long-term care planning and advisory groups

- Develop an interagency approach to older adult behavioral health workforce development and training across the service delivery system

- Foster better coordination among the long-term care, behavioral health, and aging service systems, such as via MOUs, to facilitate better access to services, ensure seamless transitions across programs, and promoted integrated care.

***Role of Managed Care***

Increasingly the care for older adults receiving or in need of community-based long-term care is being managed by managed care organizations. Some managed care plans, like the dual eligible demonstration programs, include integration of physical and behavioral health services, while others plans serving older adults do not. Even where plans that are serving an older population integrate care, there is little attention to providing supports and services tailored to the unique

issues and needs facing an older population with complex medical and psychiatric comorbidities. Managed care companies would be wise to invest in approaches that focus on the behavioral health needs of an older population and that emphasize cost-effective, integrated service delivery models.

***Recommendations:***

- Invest in evidence-based older adult behavioral health models (See Appendix for list of interventions.)

- Explore financing innovative workforce roles and models that leverage non-mental health professionals, such as peers, paraprofessionals, care and case managers, and community health workers, to identify behavioral health issues and deliver low behavioral health interventions[21].

- Emphasize outcomes that go beyond decreasing ER visits and hospitalizations such as addressing quality of life and the social determinants of health.

***Workforce Issues***

As noted in The Institute of Medicine of the National Academies (IOM) Report, *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands*?, the biggest challenge with meeting the behavioral health needs of older adults is that the workforce serving older adults is not large enough nor adequately trained to meet the mental health needs of this growing population[22]. Older adults with behavioral health issues are served by a diverse array of providers in the health, mental health and aging service sectors. This includes:

- Health/long-term care: Primary care physicians, advanced practice nurses, physician assistants, community health workers, occupational therapists, direct care workers

- Mental health care: Psychiatrists, psychiatric/ mental health nurse practitioners/ psychiatric clinical nurse specialists, psychologists, social workers, counselors, marriage and family therapists, peer support specialists

[21] Stanley, M. et al. (2014). Lay providers can deliver effective cognitive behavior therapy for older adults with generalized anxiety disorder: a randomized trial. *Depression and Anxiety*. *31*(5), 391-401.
[22] Institute of Medicine. (2012). *The mental health and substance use workforce for older adults*: *In whose hands?* Washington, DC: The National Academies Press.

- Aging service providers in senior centers, day programs, and case management programs

- Family and unpaid caregivers

Education and training for this workforce often does not include skills and competences needed to serve older adults with behavioral health issues. While there are geriatric behavioral health specialists—providers with specific training and expertise to serve older adults—there are far too few to meet the current, let alone, growing demand for care. Given the limited number of geriatric behavioral health specialists, the larger, diverse workforce noted above must be equipped with the skills to identify, engage, and treat or referral to appropriate care.

***Workforce Development: State Spotlights***

***Illinois*** is using the Health Resources and Services Administration (HRSA) Geriatrics Workforce Enhancement Program, which supports the development of the health care workforce to improve health outcomes for older adults, to train providers in PEARLS, an evidence-based older adult behavioral health intervention.

***Maryland*** has trained the state's ADRC workforce in the Mental Health First Aid Older Adult Module.

***Recommendations:***

- Build the generational competency of the diverse workforce serving older adults

- Develop and make use of new direct service roles such as community health workers, care coordinators, and peers to serve older adults with behavioral health needs[23]

- Develop cadres of providers in the mental health and substance abuse, health and aging service sectors trained and skilled in working with older adults with behavioral health conditions

- Provide psychoeducation and behavioral health training for informal caregivers

- Expand the behavioral health specialists who can be reimbursed by Medicare and Medicaid (e.g., allow Psychiatric Clinical Nurse Specialists to be reimbursed by Medicaid, allow Licensed Professional Counselors, Licensed Marriage and Family Therapists and Certified Peer Specialists be reimbursed by Medicare

***Transition Support and Integrated Care***

Most older adults with behavioral health challenges transitioning from institutional to community care are not getting proper behavioral health supports. Reasons include that they have unidentified behavioral health issues, mental health services are not integrated as part of the long-term rebalancing program, or there are limited mental health services available in the community. Integrated service delivery, particularly integration of physical health and

[23] Stanley, M. et al. (2014). Lay providers can deliver effective cognitive behavior therapy for older adults with generalized anxiety disorder: a randomized trial. *Depression and Anxiety*. *31*(5), 391-401.

behavioral health services, has expanded over the past several years. However, integrated care continues to be the exception and not the norm, especially for older adults with mental health and substance use needs.

***Transition Support Recommendations:***

- Ensure proper screening and assessment of older adults transitioning into the community so that behavioral health needs get identified
- Promote coordination between transition teams and community-based behavioral health providers to ensure seamless community transition and access to mental health services
- Prepare older consumers for community transition by providing transitional supportive counseling and utilizing evidence-based rehabilitative transition interventions, where appropriate (See Appendix A for list of interventions.)

***Integrated Care Recommendations:***

- Foster better integration of long-term care rebalancing programs, mental health, substance use, and non-Medicaid funded aging service programs
- Promote use of interdisciplinary, integrated service teams for older adults with complex medical and behavioral health needs
- Integrate evidence-based behavioral health models into community-based LTSS, particularly low cost interventions delivered by staff already delivering direct LTSS care (See Appendix for list of interventions.)

***<u>Financing and Sustainability</u>***

The various long-term term care rebalancing initiatives are effective mechanisms for embedding and sustaining older adult behavioral health services and supports. According to a SAMHSA and NCOA report on *Lessons Learned on Sustainability of Older Adult Community Behavioral Health Services* there are key program, organizational, and community factors that serve as a framework for sustainability. Key findings from the project are noted below in the recommendations[24].

***Financing: State Spotlight***

***Washington*** State used their Medicaid HCBS 1915-c Waiver to fund PEARLS, an evidence-based care management intervention for older adults with depression.

[24] McNeil, A. & Watson E. (2012). *Lessons learned on sustainability of older adult community behavioral health services*. Arlington, VA: National Council on Aging.

***Recommendations***:

- Embed behavioral health services and supports into already existing and ongoing routine services and service delivery systems

- Explore braiding different private and public funding sources including from the health, mental health, and/or aging service sectors

- Explore billable services as a mechanism for sustainability

To further explore opportunities for financing older adult behavioral health services, view the Financial Resource Guide section from the above SAMHSA and NCOA report.

## CONCLUSION

Despite the fact that unaddressed behavioral health issues among older adults are major drivers of premature and perhaps unnecessary institutionalization, many long-term care rebalancing efforts fail to adequately integrate behavioral health services and supports. Both the Olmstead decision and the financial savings to be achieved should be key motivators for states to do more to address the mental health and substance use challenges of the growing population of older Americans. The various long-term care rebalancing initiatives being implemented around the country offer opportunities for states to foster integrated service delivery, and there are numerous examples of states and communities making headway in this area. Despite challenges with fostering adequate service delivery for this population, there are achievable recommendations, which leverage existing services and supports that states can implement to promote older adult behavioral health thus improving their lives and tenure in the community.

## Effective Mental Health and Substance Abuse Interventions for Older Adults and Their Caregivers

There are a number of effective treatment interventions to address mental health and substance use conditions in older adults and their caregivers. Many, although not all, of the below complied list of interventions are drawn from SAMHSA's National Registry of Evidence-Based Programs (NREPP) website, which features a comprehensive, searchable registry of mental health and substance abuse interventions that have been reviewed and rated. The registry was designed to provide the public with access to scientifically-based approaches to preventing and treating mental and/or substance use disorders that can be readily disseminated to the field. A few of the interventions are also listed on the Administration on Aging (AoA), (now Administration for Community Living (ACL)) website and have been identified as meeting AoA's criteria of being evidence-based and suitable for older adults. Many of the below interventions have training materials, tool kits and/or manuals readily available.

Interventions are organized by target area:

- Caregiver interventions
- Mental health interventions
- Substance abuse interventions
- Transitional support interventions

### *Caregiver Interventions*

**New York University Caregiver Intervention (NYUCI)**
NYUCI is a counseling and support intervention for spousal caregivers that is intended to improve the well-being of caregivers and delay the nursing home placement of patients with Alzheimer's disease. The program also aims to help spouse caregivers mobilize their social support network and help them better adapt to their caregiving role.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=74

**Resources for Enhancing Alzheimer's Caregiver Health II (REACH II)**
REACH II is a multicomponent psychosocial and behavioral training intervention for caregivers (21 years and older) of patients with Alzheimer's disease or dementia. The intervention is designed to reduce caregiver burden and depression, improve caregivers' ability to provide self-care, provide caregivers with social support, and help caregivers learn how to manage difficult behaviors in care recipients.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=129

***Mental Health Interventions***

**Cognitive Behavioral Social Skills Training (CBSST)**
CBSST is a psychosocial rehabilitation intervention designed to help middle-aged and older outpatients with schizophrenia and other forms of serious mental illness achieve their functioning goals related to living, learning, working, and socializing in their community of choice. CBSST combines cognitive behavioral therapy (CBT) and social skills training (SST) techniques.
http://www.cbsst.org

**Cognitive Behavioral Therapy (CBT) for Late-Life Depression**
CBT for Late-Life Depression is an active, directive, time-limited, and structured problem-solving approach program that follows the conceptual model and treatment program developed by Aaron Beck and his colleagues. Patients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and develop more adaptive and flexible thoughts. The intervention consists of up to 20 50- to 60-minute sessions following a structured manual.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=119

**EnhanceWellness**
EnhanceWellness is a person-centered motivational intervention for older adults with chronic conditions. The program's goal is to help men and women better manage their illnesses and minimize related problems such as unnecessary use of prescription psychoactive medications, physical inactivity, depression, and social isolation.
http://www.projectenhance.org/enhancewellness.aspx

**Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)**
Healthy IDEAS is an evidence-based program that integrates depression awareness and management into existing case management services provided to older adults. Healthy IDEAS ensures older adults get the help they need to manage symptoms of depression and live full lives.
http://careforelders.org/healthyideas

**IMPACT (Improving Mood--Promoting Access to Collaborative Treatment)**
IMPACT is an intervention for patients 60 years or older who have major depression or dysthymic disorder. The intervention is a 1-year, stepped collaborative care approach in which a nurse, social worker, or psychologist works with the patient's regular primary care provider to develop a course of treatment.
http://impact-uw.org/

**Interpersonal Psychotherapy (IPT)**
IPT is a time-limited therapy in which depressive symptoms are explored and psychoeducation is given. Depressive symptoms are linked to related interpersonal events. Before concluding, the patient is supported while he or she considers and works out possible solutions.

van Schaik, A. et al. (2006). Interpersonal psychotherapy for elderly patients in primary care. *Archives of General Psychiatry, 14*(9). Retrieved from
http://www.ncbi.nlm.nih.gov/pubmed/16943174

**Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT)**
PROSPECT aims to prevent suicide among older primary care patients by reducing suicidal ideation and depression. It also aims to reduce their risk of death. The intervention components are (1) recognition of depression and suicidal ideation by primary care physicians, (2) application of a treatment algorithm for geriatric depression in the primary care setting, and (3) treatment management by health specialists (e.g., nurses, social workers, psychologists).
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=257

**Problem Solving Therapy**
PST is a problem-focused process consisting of seven different steps: problem identification, goal setting, brainstorming, pros and cons, solution selection, solution implementation and solution evaluation. The ultimate goal is to allow for patients to use their own ability to solve problems, which in turn increases their confidence and feelings of self-control.

Alexopoulos, G.S, et al. (2011). Problem-solving therapy and supportive therapy in older adults with major depression and executive dysfunction: effect on disability. *Arch Gen Psychiatry, 68*(1). Retrieved from www.ncbi.nlm.nih.gov/pubmed/21199963.

**The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)**
PEARLS is an intervention for people 60 years and older who have minor depression or dysthymia and are receiving home-based social services from community services agencies. The program is designed to reduce symptoms of depression and improve health-related quality of life. PEARLS provides eight 50-minute sessions with a trained social service worker in the client's home over 19 weeks.
http://www.pearlsprogram.org/

***Substance Abuse Interventions***

**Brief Intervention and Treatment for Elders (BRITE)**
BRITE is a project based in Florida serving individuals 55 years and older using the SBIRT approach. Clients are offered screening, brief intervention, and brief treatment by generalist providers or are referred to more intensive care by a substance abuse specialist provider agency. Services are offered in such places as retirement communities, senior centers, general and trauma hospitals, primary care and urgent care clinics.
http://brite.fmhi.usf.edu/BRITE.htm

**Screening, Brief Intervention, and Referral to Treatment (SBIRT)**
SBIRT is an integrated approach to the delivery of early intervention and treatment for those who are at risk for or are currently dealing with substance use disorders. Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Brief intervention focuses on increasing awareness regarding substance use and creates motivation toward behavioral change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.
http://www.samhsa.gov/prevention/sbirt/

***Transitional Support Interventions***

**Cognitive Adaptation Training**
Cognitive Adaptation Training (CAT) is an evidence-based rehabilitative approach that utilizes environmental supports to help individuals with serious mental illness compensate for impairments in cognitive functioning and manage their day to day lives in the community.

Draper, M. L., Stutes, D. S., Maples, N. J., & Velligan, D. I. (2009). Cognitive adaptation training for outpatients with schizophrenia. Journal of Clinical Psychology, 65(8), 842-853. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19521972

**Functional Adaptation Skills Training (FAST)**
FAST is an intervention for adult patients 40 years and older living in board-and-care facilities who have been diagnosed with schizophrenia or schizoaffective disorder. The goal of FAST is to improve patients' independence and quality of life. Participants in FAST meet once per week, in a group format, over the course of 24 weeks.
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=92

**Helping Older Persons Experience Success (HOPES):**
HOPES is an evidence-based group based skills training program designed to help older persons with serious mental illness successfully live in the community and transition from and stay out of nursing homes. The intervention focuses on community living skills, social skills, and health management. HOPES is associated with sustained long-term improvement in functioning, symptoms, self-efficacy, preventive healthcare screening, and advance care planning

Bartels et al. Long-term outcomes of a randomized trial of integrated skills training and preventive healthcare for older adults with serious mental illness. *American Journal of Geriatric Psychiatry*,2013. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23954039

## State Mental Health and Aging Coalition Participants and NCMHA Executive Committee Members

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Geriatric Mental Health Alliance of New York Director