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

Older Adult System-of-Care Framework

Readiness Assessment

Overview

By 2034, the number of people over age 65 in the United States is projected, for the first time in the country's history, to surpass the number of children (i.e., those under age 18).[1] Communities must be prepared to address the unique challenges associated with aging, including changes in behavioral health. Suicide, for example, is significantly higher among men over age 75 than in any other age group.[2] Depression is underdiagnosed among older adults and is often experienced by dementia patients as well as their caregivers.[3] Polypharmacy among older people seeking relief from any combination of pain, insomnia, and mental illness is rapidly growing.[4]

Anticipating a greater need for community services and supports to meet the needs of older adults, the Central East Mental Health Technology Transfer Center (MHTTC) is piloting a readiness assessment and analysis of results at no cost to **behavioral health** providers and systems. This publication was prepared for the Central East Mental Health Technology Transfer Center, Advocates for Human Potential under a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Terminology Note

As stated by SAMHSA, "Behavioral health treatments and services help people with common mental illnesses and substance use disorders."

Older Adult Services Learning Collaborative

The Central East MHTTC, in partnership with Advocates for Human Potential, Inc., (AHP) convened the Older Adult Services Learning Collaborative (OASLC) to inform the development of a readiness assessment tool. This tool is designed to help local, regional, and state-level behavioral health systems improve service capacity for older adults with mental illnesses and substance use disorders (SUDs) by taking stock of current services, supports, policies, and

[1] United States Census Bureau. (2017). *National Population Projections, 2017*. www.census.gov/programs-surveys/popproj.html
[2] Hedegaard, H., Curtin, S. C., & Warner, M. (2018). *Suicide rates in the United States continue to increase* (NCHS Data Brief No. 309). Centers for Disease Control and Prevention, National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db309.htm
[3] Alzheimer's Association. (2018). *2018 Alzheimer's disease facts and figures.* https://www.alz.org/media/Documents/facts-and-figures-2018-r.pdf
[4] Maust, D., Gerlach, L. B., Gibson, A., Kales, H. C., Blow, F. C., & Olfson, M. (2017). Trends in central nervous system–active polypharmacy among older adults seen in outpatient care in the United States. *JAMA Internal Medicine*, *177*(4), 583–585. https://doi.org/10.1001/jamainternmed.2016.9225

practices. Behavioral health professionals from across the country provided feedback on the draft version of the tool in a series of meetings held in early 2020. (See Appendix A.) OASLC participants also had the opportunity to field-test the tool for effectiveness and clarity.

Readiness Assessment Process

The readiness assessment process helps states and communities answer the questions, "What service array do we need for older adults? Are those services available? How can we offer a full continuum of services?" It takes into consideration block grants, discretionary grants, local and state funds, and other resources—especially those targeting services for older adults—within a state or community. For some states and communities, a formal needs assessment or data compiled from other assessment work, such as the Preadmission Screening and Resident Review (PASRR), may be useful.

The readiness assessment process begins with identification of relevant systems within the service area and potential stakeholders available to provide ongoing information about service system capacities. Examples include Area Agencies on Aging, coalitions or task forces that focus on behavioral health services for older adults, representatives from assisted living and skilled nursing facilities, and medical providers specializing in services for older adults.

Each system in the service area then completes the readiness assessment tool, which poses questions about (1) available services and supports in the service area and (2) current policies and practices that address the needs of older adults with mental illnesses, SUDs, and neurocognitive conditions (e.g., Alzheimer's disease, other dementia, traumatic brain injury), who come into contact with the local behavioral health system.

The assessment questions are organized around four essential goals that can yield improved systemic outcomes on behalf of older adults in need of behavioral health services:

1. Reduce the number of older adults admitted to inpatient hospital settings, in lieu of another level of care that would have been adequate, for treatment of mental illnesses and SUDs.
2. Improve the quality of transitions from inpatient hospitals and nursing facilities to community-based settings for older adults with mental illnesses and SUDs.
3. Increase the availability of community-based services and supports geared toward the **integrated care** of older adults.
4. Increase the number of behavioral health workforce members with capacity to address the integrated care needs of the older adults they serve.

> **Terminology Note**
> "Integrated care" refers to the systematic coordination of general and behavioral health care.

After responding to each prompt in the tool, users summarize findings by noting strengths, challenges, additional information needed, and next steps. This information then serves as a collective guide for strategic planning. The tool is designed to be adaptable to communities' and/or states' needs and selected priorities. As such, it can be used periodically to measure continuous quality improvement and continually engage partnerships on behalf of older adults in need of quality behavioral health services.

Readiness Assessment Tool

Behavioral health provider/system:_____

Lead contact and title:_____

Telephone number:_____ Email address:_____

Contributing partners:_____

_____

Date completed/revised (circle one):_____

Section I of the Readiness Assessment Tool asks for demographic information on the general population and the specific subpopulation of those over 65 to provide context for current and future needs in the service area, as well as to identify gaps in important data. A template is included to summarize findings and discussion generated while completing this section.

Section II presents a checklist of questions for each of the four essential goals. Responders check “Yes,” “No,” “Unsure,” or “N/A” (not applicable) next to each item. A template is provided to summarize strengths, challenges, additional information needed, and next steps.

Section III provides a framework for identifying and prioritizing key findings that will facilitate the design of strategies and action plans for improving services for older adults. Partners completing the assessment are encouraged to review the summaries in the preceding sections before completing the third section.

Section I

Overview of General Population			
Directions: Provide the following information from your service area's U.S. Census data tables.			
Most recent population estimate:			
Age and Sex	%	Race and Origin	%
Female		White	
Persons 65 years and over		Black or African American	
Population Characteristics	#	American Indian and Alaska Native	
Veterans		Asian	
Families and Living Arrangements	%	Native Hawaiian or Other Pacific Islander	
Language other than English		Two or more races	
Income and Poverty	%	Hispanic or Latino	
Persons in poverty		White, not Hispanic or Latino	

Overview of Population over Age 65				
Directions: For the following items, check either "Yes," "No," "Unsure," or "N/A" (not applicable). Provide a general description for any item marked "Yes."	Yes	No	Unsure	N/A
Do you know the age and sex distribution of this subpopulation (65 and older)?				
Do you know the number of veterans within this subpopulation?				
Do you know the language preferences of this subpopulation?				
Do you know this subpopulation's accessibility to financial resources?				
Do you know the race and ethnicity distribution of this subpopulation?				

Do you know the geographic distribution (e.g., rural, suburban, urban) of this subpopulation?				
Do you know the prevalence and range of behavioral health and other clinical issues among this subpopulation?				
Do you know the range of services those with behavioral health and other clinical issues within this subpopulation need?				
Do you know which needs are going unmet among this subpopulation?				

Overview: Summary of Findings	
Strengths	
Challenges	
Additional information needed	
Next steps	

Section II

Goal 1: Reduce the number of older adults admitted to inpatient hospital settings, in lieu of another level of care that would have been adequate, for treatment of mental illnesses and SUDs.					
Terminology note: The term "accessible" is defined as capable of being easily used in terms of availability, timeliness (i.e., no long wait lists), and affordability.		Yes	No	Unsure	N/A
1.1	Is crisis stabilization (any direct service that assists with de-escalating the severity of a person's level of distress and/or need for urgent care associated with mental illness or SUDs) accessible to older adults in your immediate community?				
1.2	Are day treatment services (group therapy, educational sessions, and individual counseling offered as outpatient programs for multiple hours a day on most days of the week, or as defined by your state) accessible to older adults in your immediate community?				
1.3	Are assisted living facilities accessible for older adults with mental illness and SUDs in your immediate community?				
1.4	Are intensive residential treatment services (such as a short-term step-down level of care in a non-hospital setting) accessible to older adults with mental illness and SUDs in your immediate community?				
1.5	Are state or other public funds used to cover the cost of psychiatric hospitalization for older adults?				
1.6	Do state-operated or -funded psychiatric hospitals specifically address the needs of older adults by offering . . .				
1.6a	. . . a dedicated geriatric treatment unit?				
1.6b	. . . memory care services?				
1.6c	. . . end-of-life or palliative care services?				
1.6d	. . . treatment of complex medical conditions?				
1.7	Has your state-operated psychiatric hospital identified priority populations eligible to receive treatment?				
1.8	Are neurocognitive conditions (e.g., Alzheimer's disease, dementia, traumatic brain injury) included as eligible diagnoses for admission to a state-operated or -funded psychiatric hospital?				
1.9	Are individuals assessed for trauma upon referral/admission to, or actual placement in, hospitals and/or residential settings?				

Goal 1: Summary of Findings	
Strengths	
Challenges	
Additional information needed	
Next steps	

Goal 2: Improve the quality of transitions from inpatient hospitals and nursing facilities to community-based settings for older adults with mental illnesses and SUDs.					
		Yes	No	Unsure	N/A
2.1	Do staff of state-operated or private inpatient psychiatric hospitals coordinate discharge in collaboration with their counterparts in community-based settings?				
2.2	Is there a dedicated team responsible for discharge planning from inpatient psychiatric hospitals (state-operated or private)?				
2.3	Do staff of nursing facilities coordinate discharge in collaboration with their counterparts in community-based settings?				
2.4	Is there a dedicated team responsible for discharge planning from nursing facilities?				
2.5	Is a comprehensive assessment instrument used to specifically identify older adult care needs?				
2.6	Is there a care coordination team dedicated to identifying the full range of older adult care needs?				
2.7	Are sufficient funds available for staffing and costs associated with transition support services?				
2.8	Are there any cross-cutting or systemic barriers to comprehensive service provision? If yes, elaborate here:				
Describe your organization's approaches to supporting transitions to community-based settings:					

Goal 2: Summary of Findings	
Strengths	
Challenges	
Additional information needed	
Next steps	

Goal 3: Increase the availability of community-based services and supports geared toward the integrated care of older adults.					
		Yes	No	Unsure	N/A
3.1	Do specific funding gaps limit the extent to which a comprehensive array of home and community-based behavioral health treatment and support services is available for older adults? If yes or unsure, describe here:				
3.2	Are home and community-based behavioral health treatment services designed to address the integrated care needs of older adults?				
3.3	Are agreements (formal or informal) in place with the local Area Agency on Aging or similar entities to identify resources for individualized care coordination, care planning, and placement for older adults?				
3.4	Have area behavioral health organizations developed formal or informal relationships with assisted living facilities to facilitate care coordination, care planning, and placement for older adults?				
3.5	Have area behavioral health organizations developed formal or informal relationships with skilled nursing facilities to facilitate care coordination, care planning, and placement for older adults?				
3.6	Do behavioral health provider agencies maintain dedicated teams responsible for providing treatment and supports to an older adult caseload?				
3.7	Have behavioral health provider agencies established referral processes with providers of community-based long-term services and supports (e.g., assisted living facilities, skilled nursing facilities) to expedite placement?				

Goal 3: Summary of Findings	
Strengths	
Challenges	
Additional information needed	
Next steps	

Goal 4: Increase the number of behavioral health workforce members with capacity to address the integrated care needs of the older adults they serve.					
		Yes	No	Unsure	N/A
4.1	Are staff with specific credentials in geriatric issues in place?				
4.2	Is formal training on older adult care needs provided to staff?				
4.3	Are best practices for addressing the needs of older adults with mental illnesses and SUDs understood and applied by staff and administrators?				
4.4	Are adults credentialed as peer providers available to support older populations?				
4.5	Is there a mechanism in place for measuring engagement of peer services?				

Goal 4: Summary of Findings	
Strengths	
Challenges	
Additional information needed	
Next steps	

Section III

Overall Summary and Proposed Actions	
Strengths noted since last assessment	
Improvements since previous review (as applicable)	
Challenges (including those continuing from previous assessments)	
Additional information needed	
Priorities for action	1. 2. 3.

Recommended Next Steps			
Directions: List each priority by number referenced above and note specific strategies for addressing that priority.	*Directions:* Note specific actions, person responsible, and proposed completion date for each strategy.		
Strategies to Implement		Action	Person Responsible	Due Date
Priority 1				
Priority 2				
Priority 3				
Follow-up assessment date:				

Appendix A: Older Adult Services Learning Collaborative

The following individuals are commended for contributing to the improvement of the Older Adult System-of-Care Framework Readiness Assessment.

- James Baldwin – Maryland
- Cheryl Bogarty – Kentucky
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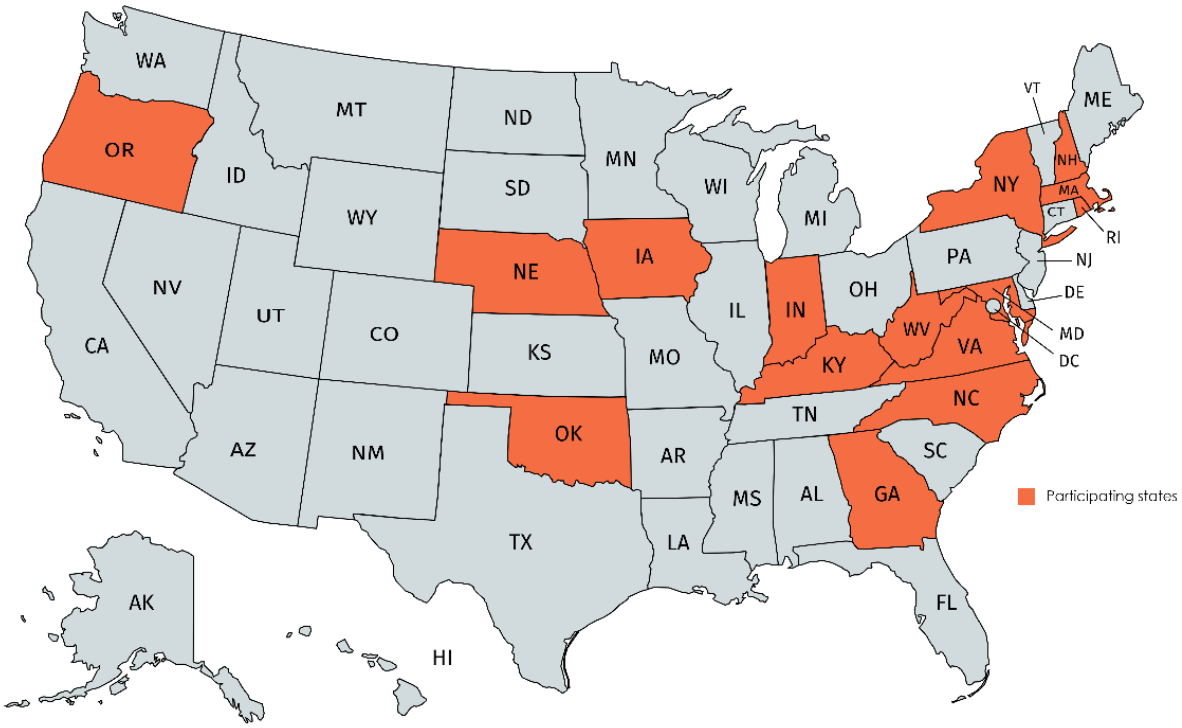

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