

EL DORADO COUNTY: DATA NOTEBOOK 2017

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS



*Prepared by California Mental Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions*

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BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

County Population (2017): 185,090

Website for County Department of Mental Health (MH) or Behavioral Health:
<http://www.edcgov.us/MentalHealth/>

Website for Local County MH Data and Reports:
<http://www.edcgov.us/MentalHealth/MHSA.aspx>

Website for local MH Board/Commission Information, Meetings, and Reports:
http://www.edcgov.us/Government/mentalhealth/pages/mental_health_commission_meetings.aspx

Specialty Mental Health Data¹ from calendar year (CY) 2014: Table 1. Race/ethnicity detail for total Medi-Cal beneficiaries who received Specialty Mental Health services.

Table 1—El Dorado MHP Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity		
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	15,446	1,009
Hispanic	5,366	138
African-American	205	20
Asian/Pacific Islander	750	13
Native American	198	17
Other	3,634	180
Total	25,596	1,377
<i>*The total is not a direct sum of the averages above it. The averages are calculated separately.</i>		

¹ See county Mental Health Plan Reports at <http://www.calegro.com>. If you have more recent data available for either calendar year or fiscal year, please feel free to update this section within current HIPAA compliant guidelines.

Supplemental County Data Page

El Dorado County: 2008-2012 American Community Survey 5-year estimates^{2,3}

Population (2010): 180,441

Adult population over 18: 139,562

Civilian veterans: 17,408 (12.5% of the adult population)

Total civilian noninstitutionalized population: 179,488

 With a disability, all ages: 20,510 (11.4%)

 Under 18 years with disability: 1,541 (3.8% of those within this age group)

 Age 18-64 years with a disability: 10,555 (9.4% of those in this age group)

Total population age 65 years and older: 26,590 (14.7 % of total population)

 Age 65 and older with a disability: 8,414 (31.6% of those in this age group)

Total households: 67,846 (100%) Population in households: 179,028 (98.5%)

 Households with a member 65 years or over: 18,509 (27.3%)

 Householder living alone, age 65 years and over: 5,554

Grandparents living with own grandchildren under 18 years: 3,111

 Responsible for grandchildren: 898 (28.9% of those living with grandchildren)

 Grandparents who are female: 486 (54.0%)

 Grandparents who are married: 755 (84.1%)

Percentage of all families whose prior year income was below poverty level: 5.2%

Percentage of all persons living under the federal poverty level: 8.1%

Percentage of aged 65 and over with prior year income under poverty level: 4.3%

Statewide: of those age 65 and over, 10 % live below the federal poverty level.

² All numbers are based on the civilian population not residing in institutions. Assumptions and statistical models are based on the population of 180,441 in the year of the last U.S. census, 2010.

³ <http://www.labormarketinfo.ca.gov/file/census2012/eldordp2012.pdf>, see pages 2 and 7 for details about race/ethnicity, cultural origin, languages spoken at home, etc.

INTRODUCTION: PURPOSE, GOALS, AND DATA RESOURCES

What is the “Data Notebook?”

The Data Notebook is a structured format for reviewing information and reporting on specific mental health services in each county. The topic for our 2017 Data Notebook reviews behavioral health services and needs in the system of care for older adults. This topic follows our yearly practice of focusing on a different part of the behavioral health system.

The Data Notebook is developed each year in a work group process with input from:

- CA Mental Health Planning Council members and staff,
- CA Association of Local Behavioral Health Boards and Commissions (CALBHB/C),
- County Behavioral Health Directors Association of California (CBHDA) through both staff and individual county directors,
- Subject matter experts on the topic of the Data Notebook and stakeholders with lived experience.

Local mental health boards/commissions are required annually to review performance data for mental health services in their county and to report their findings to the California Mental Health Planning Council (CMHPC). To provide structure for the report and to make the reporting easier, each year the CMHPC creates a Data Notebook for local mental health boards/commissions to complete.

The Data Notebook structure and questions are designed to meet important goals:

- To assist local boards to meet their legal mandates⁴ to review performance data for their county mental health services and report on performance every year,
- To serve as an educational resource on behavioral health data for local boards,
- To obtain opinion and thoughts of local mental health boards on specific topics,
- To identify unmet needs and make recommendations.

We encourage the members of all local mental health boards to participate in reviewing and developing the responses for this Data Notebook. This is an opportunity for the local boards and their public mental health departments to work together on critical issues. This process may help identify what is most important to your local board/commission and stakeholders and inform county leadership planning for behavioral health needs.

⁴ W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

After the Data Notebook reports are submitted to the CMHPC, staff compile the responses from the local boards/commissions so that the information can be analyzed to create a yearly report to inform policy makers, stakeholders and the general public. These Statewide Overview reports are posted at:

<http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx>.

Our goal is to promote a culture of data-driven quality improvement in California's behavioral health services and thereby to improve client outcomes and function. Data reporting helps provide evidence to support advocacy and good public policy.

This year, we present data and discussion for review of behavioral health services for older adults, which is organized in these four main sections:

- 1) An integrative view of "whole person care" for older adults in the overall system of care for behavioral health.
- 2) Discussion of demographics and challenges presented by expected increases in total number of older adults and increased needs for behavioral health services; we also want to know about different groups of older adults in order to promote appropriate outreach and engagement with services.
- 3) Conditions that can create barriers to accessing services (language, geographic or other social isolation, and disabilities, etc.) and therefore call for specialized attention and effort.
- 4) Data and information about the continuum of care for older adults with mental health and/or substance use treatment needs, including those providing care to dependent loved ones, those facing crises and/or significant changes in their ability to care for themselves.

How Do the Data Sources Define Older Adults?

It is common to refer broadly to adults age 60 and over as "older adults." However, discussions of data require precise definitions which differ depending on the information source and its purpose. Researchers may define age subcategories to describe psychological or biological⁵ stages of development and aging, for example: the "young old" (60-75), the "medium old" (75-85), and the "older old" (86 and older). These categories are used widely in the mental health and medical literature, because the likelihood of frailty, chronic disease and disability increases across these age spans.

⁵ Biological development loosely refers to the stages of physical, cognitive and emotional growth and aging.

Therefore, we keep these age groups in mind even though many state and federal data sources reduce the number of categories to simplify the statistical analysis.

Also, there are relatively few older adults receiving specialty mental health or substance use treatment services, so only broad categories of age are reported in some datasets to avoid the small numbers problem. Thus, we cannot always get data for all the categories desired, which affects not only age but race/ethnicity or other items.

Ideally, we might like to have all data broken down by the same age groups to simplify discussion. Unfortunately, that is not possible because we do not have access to the raw data sets (nor the resources) for such a major re-analysis. Here, we use the age breakdowns provided by the public data sources that are available to us. That means data reports on different topics use different age criteria to define older adults.

Resources: Where do We Get the Data?

We customize each report by placing data for your county within the Data Notebook, followed by discussion questions related to each topic. Statewide data are provided for comparison for some items. Other issues are highlighted by information from research reports. County data are taken from public sources including state agencies. Special care is taken to protect patient privacy for small population counties by “masking” (redaction) of data cells containing small numbers. Another strategy is to combine several small counties’ data (e.g., counties under 50,000 population).

Many questions in the Data Notebook request input based on the experience and perspectives of local board members. Board members will need to address related questions about local programs and policies in their discussion. That information may be obtained from local county departments of behavioral health or mental health.

This year we present data from California Departments of Aging, Health Care Services (DHCS), the California External Quality Review Organization, the American Community Survey and other sources listed in Table 2. We also consulted the recent reports on the Older Adult System of Care by Drs. Janet Frank and Kathryn Keitzman at UCLA for their contract with the Mental Health Oversight and Accountability Commission.⁶

⁶ Frank JC, Keitzman KG, Damron-Rodriguez J, Dupuy D. *California Mental Health Older Adult System of Care Project: Proposed Outcomes and Indicators for Older Adult Public Mental Health Services*. UCLA Center for Health Policy Research. 2016, June 30. [California Mental Health Older Adult System of Care Project: Proposed Outcomes and Indicators for Older Adult Public Mental Health Services](http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1559). <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1559>

Table 2. Who Produces the Data and What is Contained in these Resources?

<p>CA DHCS: Mental Health Analytics Services and Performance Outcomes Systems,⁷ http://www.dhcs.ca.gov</p>	<p>Data for Specialty Mental Health Services provided for adults and youth with Serious Emotional Disorders (SED) or Serious Mental Illness (SMI) funded by the Medi-Cal system. One unit analyzes the data for adults of all ages. A separate group analyzes data for services provided to Medi-Cal covered children/youth through age 20 (federally defined EPSDT⁸ benefits).</p>
<p>CA DHCS: Office of Applied Research and Analysis (OARA)</p>	<p>Substance Use Disorders Treatment and Prevention Services for youth and adults. Annual reports contain statewide data, some of which is derived from data entered into the “Cal-OMS” data system.</p>
<p>CA Department of Aging</p>	<p>Administers programs and services for older adults in partnership with the federal government and federal funding. See www.aging.ca.gov for information.</p>
<p>External Quality Review Organization (EQRO), at www.CALEQRO.com</p>	<p>Annual evaluation of the data for services offered by each county’s Mental Health Plan (MHP). An independent review discusses program strengths and challenges; highly informative for local stakeholders.</p>
<p>American Community Survey 5-year Estimates</p>	<p>The 2008-2012 ACS report is a detailed survey of communities based on the 2010 U.S. Census.</p>
<p>Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov</p>	<p>Independent data reports and links to other federal agencies (NIMH, NIDA). Example: <u>National Survey on Drug Use and Health (NSDUH)</u>, which covers mental health, alcohol and drug use in adults and youth with analysis of needs and how many receive services.</p>
<p>County Behavioral Health Directors Association of California (CBHDA); see www.cbhda.org/</p>	<p>An electronic system (eBHR) to collect behavioral health data from CA counties for reporting in the “Measures Outcomes and Quality Assessment” (MOQA) database. Also used by counties to report some data for MHSA programs and outcomes.</p>

⁷ See: www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx, and http://www.dhcs.ca.gov/services/MH/Documents/POS_StatewideAggRep_Sept2016.pdf.

⁸ EPSDT refers to Early, Periodic Screening, Diagnosis and Treatment. These federally-defined services are available to Medi-Cal covered children and youth from birth through age 20.

HEALTHY AGING AND THE OLDER ADULT SYSTEM OF CARE

Social Supports and Community Engagement for Mental Health

These services are vital to mental health and sustaining recovery, as well as physical health and maintaining the functions of daily living. A number of services are available to support healthy aging in the community.

Examples of services for older adults include:

- Senior centers (social, exercise, special interest groups)
- Shuttle vans/Paratransit (transportation is a critical barrier for many across all age groups, but most especially for older adults with limited mobility).
- “Meals on Wheels” (programs and volunteers provide more than nutrition: brief socialization and a check on the person’s welfare or wellness, etc.).
- “HiCAP:” counseling and information about insurance issues, often conducted by volunteers who are older adults trained to assist their peers in navigating confusing problems with insurance (including Medicare).
- Medicare Supplement information and support: may cover gym memberships, where available.
- In-Home Supportive Services (IHSS), which are services provided to allow one to remain in the community and live safely in their own home.
- Grief/Loss Support Groups (maybe supported by county MH or MHSA funds).
- Care Coordination (may also be provided by county MH and include information or help linking to specific services, financial supports, or insurance issues).

The above services are part of the social safety net and a foundation to promote the well-being and mental health of older adults living in the community. Because of the accumulated effect of personal losses, it is helpful to provide support for those experiencing grief, trauma, or depression in response to such losses.

County agencies also provide a variety of mental health and social supports to promote continued engagement of older adults with the larger community. The goals for older adults’ mental health are to prevent profound isolation, depression, anxiety and to avoid re-triggering of trauma or serious mental health issues from one’s earlier life.

California strives to provide coordinated care for behavioral health and physical health care. This objective can be more challenging to achieve for the older adults, due to complex health care needs and changes in the individual’s life and family circumstances. Some have suggested a need for more collaboration between Aging program service providers and county behavioral health and social service programs as one way to help support an Older Adult System of Care (OASOC).

Integrated Health Care for Older Adults: Treating the Whole Person

The CA Department of Health Care Services has implemented the Whole Person Care (WPC) Pilot Program. WPC is a five-year program authorized under the Medi-Cal 2020 waiver. It coordinates physical health, behavioral health, and social services in a patient-centered manner, with the goals of improved member health and well-being through more efficient and effective use of resources. It is anticipated that the WPC Pilot Program will result in better health outcomes through enhanced comprehensive coordinated care provided at the local level. In late 2016, 18 counties were approved to participate and in March, 2017 more counties have applied.

1. Has your county applied or been approved to participate in the Whole Person Care Pilot Program?

Yes ___ No

If so, will older adults be served in your county's program? Yes ___ No ___

2. In a prior Data Notebook (2014), counties provided examples of efforts to ensure integrated physical health care with behavioral health care. Please check which services or activities your county provides for older adults.

Procedures for referral to primary care

Procedures for screening and referral for substance use treatment

Program or unit focused on the Older Adult System of Care (AOSOC)

Linkage to Federally Qualified Healthcare Center (FQHC) or similar

Links to Tribal Health

Case management/care coordination to other social services e.g., housing, CalFRESH, Meals on Wheels, In-Home Supportive Services (IHSS)

Health screenings, vital signs, routine lab work at Behavioral Health site

Health educator or RN on staff to teach or lead wellness classes

Training primary care providers on linking medical with behavioral health

Use of health navigators, *promotores*,⁹ or peer mentors to link to services

Other, please specify. MHSA PEI programs

*= If the older adult is seeing a psychiatrist or medical support provider

**= Formal training provided through Managed Care Plans and other organizations such as ACCEL or medical group.

*** = Not specific for older adults, but available as part of the services to the general population.

⁹ In the Hispanic/Latino community, these are health 'promoters' and representatives, who may also assist in navigating the complexities of the health care system.

DEMOGRAPHIC TRENDS : CHALLENGES FOR SERVICE ACCESS

Who are California’s Older Adults?

“Older Adults comprise a substantial portion of the people in California. In 2016, approximately 5.5 million Californians, or 14% of the population, were age 65 or older.¹⁰

Of those, “approximately 1.6 million (30 per cent of California’s total older adult population) was foreign-born.”⁵

It’s well-known that there are disparities in access to health services, especially behavioral health care. To help us plan outreach and services, we want to know the cultural and race/ethnicity backgrounds of California’s older adults, among other characteristics. The table below provides some of this information.¹¹

Table 3. Race/Ethnicity of Older Adults in CA age 65 and over, 2011

Race/Ethnicity	Age 65 to 74	Age 75 and Older	Total # of All Adults \geq 65	Percent of All Adults \geq 65
White, Not Hispanic	1,398,928	1,295,788	2,694,716	61.3 %
Asian, Not Hispanic	333,396	261,954	595,350	13.5 %
Black, Not Hispanic	135,329	97,018	232,347	5.3 %
All Others ¹² , Not Hispanic	51,323	30,844	82,167	1.9 %
Hispanic (any race)	462,706	330,420	793,126	18.0 %
Totals	2,381,682	2,016,124	4,397,806	~ 100.0 %

“California’s older adults will continue to grow more racially, ethnically, and culturally diverse. While 62 percent of older adults were White/Non-Hispanic in 2010, by 2050 the majority will be from groups formerly considered to be minorities.”¹¹

¹⁰ California Department of Finance, Demographic Reports and Projections, 2017. www.dof.ca.gov.

¹¹ California State Plan on Aging – 2013-2017, California Department of Aging, www.aging.ca.gov.

¹² Due to statistical reasons regarding sampling, this report combined totals into “All Others, Non-Hispanic” for the following categories: American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Some Other Race, and Two or More Races. Due to rounding, percentages may not sum to 100 %.

How do We Plan for Future Needs in the Older Adult System of Care?

Most counties obtain data that forecasts population numbers for groups by age and race-ethnicity in order to plan for future needs. It is predicted that the numbers of older adults will surge, sometimes referred to as the “silver tsunami.” Interdisciplinary and cross-agency collaboration at local, state, and federal levels will be essential.

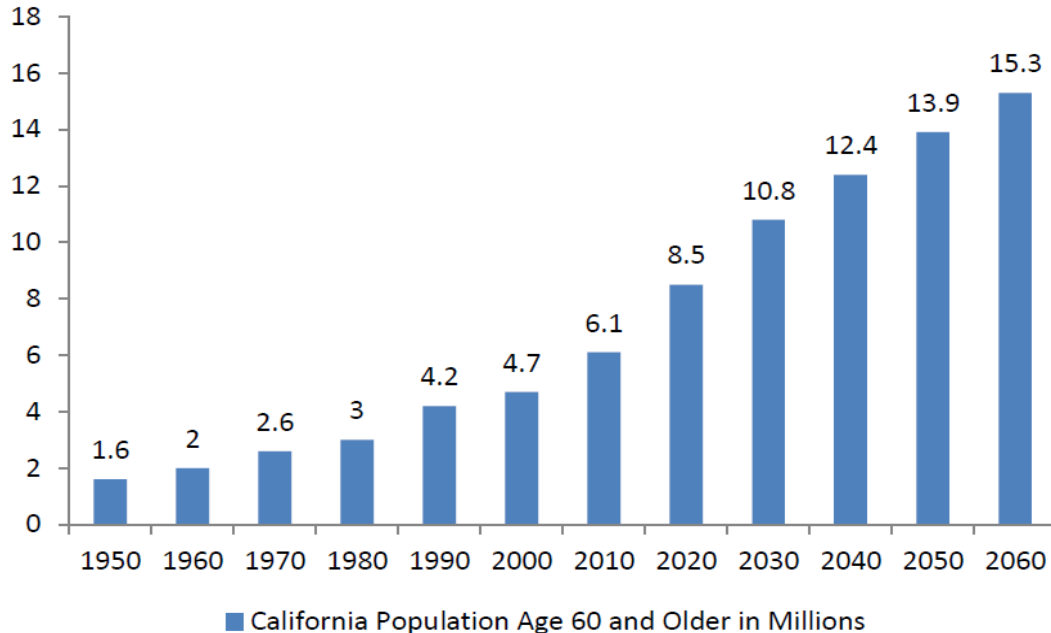


Figure 1. Projected Increases in Population Age 60 and over in California. ¹³
Compare the predicted numbers for your county with those for the state:

	2010 Population age 60+	2030 Population age 60+	Per Cent Change over 20 years
El Dorado County	39,740	72,581	83 %
California	6,016,871	10,879,098	81 %

3. Is your county doing any advanced planning to meet the mental health and substance use service needs of your changing older adult population in the coming years? Yes No If yes, please describe briefly.

We have created new older adult programs under our Community Services and Supports in the MHSA Plan. County of El Dorado’s Health and Human Services Agency also is moving toward an adult system of care model, which incorporates an integrated system of care.

¹³ California State Plan on Aging 2013-2017, California Department of Aging, www.aging.ca.gov.

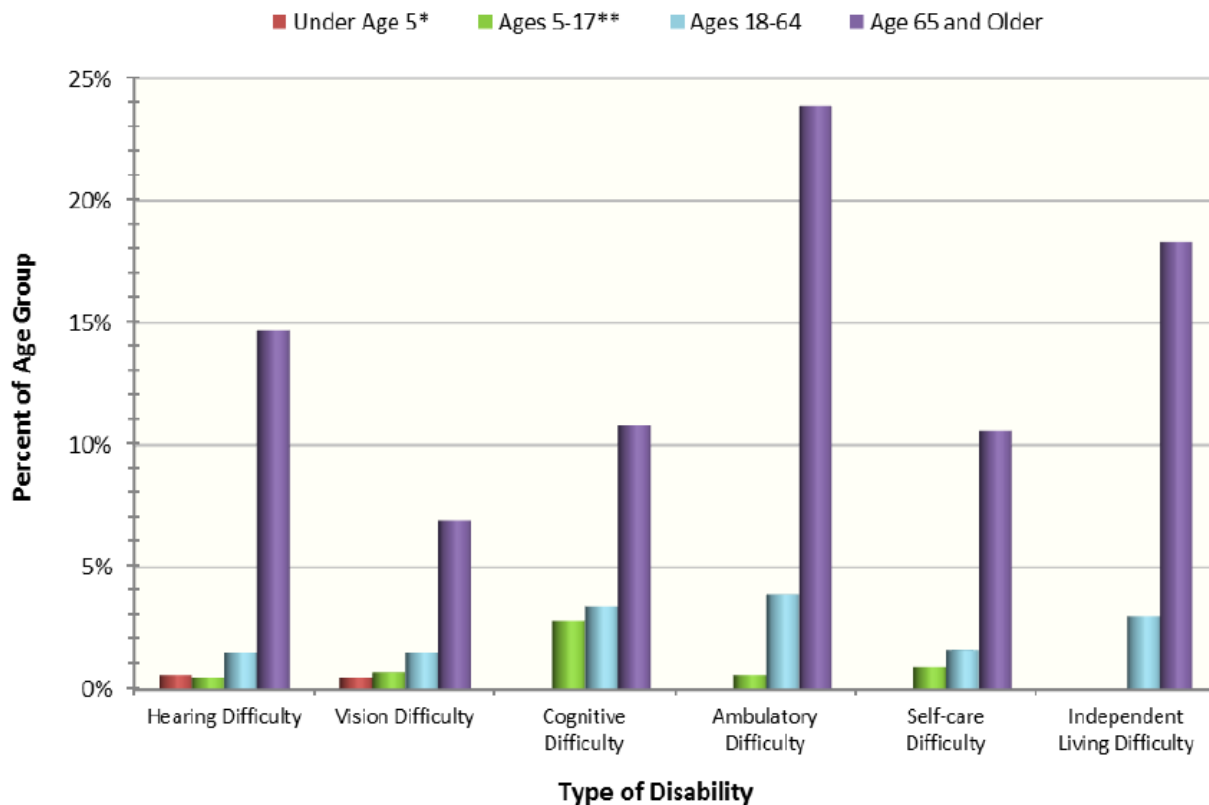
Barriers to Services for Older Adults

Disabilities in Older Adults Can Present Barriers to Service Access

Statewide, about 40% of adults age 65 or over have a physical or cognitive disability.

Table 4. Disability Status by Age and Sex in California, 2011

Age Group	Male		Female		Total	
	With a Disability	Percent of Age	With a Disability	Percent of Age	With a Disability	Percent of Age
Under 5	9,476	0.7%	9,977	0.8%	19,453	0.8%
5-17	167,058	4.8%	97,471	3.0%	264,529	3.9%
18-34	220,823	4.8%	169,127	3.7%	389,950	4.3%
35-64	723,401	10.2%	770,865	10.4%	1,494,266	10.3%
65-74	266,215	24.3%	306,784	24.2%	572,999	24.3%
75+	388,394	49.0%	623,855	54.3%	1,012,249	52.1%
Total	1,775,367	9.7%	1,978,079	10.5%	3,753,446	10.1%



*For children under 5 years old, only questions regarding hearing and vision difficulties were asked.

**For children between the ages of 5 and 14, only questions regarding hearing, vision, cognitive, ambulatory, and self-care difficulties were asked. F

Figure 2. Type of Disability in Different Age Groups in California (2011), above.

The data shown above only shows specific types of disability and does not account for co-occurring chronic illnesses such as heart disease, diabetes, hypertension, or conditions associated with chronic pain such as arthritis or other musculoskeletal disorders. Our mental health and well-being intertwine inseparably with the experience of physical disability and disease.

In your county, the data show:

El Dorado County (2011): There were: 26,590 persons age 65 years and older. Of those, the number of individuals age 65 and older with a disability: 8,414 . That number represents 32 % of this age group.

Geographic Isolation and Socioeconomic Factors can Present Barriers to Accessing Services

Next, we consider some data about the older adults that describe some challenges for mental health and well-being that also can present obstacles to accessing mental health services. These challenges include: living alone, in geographical isolation, in poverty or near poverty, disability status (SSI/SSP support indicator), whether the individual is from a historically underserved minority or cultural group, or communicates primarily in a language other than English.

The California Department of Aging prepared the following demographic projections¹⁴ for 2016 for your county:

El Dorado County (2016):

Age 60+: 51,761	Age 75+: 13,877
Nonminority: ¹⁵ 45,749	Minority: ¹⁶ 6,012
Low income: 2,935	Non-English proficient: 220
Medi-Cal: 3,890	SSI/SSP (65+): 674
Lives alone (60+): 7,305	Geo-isolation (60+): 16,600

¹⁴ California Department of Aging, 2015, www.aging.ca.gov.

¹⁵ Using federal data guidelines, the Department on Aging defines “nonminority” as non-Hispanic Whites.

¹⁶ The federal data guidelines used by the Department on Aging define “minority” as everyone else, that is, all race/ethnicities that are not Caucasian and are not Hispanic.

Limited English Proficiency is a Barrier for Behavioral Health Access

One major barrier for older adults' access to behavioral health care is the language spoken at home and whether the individual speaks English "less than well." Due to the state's historical origins and the large inflow of immigrants, California "is one of the most language-diverse in the nation,"¹⁷ with more than 100 languages spoken.

One-third of older adults age 65 and over speak a language other than English at home, but about half of those (or one-sixth of elders) speak English "less than well." Many counties have difficulty finding behavioral health staff who speak Spanish, the language spoken most frequently in California besides English. Using translators (if available) or the telephone-based translation service can be awkward for addressing highly personal issues in mental health and substance use treatment.

Several counties have high rates (between 12 and 21 percent) of older adults who have difficulty communicating in English. These include Alameda, San Francisco, San Mateo, Santa Clara, Merced, San Benito, Monterey, Tulare, Los Angeles, Orange, and Imperial counties.⁵

4. Are there groups in your county who are at significant risk of being unserved or underserved due to limited English proficiency?

Yes No **Spanish**

If yes, please list the top three major language groups or communities in greatest need of outreach for behavioral health services in your county.

5. Describe one strategy that your county employs to reach and serve various cultural and/or race-ethnicity groups within your population of older adults?
Community Hubs in libraries, Promotoras
6. Are there other significant barriers to obtaining services for older adults in your county? Yes No If yes, please check all that apply.

Transportation

Geographic Isolation

Lack of awareness of services

Mobility issues due to co-occurring physical conditions or disabilities

Lack of geriatric-trained practitioner

Stigma also prevents older adults from accessing services

¹⁷ http://www.dof.ca.gov/Reports/Demographic_Reports/documents/2011ACS_1year_Rpt_CA.pdf

BEHAVIORAL HEALTH: OLDER ADULTS CONTINUUM OF CARE

Substance Use Treatment for Older Adults: Barriers and Stigma

This section may be relevant only if your board has integrated co-occurring substance use disorders into its mission. If not, you may choose to skip this topic and question.

Addiction and late-onset alcoholism are more common for adults over the age of sixty than many think. Often the problem is invisible to the family or larger society, particularly if the person is not working, lives alone, or is a member of a social group that uses marijuana or drinks “recreationally.” Some “baby boomers,” now age 55 and over, grew up experimenting with drugs and have fewer reservations about drug use. Treatment of chronic pain conditions can lead to unintended misuse and addiction to narcotics or opiates. Some older adults are forgetful and may take their pills again or mix them with alcohol, and may become “accidental addicts.” Depression and anxiety in older adults may lead to inappropriate “self-medication.”¹⁸

Stigma, denial, lack of awareness, and nominally acceptable social use (e.g. alcohol, marijuana, prescription drugs) all play some role in both the problem and in the barriers to treatment for older adults. All these factors lead clients and family members to place considerable importance on effective strategies to identify, reach and engage older adults in substance use treatment that is specifically designed for older adults.

How large is the problem? National reports show that there are significant unmet needs for substance use disorder (SUD) treatment in older adults. Very few older adults enroll in SUD treatment, and yet the need is well-documented.

In the U.S. (2015) it was reported¹⁹ that there were at least 1.7 million adults aged 50 or older who had both mental illness and SUDs in the past year. That number corresponds to 1.6 percent of all adults 50 and older. Of these, 57 percent received mental health care or SUD treatment at a specialty facility in the past year. Mental health care only was received by 47 percent of these, both mental health care and SUD treatment were received by 7 percent, but less than 4 percent received SUD treatment alone.

Next, we consider some data for older adults in California.

¹⁸ Addiction in Older Adults: Why It's Prevalent. What Can Be Done. – Hazelden.
<https://www.hazelden.org/web/public/document/older-adults-prescription-medication-abuse-addiction-generic.pdf>

¹⁹ Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health (NSDUH). www.samhsa.gov. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2016.

Focus on Fifty-five (and over) in California: Analyses²⁰ of SUD services for clients age 55 and over yielded these findings for those admitted to treatment in FY 2014-2015.

- About 11,000 unique clients ages 55 and over were admitted to publically monitored SUD treatment. This age group accounted for only about 10% of total clients. Very few--about 80 clients--were age 75 or older.
- Most were admitted to the Outpatient Narcotic Treatment Program (NTP) -- maintenance service type (33%), or to the Outpatient Drug Free service type (27%). Residential Detoxification was next at 17%, and then Residential Treatment at over 16%.
- About 47% reported only drug (other than alcohol) problems, about 29% reported both alcohol and drug use, and 24% alcohol only.
- The top four drugs of abuse that are most commonly reported include heroin (35%), alcohol (34%), methamphetamine (almost 12%), and cocaine/crack over 6%). These four drugs accounted for 87% of substance use in adults over 55.
- For clients under 55, methamphetamine is the most commonly-reported drug.

Some SUD clients had co-occurring mental health disorders. Although the Cal-OMS-Tx data system does not collect DSM-V diagnoses, the clients were asked questions about mental health services received in the 30 days prior to entering treatment. Responses were taken as indicating likely mental health issues occurring in the prior 30 days.

- The combined percentages for clients reporting ER (emergency mental health use) or 24 hours or more psychiatric facility days are small: 3-4% range.
- About 24% reported psychiatric drug use. This is a concern because SAMHSA estimates the same 24% for all adults nationally (not just older adults).

Those SUD treatment clients, age 55 and over, with a co-occurring mental health condition were found to be somewhat less successful than other SUD clients on standard outcome measures. These outcome measures included primary drug abstinence, employment, stable housing, and participation in social support recovery days. Those with co-occurring disorders were also more likely to have been arrested.

²⁰ Findings from the Cal-OMS Tx data system were provided by the Office of Applied Research and Analysis, California Department of Health Care Services. (Tx = treatment).

TABLE 5. Data below show how many older adults (age 55 +) received different types of SUD services relative to other age groups in your community and the state.

Your County: EL DORADO

Number and Percent of Clients by SUD Treatment Type (FY 15-16)

Age Group	Detoxification	Outpatient NTP	Outpatient non-NTP	Residential Tx	Total (each row)
Age 55 & over	1 1.89 %	0 0 %	33 62.26 %	19 35.85 %	53
Age 37-54	4 2.05 %	0 0 %	108 55.38 %	83 42.56 %	195
Age 26-36	8 2.35 %	0 0 %	155 45.59 %	177 52.06 %	340
Age 15-25	1 0.46 %	1 0.46 %	123 56.68 %	92 42.4 %	217

CALIFORNIA: Statewide

Number and Percent of Clients by SUD Treatment Type (FY 15-16)

Age Group	Detoxification	Outpatient NTP	Outpatient non-NTP	Residential Tx	Total (each row)
Age 55 & over	3,005	3,674	3,363	2,061	12,103
Age 37-54	8,395	7,340	16,475	9,148	41,358
Age 26-36	7,442	7,719	20,216	11,170	46,547
Age 15-25	3,555	2,974	18,467	6,014	31,010
Column TOTALS:	22,397	21,707	58,521	28,393	131,018

In the state and county data above, the age break for older adults was lowered to 55 because SUD problems in older adults may have roots in late middle age, with increased impairment in subsequent years. Examination of the data across many counties results in two key observations (among others possible):

- The number of adults age 55 and over who received SUD treatment of any type is generally much less than for other age groups, even though older adults represent an increasing share of the total population.
- In the majority of small counties with populations <100,000, there are relatively few options for types of SUD treatment besides outpatient treatment (non-NTP). The large number of “zeroes” shown under other types of treatment may indicate a disparity in access to those services.

7. One of our goals is to identify unmet needs for substance use treatment in older adults. Based on local community needs assessments or other reports, what substance use treatment services are available in your county for older adults?

Please check all that apply.

Outpatient NTP (narcotics treatment program (methadone, etc))

Outpatient (non-NTP)

Detoxification

Residential Treatment

Dual Diagnoses Programs

Workforce licensed/certified to treat co-occurring MH and SUD disorders

Safe housing options for clients working to be clean and sober (also applies to dual diagnosis clients)

SUD Treatment program designed for older military veterans

Other, please specify. _____

*= available for all population age groups, not just older adults

**= Safe housing options for clients working to be clean and sober but DOES NOT APPLY to dual diagnosis clients.

Mental Health Services for Older Adults²¹

Although our main focus here is on serious mental illness, we keep in mind that major depression shortens lives due to interactions with medical conditions and due to suicide. Untreated depression in older adults also increases the risk for developing dementia.

Major depression and anxiety disorders are the most prevalent mental health concerns in older adults in the U.S. Approximately 11 percent of older adults have anxiety disorders.²² About 15-20 percent of older adults have experienced depression at some point.²³ Within one year (2015), about 4.8 percent (or 5.2 million) adults over 50 experienced a major depressive episode, and 62% of those experienced major impairment.²⁴ About 67% of those with major depression received treatment.²⁵

Even mild depression lowers immunity and compromises a person's ability to fight infections and cancers.²³ Untreated depression results in worse disease progression and increased risk of death following a heart attack or stroke or in congestive heart failure.²⁵ Nearly half of all treatment for depression occurs in the primary care setting and often involves medication, but doctors report difficulty and long waits getting appointments for patients to speak with a therapist.

Many older adults experience cultural barriers that deter them from seeking treatment for behavioral health issues. However, the greatest barrier to accessing mental health services is financial and applies across the life span, including older adults. Those over age 65 rely on Medicare, which covers some outpatient mental health services (Part D). Some older adults have both Medicare and Medi-Cal coverage.

In the following pages, we examine Medi-Cal-funded Specialty Mental Health Services which are targeted for those with serious mental illness.

The total count of unique clients age 55 and over who received Specialty Mental Health Services was 69,087 in CY 2015; about 41% were male and 59% were female. **Our Commission would like to see actual numbers versus the percentage.**

The Affordable Care Act (ACA) enabled 28% of these older adults (total 19,376) to access mental health services. Nearly all of those clients fell into the age group 55-69.

²¹ We express appreciation for the Specialty Mental Health Services data in this section, which were prepared by Behavioral Health Concepts, Inc. (the current External Quality Review Organization, EQRO) and were presented by Dr. Saumitra SenGupta to a committee meeting of the Planning Council on April 20, 2017. Data analysis and graphs were constructed by Rachel Phillips, M.S.

²² American Psychological Association, 2005. <http://www.apa.org/about/gr/issues/aging/mental-health.aspx>

²³ Geriatric Mental Health Foundation, 2008.

²⁴ Key Substance Use and Mental Health Indicators in the U.S.: Results from the 2015 National Survey on Drug Use and Health, 2016. <http://www.samhsa.gov>.

²⁵ Preparing for Mental Health Needs of Older Adults, by B. Forester, MD et al, webinar (2017), www.samhsa.gov.

The following data shows which age groups of older adults were most likely to receive Specialty Mental Health Services in CY 2015. Ages 55-69 account for the majority of older adults who received services. Of those, the age group 55-59 had the largest number of individuals who received services. Age 80 and over had the fewest services compared to the other categories of older adults.

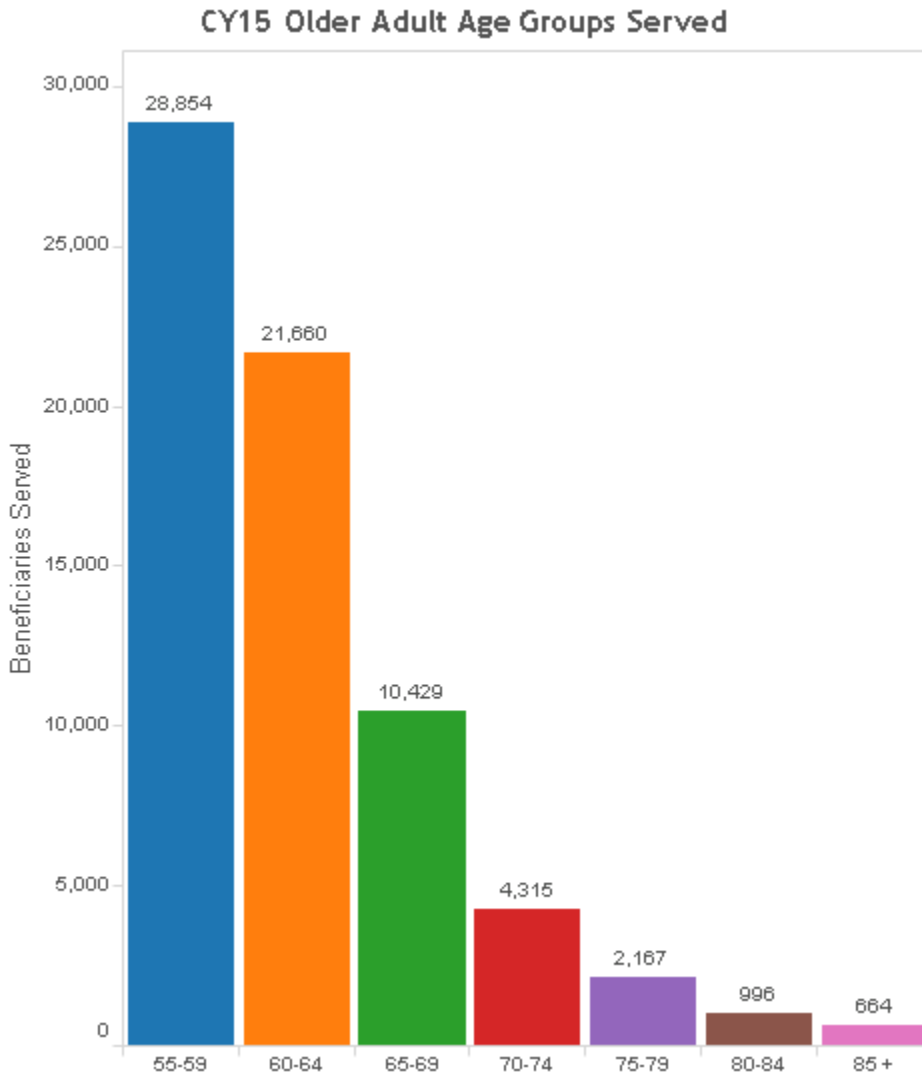


Figure 3. Subcategories by Age of Older Adults who received Specialty Mental Health Services in California (CY2015). Our Commission would like to see this represented as a percentage of the total population

Older adult (age 55 and over) Specialty Mental Health clients were found in greatest numbers in L.A. County, followed by the Southern region and Bay Area counties,²⁶ as shown in the next figure. The Superior region had the lowest number of older adults who received these services, which reflects this region’s composition of mostly small-rural and small-population counties spread over large geographic areas.

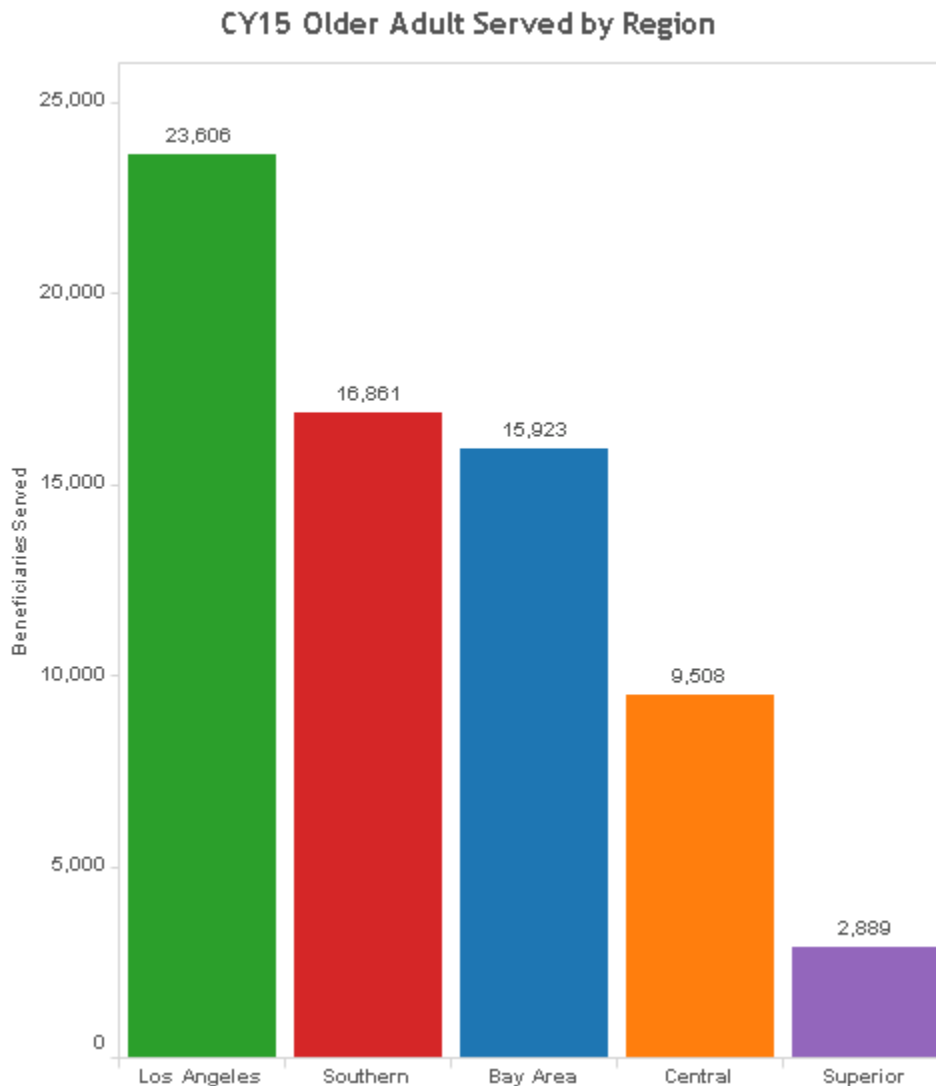


Figure 4. The numbers of persons in each region who received Specialty Mental Health Services (“beneficiaries”, CY 2015). Los Angeles County is taken to be its own region.

²⁶ Bay Area : Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma counties

Central region: Amador, Alpine, Calaveras, El Dorado, Fresno, Inyo, Kings, , Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Sierra, Stanislaus, Sutter, Tuolumne, Tulare, Yolo, Yuba counties

Superior Region: Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Siskiyou, Tehama, Trinity counties

Southern: Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Ventura.

Next, we present data to address how many older adults in each of the major race/ethnicity demographic groups received Specialty Mental Health Services. Data for older adults in five major race/ethnicity categories plus “Other”²⁷ are shown below.

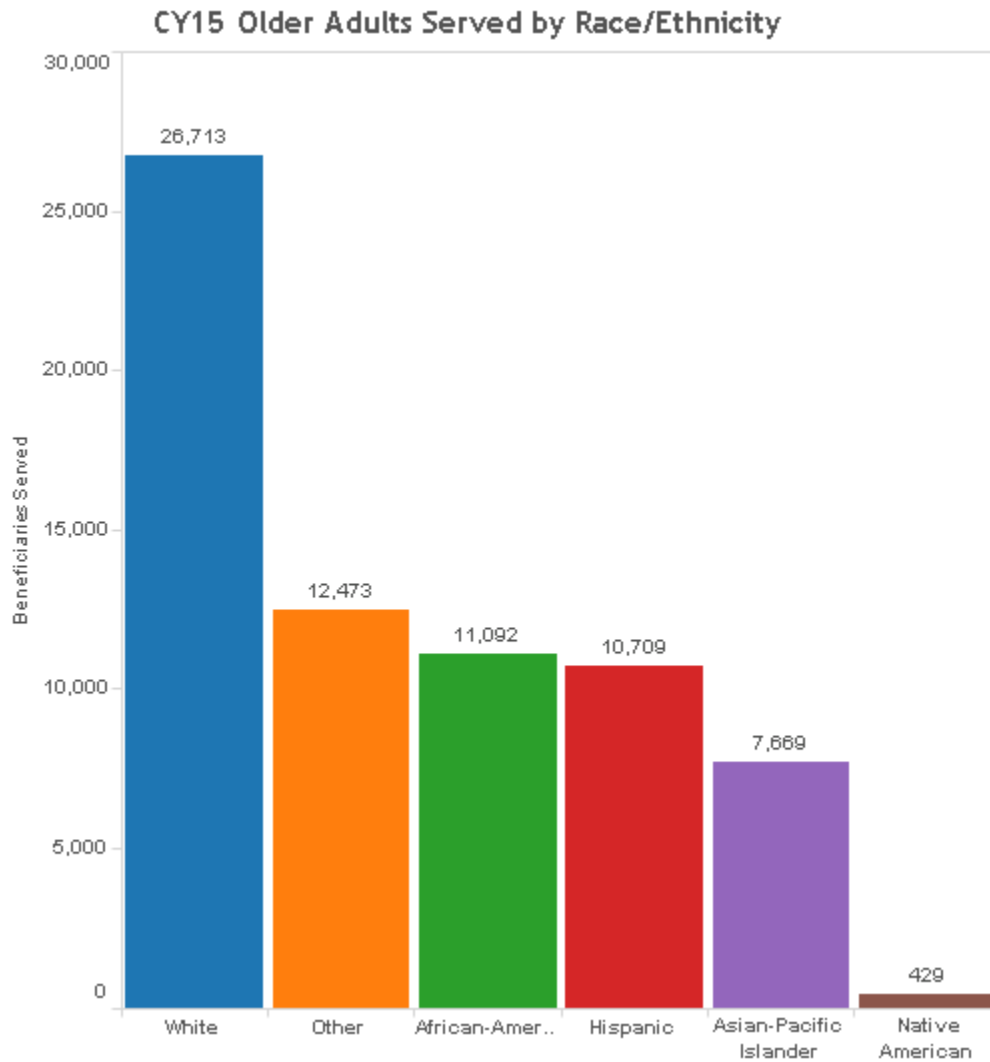


Figure 5. The major demographic groups of older adults who received Specialty Mental Health Services (CY2015), by race/Ethnicity, shown with the number of persons in each group (“beneficiaries served”).

²⁷ “Other” was defined to include the categories of one or more races, another category not given as an option, or those for whom this information was not supplied (therefore “unknown”).

It is important to know the most common types of mental health services received by older adult clients. These data are shown in the figure below. The top three most frequent types of services were medication support, mental health services, and case management. The numbers of clients who received crisis intervention and crisis stabilization services are not very large, but these services are important in helping to avoid hospitalization and other expensive residential treatment services.

The least frequently-used services were day treatment, residential services, and inpatient services. However, these last three categories are the most expensive services to provide, based on the cost per individual claim for clients who needed those services. High-expense claims can strain county budgets when there is increased use.

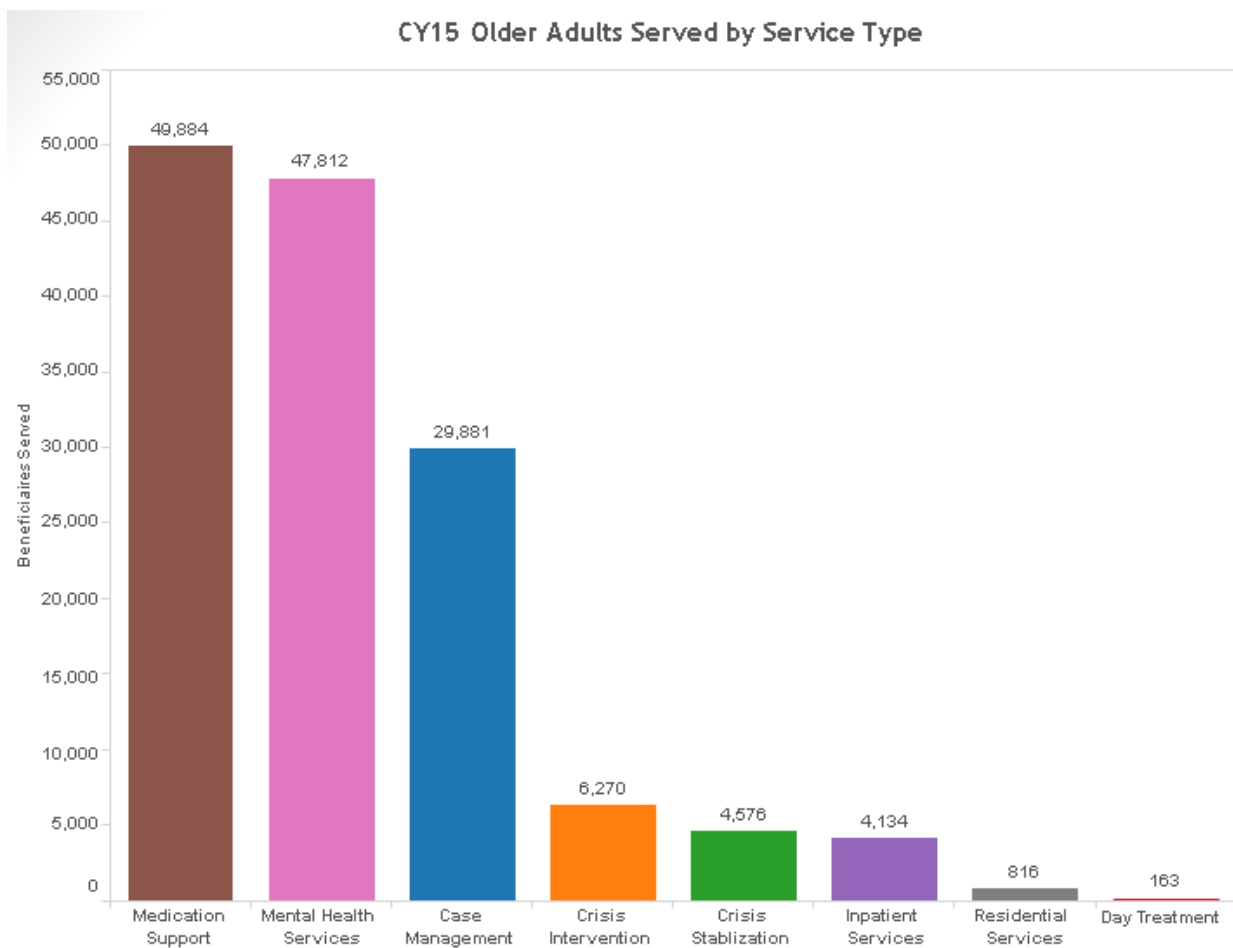


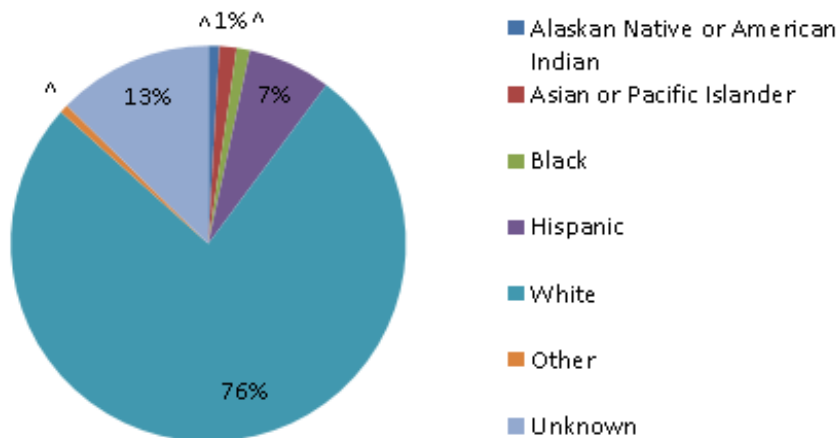
Figure 6. The most frequently used specialty mental health services are shown by the total number of older adults (“beneficiaries served”) who received each type of service.

After reviewing the statewide data above, we now examine data from your county for adult and older adult clients served compared to all Medi-Cal certified eligible adults.

Demographic Data for Your County: El Dorado (FY 2014-2015)

Top: Major race/ethnicity groupings of eligible adults who received one or more specialty mental health services during the fiscal year.

Fiscal Year 14-15 Race Distribution



Below: Age Groups of Medi-Cal eligible adults who received one or more specialty mental health services during the fiscal year. Note the percentage for older adults.

Fiscal Year 14-15 Age Group Distribution

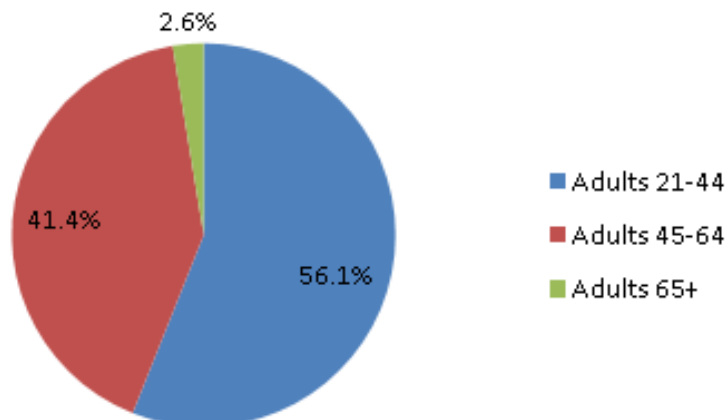


Figure 7. Demographic data for your county (FY14-15): adults and older adults who received Medi-Cal funded specialty mental health services (SMHS).²⁸

²⁸ See Performance Outcomes Reports for adults from California Department of Health Care Services, <http://www.dhcs.ca.gov/services/MH/Pages/2016-Adult-Population-County-Level-Aggregate-Reports.aspx>. Smaller counties with populations under 30,000 only list the numbers if they are within HIPAA privacy guidelines for data reporting. Redacted (or masked) data values are marked by the symbol “^”.

**Table 6. Data for your County: El Dorado (FY 2014-2015)
Specialty Mental Health Service Visits (SMHS) and Service Penetration Rates**

Top: Adults who received at least one SMHS visit during the year. Our Commission would like to see a Medi-Cal expected penetration rate.

	Adults with 1 or more SMHS Visits	Certified Eligible Adults	Penetration Rate
All	938	24,719	3.8%
Adults 21-44	526	12,925	4.1%
Adults 45-64	388	9,257	4.2%
Adults 65+	24	2,537	0.9%
Alaskan Native or American Indian	^	179	^
Asian or Pacific Islander	13	843	1.5%
Black	^	226	^
Hispanic	64	2,428	2.6%
White	717	18,032	4.0%
Other	^	218	^
Unknown	119	2,793	4.3%
Female	493	12,891	3.8%
Male	445	11,828	3.8%

Bottom: Adults who received five or more SMHS visits during the year. SMHS does not include mild to moderate mental impairment, so older adults who met mild to moderate impairment would not be captured in this data.

	Adults with 5 or more SMHS Visits	Certified Eligible Adults	Penetration Rate
All	628	24,719	2.5%
Adults 21-44	346	12,925	2.7%
Adults 45-64	268	9,257	2.9%
Adults 65+	14	2,537	0.6%
Alaskan Native or American Indian	^	179	^
Asian or Pacific Islander	^	843	^
Black	^	226	^
Hispanic	48	2,428	2.0%
White	468	18,032	2.6%
Other	^	218	^
Unknown	82	2,793	2.9%
Female	331	12,891	2.6%
Male	297	11,828	2.5%

Notes: County data for Medi-Cal eligible adults (“certified”) who received Specialty Mental Health Services during the year. The table at top shows numbers for those who

received at least one service (one measure of “access”). The lower table shows how many adults received five or more services during the year (one measure of “engagement”). Take special note of data for “Adults 65+.”

8. Based on either the data or your general experience in your county, do you think your county is doing a good job of reaching and serving older adults in need of mental health services?

Yes___ No__x_

Our Commission believes our County does a good job with services being open to individuals across the lifespan, and the County offers a lot of “soft” services such as Meals on Wheels, Adult Day Care, etc., to engage older adults. However, the services offered are not necessarily “clinical” services.

If ‘No,’ then what strategies might better meet the MH needs of older adults?

Provider education in geriatrics across the spectrum, dedicated geriatric practitioners, outreach and education specific to older adult population and their families and caregivers.

Community Supports for Mental Health Emergencies and Crisis Services

Our understanding is that there are relatively few counties with crisis intervention or stabilization services with specialized training in helping older adults. Instead, they rely mainly on the adult system of care for all adults. In the CMHPC Statewide Overview Report²⁹ (2015), responses from a number of counties identified needs for crisis services specifically targeted to older adults.

9. Does your county have resources to provide mental health crisis services designed specifically to meet the needs of older adults?

Yes___ No_x*___ If yes, please check all that apply below.

*The listed services are available for all populations, but we do not have specific programs only for older adults. County of El Dorado does have one clinician who has older adult knowledge. The County also is engaging in a current effort of mental health clinicians riding with law enforcement for mobile crisis interventions, which will also serve the older adult population. (BH staff does sometimes accompany APS on home visits for older and dependent adults with mental health concerns, staffing permitted.)

²⁹ CMHPC Statewide Overview Report on Behavioral Health in California, December 2015.
<http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx>.

___Mental health providers trained in MH needs of older adults **Crisis Intervention Training – it is not specific to older adults.**

___Crisis Intervention Teams have someone trained in the needs of older adults

___Provide training and work more closely with law enforcement in handling MH crisis of older adults

___Crisis Drop-In Center with ability to serve older adults

___Services for older adults at risk for suicide

___23-Hour Crisis Stabilization Services for older adults

___Crisis residential treatment for older adults

___Psychiatric hospital or unit able to take older adults with complex medical needs, when mental health crises are too serious to be met by other services

The PHF does not deal with medical needs.

Mental Health Supports for Older Adults who Provide Care for Children or other Family Members

Grandparents may be the primary care providers for children due to a number of circumstances. For example, the state of California has programs and policies to increase efforts to identify relatives who can provide foster care by programs such as “KinCare.” Placements may include grandparents, ‘great-aunts’ and/or ‘grand-uncles’ or other relatives. Some of these children have complex mental health and behavioral issues that involve systems for juvenile justice, substance use treatment, or special education services. Child welfare or other social services departments may have programs to provide supportive services to family relatives who provide foster care. We do not have data for foster children living with relatives to share with you.

However, the statewide data for grandparents who are responsible for children under 18 may be informative. In some cases, the child’s parents are adults who also live in the household but for various reasons are not considered to be the responsible guardian.⁶

Table 7. Grandchildren Living with a Grandparent by Responsibility and Presence of the Parent (California, 2011)⁶

Grandparent Householder Responsibility for Own Grandchildren	Number	Percent
Responsible	310,107	40.0%
Parent Present	228,819	29.5%
No Parent Present	81,288	10.5%
Not Responsible	464,786	60.0%
Total	774,893	100.0%

The data for your county show:

El Dorado County (2011):

Total persons age 65 years and older: 26,590 (14.7 % of total population).

Grandparents living with own grandchildren under 18 years: 3,111.

Grandparents responsible for grandchildren: 898 (which is 29 % of the grandparents living with children under the age of 18.)

The stresses and demands experienced by elderly foster parents or grandparents also apply to another population of caregivers. Older adults may be the primary care providers for other adults: perhaps an adult child or an aging spouse. Such family members may have cognitive impairment, developmental delay, complex medical or mental health issues, or serious physical disabilities. These elderly caregivers may need emotional support, mental health services, respite care, or other assistive services. We do not have data for how many older adult caregivers are providing extensive care in their home for a close relative.

The following question focuses mainly on mental health or other supportive services for older adults who are the primary care providers for those under 18: most often grandchildren, grandnieces/nephews, or other 'kinfolk' or relatives. However, if you wish, you may also include services or programs that assist older adults who provide extensive care for a dependent adult family member.

10. Does your county have specific services or programs to support older adults who provide extensive care for dependent family members, so that caregivers can meet their own mental health and other needs?

Yes_x* No___

If yes, please check all that apply below. **Services are for the general population, not just older adults.**

Group therapy-**No**; or support groups- **Yes (Family Caregiver Support Program)**

Counseling/parenting strategies

Respite care services

In-home supportive services (IHSS)

Stress management program

Mental health therapy, individual **Not specific to caregivers or caregiving**

Other, please specify: **Adult Day Services, MHSA PEI- Senior Peer Counseling**.

Significant Changes in Behavioral/Cognitive Function in Older Adults

This section builds on the continuum of care for older adults experiencing urgent mental health conditions who exhibit a sudden change in their behavioral health and ability to care for themselves. Planning Council stakeholder discussions identified major concerns about experiences with mentally ill (but stable) older adult family members who exhibit a sudden worsening or new behavioral and cognitive symptoms.

These conditions may present diagnostic challenges for professional care providers to tell the difference between severe depression, early dementia, or medical delirium related to change in physical or medical condition (including prescription medication issues). The diagnosis will (1) differentiate those clients who need primarily mental health services from other types of services, and (2) those who have medical or cognitive issues that interfere with the tasks of daily living and self-care.

Major depression affects up to 20 percent of elderly adults, some of whom may exhibit "pseudodementia:" cognitive impairment arising from the depressive disorder itself.

Delirium is an acute confusional state caused by an underlying medical disorder which usually resolves promptly in response to medical treatment. Delirium may be experienced by 10-30 percent of hospitalized elderly patients.

Dementia manifests in gradually increasing cognitive impairment, memory problems, and difficulty coping with the ordinary functions of daily life.

Evaluation of elderly patients includes their baseline ability to perform the normal activities of daily living (ADLs). “ADLs relate to personal care including bathing or showering, dressing, getting in or out of bed or a chair, using the toilet, and eating.”³⁰ Other functions, called instrumental activities of daily living (IADLs), include preparing food, managing finances, grocery shopping, using a telephone, and doing housework.²¹

Distinguishing between mental illness, depression, or early dementia in elderly patients is critical to ensure referral to the most appropriate agency or provider to get the right care. Prompt assessment is essential to avoid overwhelming departments of behavioral health with individuals who would be better served by other agencies or by medical specialists in dementia-focused care.

The information in the table below is presented to inform patients and families and to help facilitate conversations with professional care providers who have expertise in making these determinations and planning treatment.

Table 8. Characteristics of Depression, Delirium and Dementia²⁷

	Depression	Delirium	Dementia
Onset	Weeks to Months	Hours to Days	Months to Years
Mood	Low/Apathetic	Fluctuates	Fluctuates
Course	Chronic; responds to treatment	Acute: responds to treatment	Chronic, with deterioration over time
Self-Awareness	Likely to be concerned about memory impairment	May be aware of changes in cognition; fluctuates	Likely to hide or be unaware of cognitive deficits
Activities of Daily Living (ADLs)	May neglect basic self-care	May be intact or impaired	May be intact early, become impaired as disease progresses
Instrumental Activities of Daily Living (IADLs)	Maybe intact or impaired	May be intact or impaired	May be intact early, but impaired before ADLs as the disease progresses.

³⁰ American Medical Association Journal of Ethics, June 2008, Volume 10, Number 6, pages 383-388, downloaded from <http://journalofethics.ama-assn.org/2008/06/cpr11-0806.html>.

As part of their Older Adult System of Care, some county Departments of Behavioral Health have a division (e.g. San Mateo, Orange) or may contract with a provider, (e.g. Gardner in Santa Clara) for outreach and services to older adults with chronic mental illness, some of whom are homebound or have limited mobility for travel to a care provider. These programs may help keep the client out of a mental health facility or hospital. When the time comes, clients who display increasing physical frailty or cognitive impairment may be helped with care coordination or linkages for transition to an assisted care facility more appropriate to their changing needs. Counties may address such problems in a variety of ways.

11. Does your county have a special program(s) to address the needs of older adults with chronic mental illness who also begin to be affected by mild cognitive impairment or early dementia? Yes___ No_x__

If yes, please provide one example.

OLDER ADULTS HELPING OTHERS:

Peer Counselors and Health Navigators

Peer counselors are individuals with “lived experience” in the experience of recovery from mental illness and/or substance use disorders. These individuals receive specific training in the scope of their role and how to be effective at helping others who are on the road to recovery. Health navigators are a specific type of peer counselor that helps people navigate the health care system and may provide information about other services which are available, such as food, housing, or medical care. Clients and family members of clients may participate in this type of work, depending on their past experience and personal skills.

12. Does your community train and/or utilize the skills and knowledge of older adults as peer counselors, and/or health navigators? Yes_x__ No___

If yes, then please provide one example of how this occurs.

Senior Peer Counseling
HICAP

QUESTIONNAIRE: How Did Your Board Complete the Data Notebook?

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Mental Health Planning Council. Questions below ask about operations of mental health boards, behavioral health boards or commissions, regardless of current title. Signature lines indicate review and approval to submit your Data Notebook.

(a) What process was used to complete this Data Notebook? Please check all that apply.

MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions.

MH Board completed majority of the Data Notebook **Temporary Ad Hoc committee partnered with County Behavioral Health staff to complete the Notebook.**

County staff and/or Director completed majority of the Data Notebook

Data Notebook placed on Agenda and discussed at Board meeting

MH Board work group or temporary ad hoc committee worked on it

MH Board partnered with county staff or director

MH Board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.

Other; please describe: _____.

(b) Does your Board have designated staff to support your activities?

Yes No

If yes, please provide their job classification **Mental Health Director, Assistant Director of Adult System of Care, Deputy Director, Program Managers, Sr. Dept. Analyst, Administrative Technician**

(c) What is the best method for contacting this staff member or board liaison?

Name and County: [County of El Dorado, Heather Longo, Sr. Dept. Analyst](#)

Email heather.longo@edcgov.us_____

Phone # [530/621-6340](#)_____

Signature: _____

Other (optional): _____

(d) What is the best way to contact your Board presiding officer (Chair, etc.)?

Name and County: [County of El Dorado, Jim Abram, Chair,](#)
[Mental Health Commission](#)

Email: jimabram@comcast.net_____

Phone # [530/644-5505](#)_____

Signature: _____

REMINDER:

Thank you for your participation in completing your Data Notebook report.

Please feel free to provide feedback or recommendations you may have to improve this project for next year. We welcome your input.

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.ca.gov.

For information, you may contact the email address above, or telephone:

(916) 327-6560

Or, you may contact us by postal mail to:

- Data Notebook
- California Mental Health Planning Council
- 1501 Capitol Avenue, MS 2706
- P.O. Box 997413
- Sacramento, CA 95899-7413

