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

Organizational and Systems Readiness for Ensuring Access to Appropriate Care Levels

August 8, 2019

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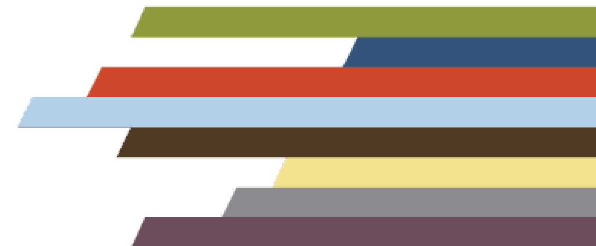

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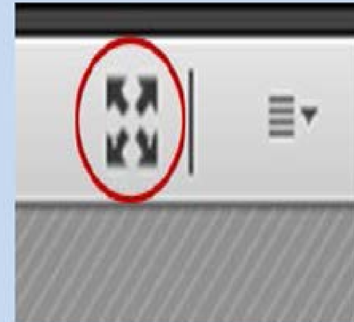

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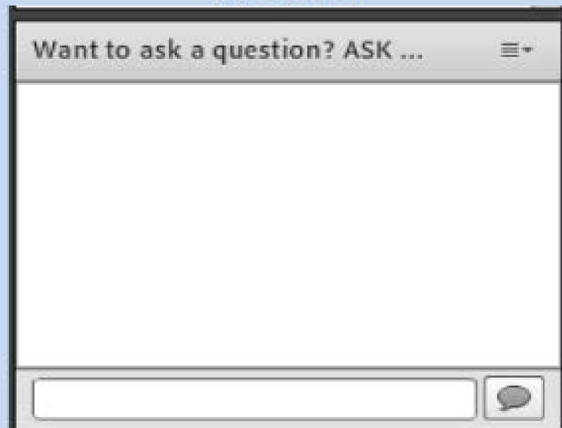

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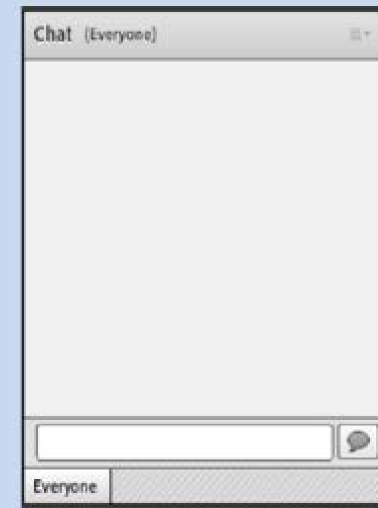
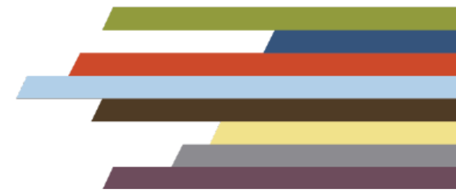


Organization and Systems Readiness

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

- **Speakers**
  - Alicia D. Smith, MHA, President
    Vorys Health Care Advisors LLC
  - Jacki Millspaugh M.Ed., LPC-S, Clinical Support Manager
    Oklahoma Department of Mental Health and Substance Abuse Services



MHTTC Network

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

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

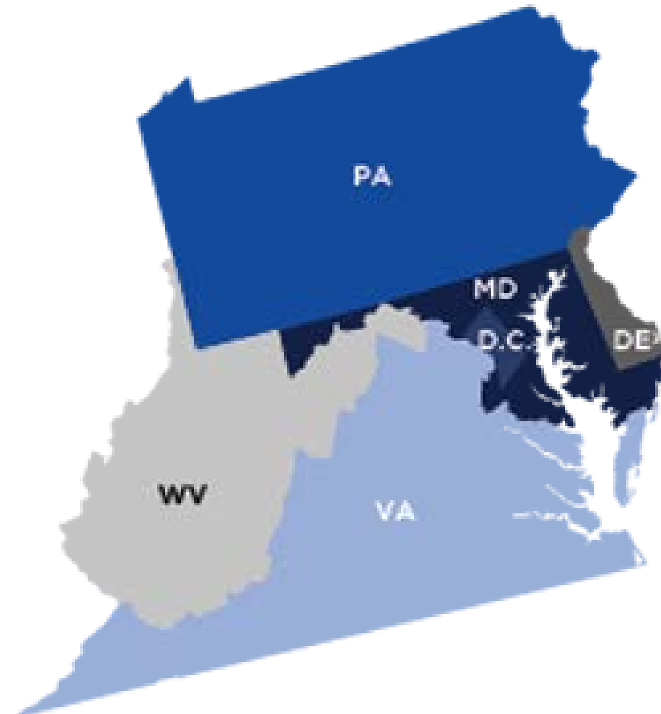
District of Columbia

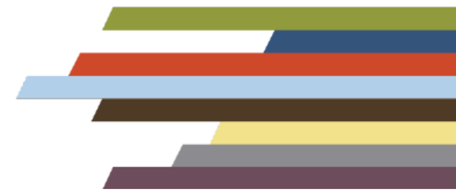
Maryland

Pennsylvania

Virginia

West Virginia





Improving Services for Older Adults

~~June 20~~ – The Changing Demographic Landscape & Effective Planning to Achieve Service System Changes

Recording Available

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

Recording Available

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

Optional Follow Up Discussion Groups - TBA

Central East (HHS Region 3)
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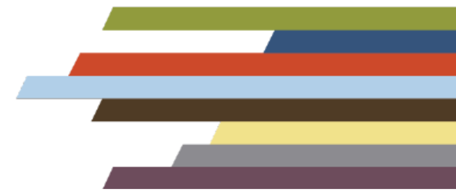
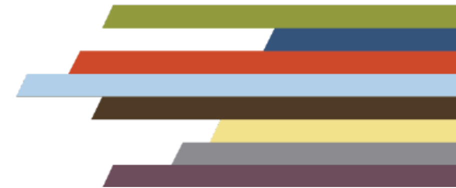


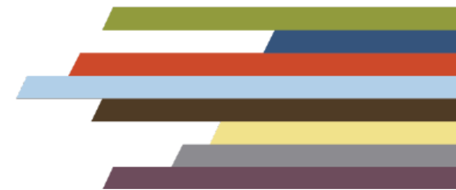
Session Three Overview

- Key Takeaways from Sessions 1 and 2
- Overview of an Older Adult System of Care Framework
- Readiness Assessment and Key Outcomes Metrics
- State Responder Feedback and Discussion
- Next Steps



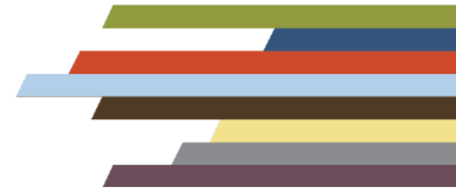
Alicia D. Smith, MHA

President, Vorys Health Care Advisors LLC



Jacki Millspaugh, M.Ed., LPC-S

Clinical Support Manager, Oklahoma Department of Mental Health and Substance Abuse Services



Session #1 Quick Recap

Population Characteristics

Overall Health Issues

Mental Health & Substance Use Concerns

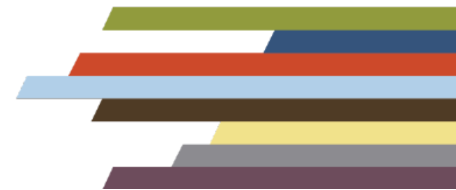
Social Determinants of Health

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

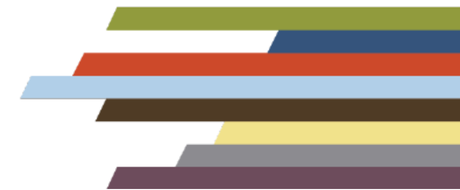


Region 3 Older Adult Projections

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.

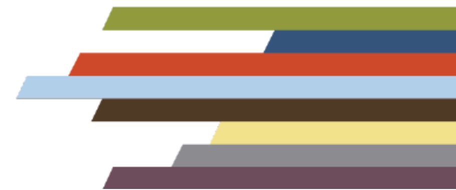


Common Transition Barriers

Session #2 Quick Recap: Tennessee

Subacute Discharge Initiative

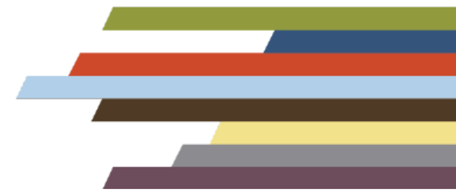
- State operates 4RMHIs providing 577 beds
  - Acute – 326 beds
  - Max Secure – 30 beds
  - Sub-Acute – 221
- Demand for acute beds required a reduction in subacute beds
- Several individuals needed help with activities of daily living (ADLs) who did not qualify for nursing home services.



Session #2 Quick Recap: Tennessee

Subacute Discharge Initiative (cont'd)

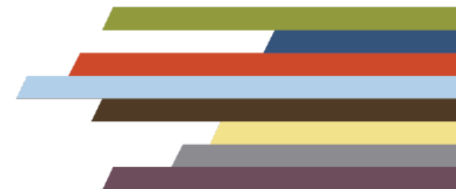
- The initiative is a collaboration between Tennessee Department of Mental Health and Substance Abuse Services and the state's 3 managed care organizations (MCOs)
- In April 2018 began bi-weekly calls with the MCO's and 3 RMHI's (one RMHI is all acute) to discuss the needs of each individual patient that was clinically ready for discharge but had a barrier preventing discharge into the community
- State developed Intensive Long-Term Support (ILS) residential services



Session #2 Quick Recap: Tennessee

Subacute Discharge Initiative (cont'd)

- Original goal was to discharge 126 individuals across the 4 RMHIs
- Through 6/22/2019, there have been 168 discharges, allowing the state to increase acute capacity



Session #2 Quick Recap: Tennessee

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

Older Adult System of Care Framework

Behavioral Health

Social Services

Recreation & Community

Wellness Services

Physical Health

Support Services

Older Adult

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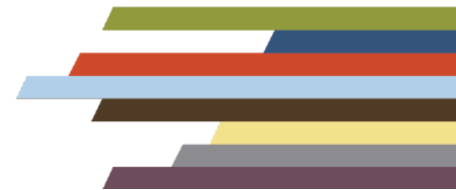


Older Adult System of Care Framework

Support Services

- Housing
- Daily Living
- Home and Community
- Transportation

Behavioral Health

- Mental Health
- Substance Use Disorder
- Crisis Services

Social Services

- Referral and Linkages
- Benefits Assistance
- Adult Protective

Older Adult System of Care Framework

Physical Health

- Primary Care
- Dental
- Pharmacy
- Hospital

Wellness Services

- Nutrition
- Exercise
- Spiritual
- Prevention

Recreation Activities

- Sharing Wisdom
- Community Engagement
- Social Connections

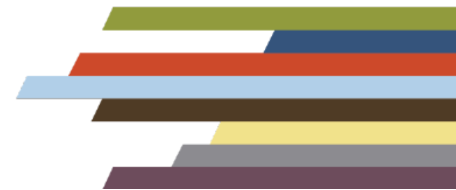
Discussion

Older Adult System of Care Framework

Support Services	• Home and Community • Daily Living • Housing • Transportation
Behavioral Health	• Mental Health • Substance Use Disorder • Crisis Services
Social Services	• Referral and Linkages • Benefits Assistance • Adult Protective
Physical Health	• Primary Care • Dental • Pharmacy • Hospital
Wellness Services	• Nutrition • Exercise • Spiritual • Prevention
Recreation Activities	• Sharing Wisdom • Community Engagement • Social Connections

Readiness Assessment

- Purpose and goals
  - To explore a framework and process for assessing organizational readiness to address older adult needs
  - To understand available resources in communities and identify potential gaps
  - To cultivate an understanding of practices used in communities that can be adapted and shared



Readiness Assessment

Outcomes Metrics

1. Reduce the number of older adults inappropriately admitted to inpatient hospital settings for treatment of mental illnesses.
2. Increase the number of transitions from inpatient hospitals and nursing facilities to community-based settings for older adults with mental illnesses.
3. Increase the availability of community based services and supports geared toward integrated care needs of older adults.
4. Increase the number of members of the behavioral health workforce with capacity to address the integrated care needs of older adults they serve.

Discussion of Key Metric 2

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Key Metric 2: Increase the number of transitions from inpatient hospitals and nursing facilities to community-based settings for older adults with mental illnesses.	
2.1. Does your organization conduct discharge planning in collaboration with staff from inpatient psychiatric hospitals (state-operated or private)?	☐Yes ☐ No ☐ Unsure ☐ N/A
2.2 Does your organization maintain a dedicated team responsible for discharge planning from inpatient psychiatric hospitals (state-operated or private)?	☐Yes ☐ No ☐ Unsure ☐ N/A
2.3 Does your organization conduct discharge planning in collaboration with staff from nursing facilities?	☐Yes ☐ No ☐ Unsure ☐ N/A
2.4 Does your organization maintain a dedicated team responsible for discharge planning from nursing facilities?	☐Yes ☐ No ☐ Unsure ☐ N/A
2.5 Does your organization utilize the PASRR screen as part of the person-centered planning process?	☐Yes ☐ No ☐ Unsure ☐ N/A
2.6 Does your organization utilize its own comprehensive assessment instrument designed specifically to identify older adult care needs?	☐Yes ☐ No ☐ Unsure ☐ N/A
2.7 Does your organization maintain a dedicated care coordination team responsible for identifying the full range older adult care needs?	☐Yes ☐ No ☐ Unsure ☐ N/A
2.8 Are sufficient funds available to your organization for payment of staffing and related costs associated with transition support services?	☐Yes ☐ No ☐ Unsure ☐ N/A
Use this space to provide additional information regarding your organization's approaches for increasing transitions to community settings:	

Questions

Evaluation

Evaluation Link

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

Appreciation

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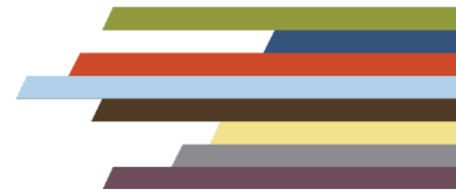

Contact Us

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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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