Central East (HHS Region 3)
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Improving Services for Older Adults

Integrated Care Needs of Older Adults with Serious Mental Illness and Implications for Effective Care Transitions

July 10, 2019

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Substance Abuse and Mental Health Services Administration
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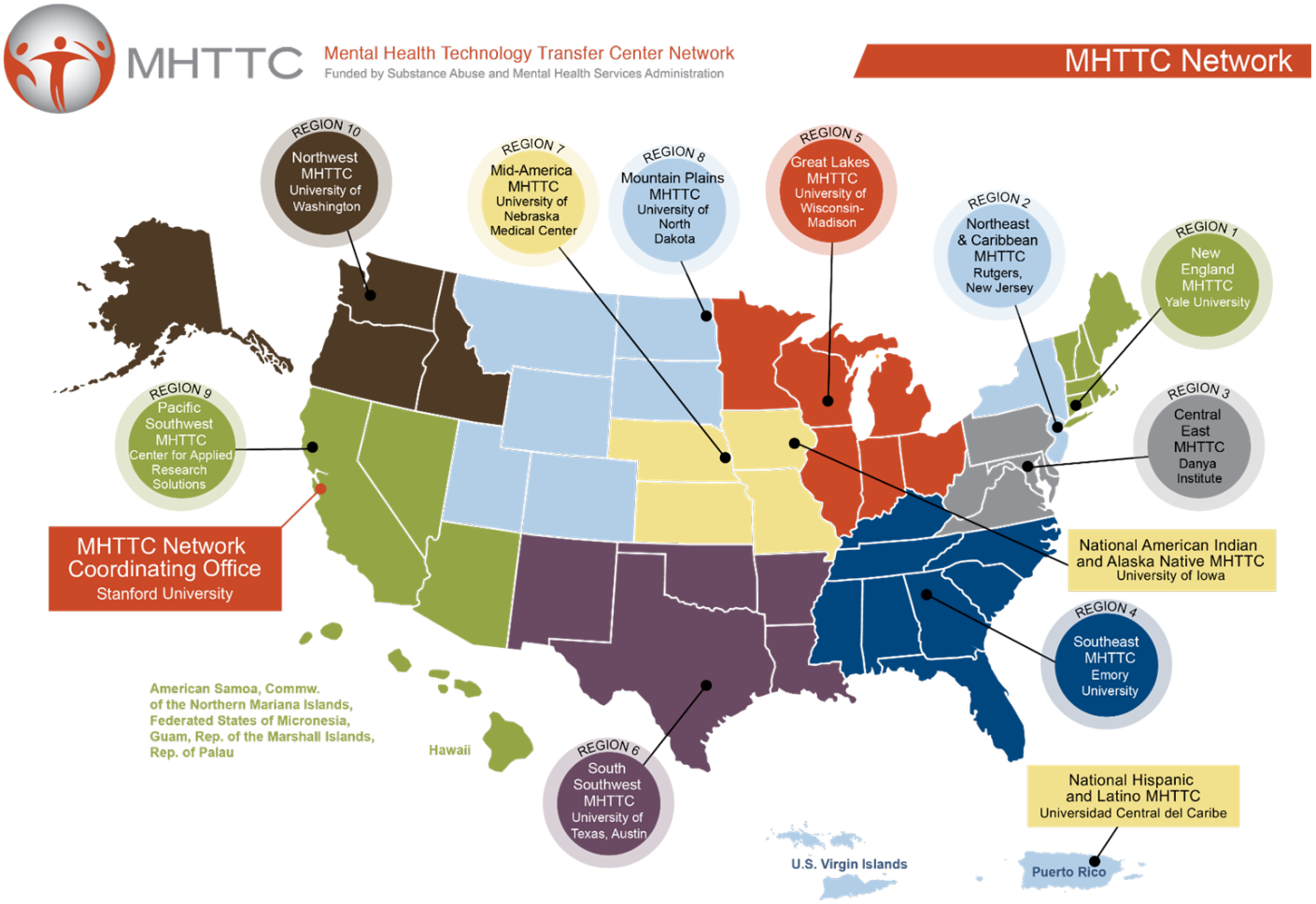
Integrated Care Needs of Older Adults

- **Facilitator**
  - John Hudgens, Advocates for Human Potential, Inc.

- **Speakers**
  - Alicia D. Smith, MHA, President
    Vorys Health Care Advisors LLC

  - Melissa Sparks, MSN, RN, Deputy Assistant Commissioner
    Tennessee Department of Mental Health and Substance Abuse Services.

MHTTC Network



Central East MHTTC Goals

Funded by SAMHSA to:

- Accelerate the adoption and implementation of mental health related evidence-based practices
- Heighten the awareness, knowledge, and skills of the behavioral health workforce
- Foster alliances among culturally diverse practitioners, researchers, policy makers, family members, and consumers
- Ensure the availability and delivery of publicly available, free of charge, training and technical assistance

Central East Region

HHS REGION 3

Delaware

District of Columbia

Maryland

Pennsylvania

Virginia

West Virginia

Improving Services for Older Adults

~~June 26~~ Recording Available — The Changing Demographic Landscape & Effective Planning to Achieve Service System Changes

July 10 — Integrated Care Needs of Older Adults with Serious Mental Illness and Implications for Effective Care Transitions

August 8 — Organizational and Systems Readiness for Ensuring Access to Appropriate Care Levels

Optional Follow Up Discussion Groups - TBA

Session Two Overview

- Summary of Session 1 Discussion
- Integrated Care Needs & Care Transition for Older Adults
- Lessons Learned
- System of Care Framework

Alicia D. Smith, MHA

President, Vorys Health Care Advisors LLC

Session #1 Quick Recap

Population Characteristics

Overall Health Issues

Mental Health & Substance Use Concerns

Social Determinants of Health

Session #1 Quick Recap (cont'd)

- Discussion of Virginia's historical investment in institutional settings
- Lack of care continuum for older adults with co-occurring neurocognitive disorders, behavioral challenges, and medically complex conditions
- Lack of comprehensive, coordinated network of services and supports resulted in older adults with complex needs being primarily served by public sector - *at times of crisis*
- State Level Long- and Short-Term Strategies
  - Enhance community-based services
  - Enhance cross agency collaboration
  - Embed incentives for evidence informed practices
  - Develop centers of excellence and support

Session #1 Quick Recap (cont'd)

- Northern Virginia's local response was creation of RAFT (Regional Older Adult Facility Mental Health Support Team)
- Program successes include:
  - Decreased hospitalizations at state-operated facility
  - Intensive mental health services resulting in diversion
  - Problem resolution with stakeholders to create flow to community
  - Creating trust with long-term service and support (LTSS) system
- Lessons learned related to culture change, recognition of mental illness as a medical condition, education training, funding

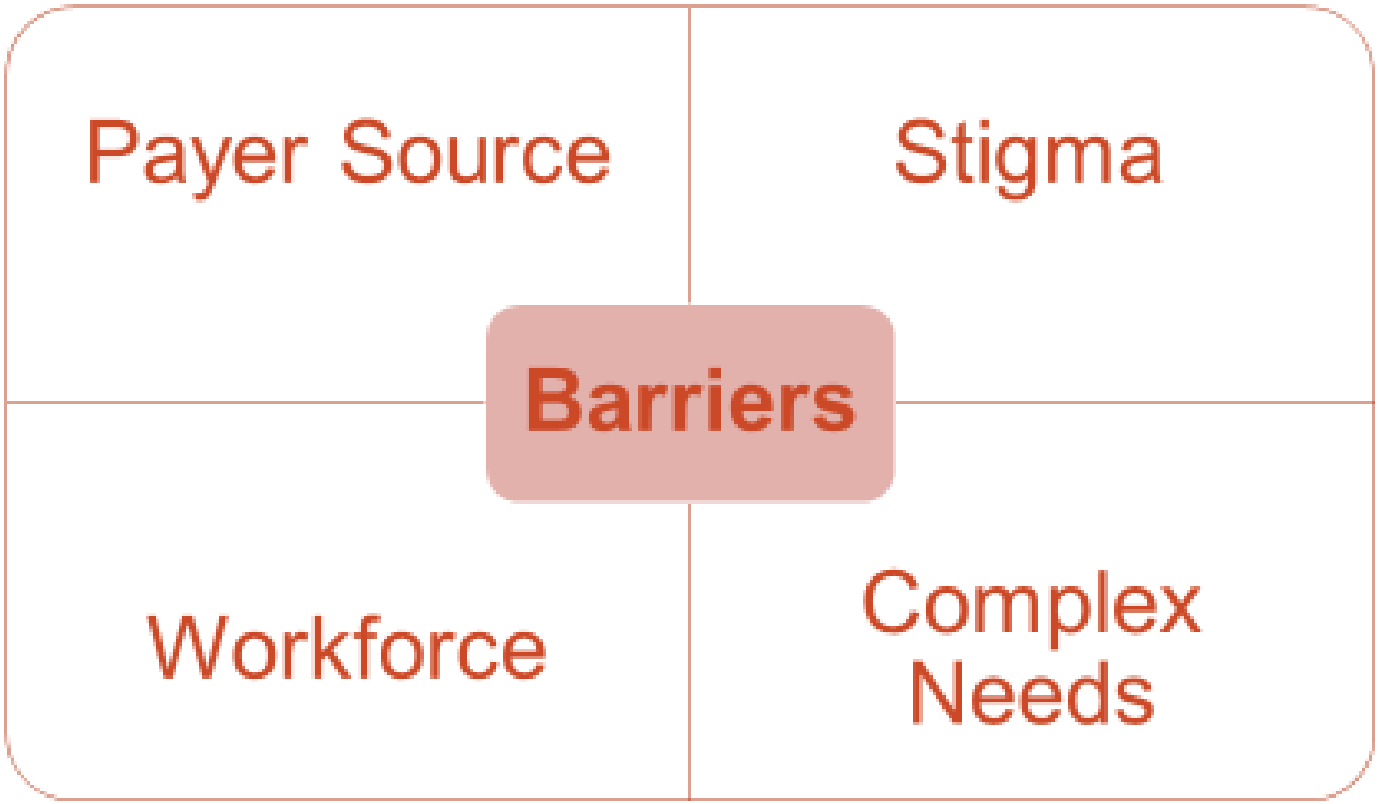
Region 3 Older Adult Projections

Region 3 Older Adult Behavioral Health Profiles

65+ Age Group	2015	2025	2030	65+ Adults Served by the state Mental Health System
Delaware	16.0%	21.1%	23.5%	5.5% (540 adults)
District of Columbia	12.2%	13.2%	13.4%	3.8% (900 adults)
Maryland	13.5%	16.3%	17.6%	1.1% (1,850 adults)
Pennsylvania	16.9%	21.0%	22.6%	3.7% (22,820 adults)
Virginia	14.1%	17.4%	18.8%	4.7% (5,310 adults)
West Virginia	18.1%	23.1%	24.8%	3.8% (2,200 adults)

SOURCE: Older Adults Behavioral Health Profiles, Region 3, Developed Under the SAMHSA State Technical Assistance Task Order, August 2016.

Common Transition Barriers



Poll Question: Which of the following strategies is your state implementing related to older adults with serious mental illness?

- Vote in the box that appears on your screen
- Click the circle next to the answer you want
- Check all that apply
- There is NO submit button

Melissa Sparks, MSN, RN

Deputy Assistant Commissioner for the Division of Hospital Services, Tennessee Department of Mental Health and Substance Abuse Services.

All the Right Moves:
Transitioning Individuals Out of Psychiatric Institutions

Background

Tennessee operates four (4) Regional Mental Health Institutes providing 577 beds

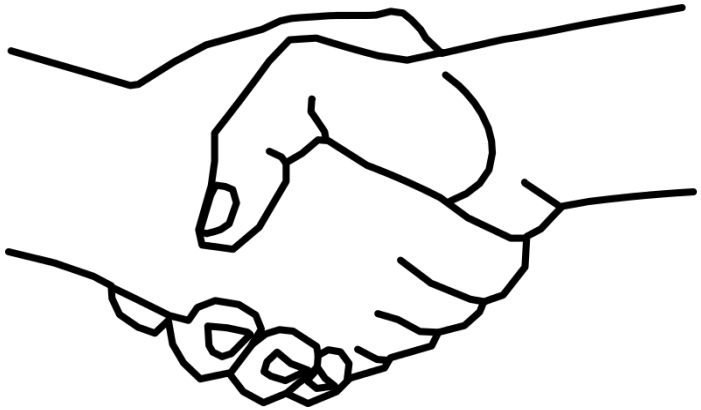
- Acute – 326 beds
- Max Secure – 30 beds
- Sub-Acute – 221

Demand for acute beds created a need to reduce the number of subacute beds in the system.

All the Right Moves:
Transitioning Individuals Out of Psychiatric Institutions

Program Description

The initiative is a collaboration between TDMHSAS and TN's three (3) Managed Care Organizations to develop unique community supports designed to provide for the individualized needs of long term clients transitioning from a state psychiatric hospital.



All the Right Moves:
Transitioning Individuals Out of Psychiatric Institutions

Implementation

Beginning April, 2018, bi-weekly calls were established with each of the three (3) MCO's and three (3) RMHI's (one RMHI is all acute) to discuss the needs of each individual patient that was clinically ready for discharge but had a barrier preventing discharge into the community.

TN MOVE Initiative

Mission: To transition adults staying longer than 90 days in a Regional Mental Health Institute (RMHI) to the community with short-term intensive individual, family and housing support services when an individual is identified as clinically ready for discharge.

Context

- Barriers to discharge delay transitions for individuals clinically ready for discharge.
- Community living options are not accessible.
- Clients' legal status is a barrier to discharge.
- Clients' previous treatment history and prior hospitalizations are a barrier to treatment.

Goals

- To provide recovery-focused, intensive and customized care coordination services in the least restrictive most integrated setting.
- To provide continuity of care between the RMHI, families, and community service providers.
- To provide care coordination services:
  1. Centered on the individual
  2. Sensitive to the family
  3. Culturally and linguistically competent
  4. Community-based

Strategies

- Develop RMHI/ Community Transition Teams (10:1) for:
  1. Care coordination
  2. Peer support
  3. Medical support
- Placement in stable living situations
- Maximize service benefits by third party payers
- Provide 24/7 access to crisis support
- 3/week care coordination for 6 to 12 months
- Special assistance funds

Outcomes

- Decreased RMHI length of stay
- Restoration or application for service benefits
- Client satisfaction with living situation/care coordination
- Decreased psychiatric hospital readmissions
- Discharge success
- Crisis planning
- Improved RMHI/ Community relationships
- CMHA services initiated
- Care coordination plans meet quality standards

All the Right Moves:
Transitioning Individuals Out of Psychiatric Institutions

Lessons Learned

- With the right supports individuals who were previously considered not dischargeable are able to live their lives in the community.
- Discharge plans are only as good as the community providers available willing to accept the challenge.
- Not all long term clients are suited for community placement
- Team work makes the dream work!

Questions

Evaluation

Evaluation Link

Once you complete the evaluation, you will be directed to the resource page and certificate request form.

Fact Sheets and Resources

- Emerging Factors
- Aging Population, Changing Needs
- Substance Use
- Organizational Adaptations and Service Systems Improvements
- Older Adult Select Resources
- Presentation Slides

Appreciation

Contact Us

Central East (HHS Region 3)
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

a program managed by

THE DANYA INSTITUTE

Central East MHTTC website

Oscar Morgan, Project Director

Danya Institute website

Email

240-645-1145

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