HCAi
Department of Health Care Access and Information

Agenda Item 16:

Behavioral Health and the Aging Population

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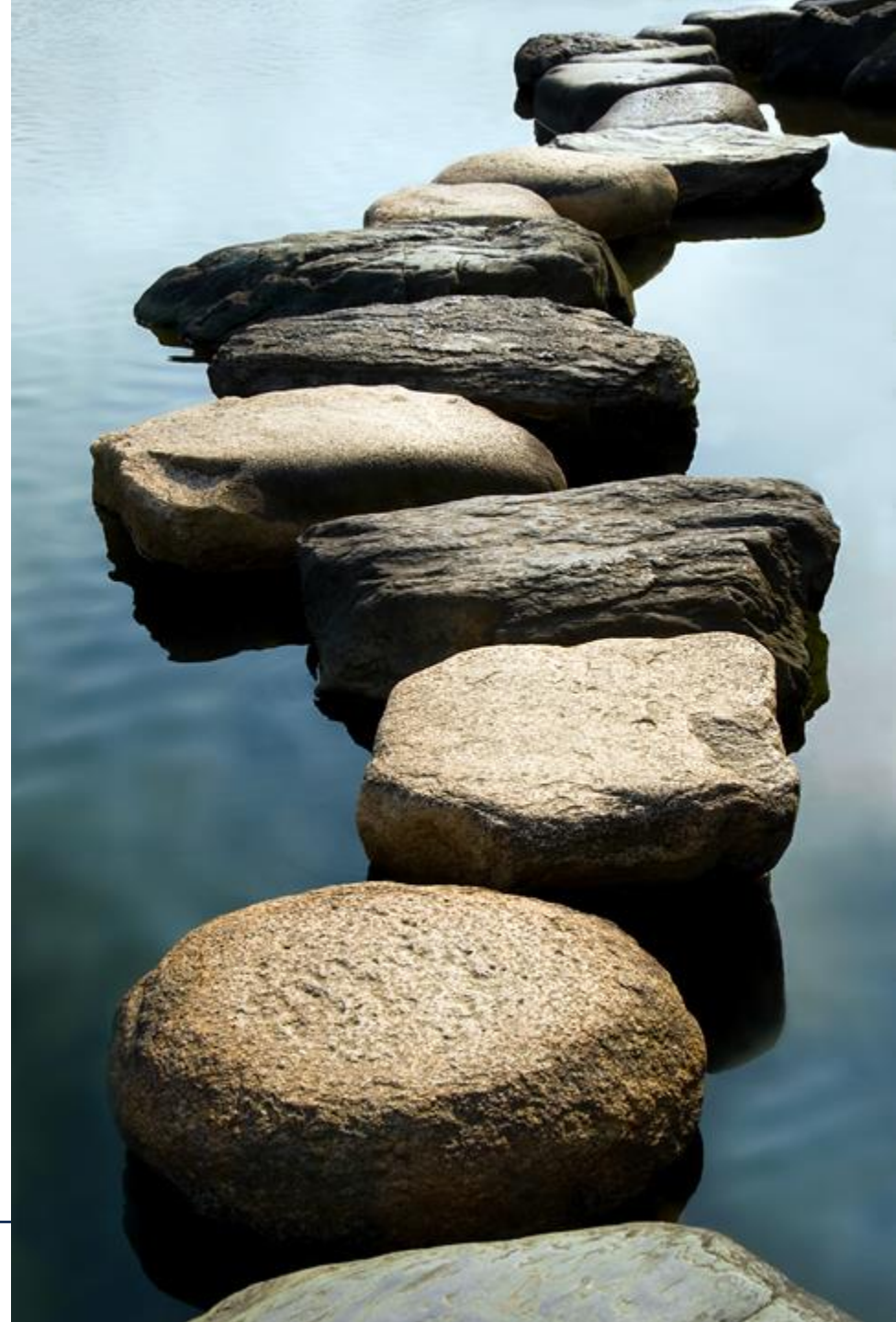
Road Map

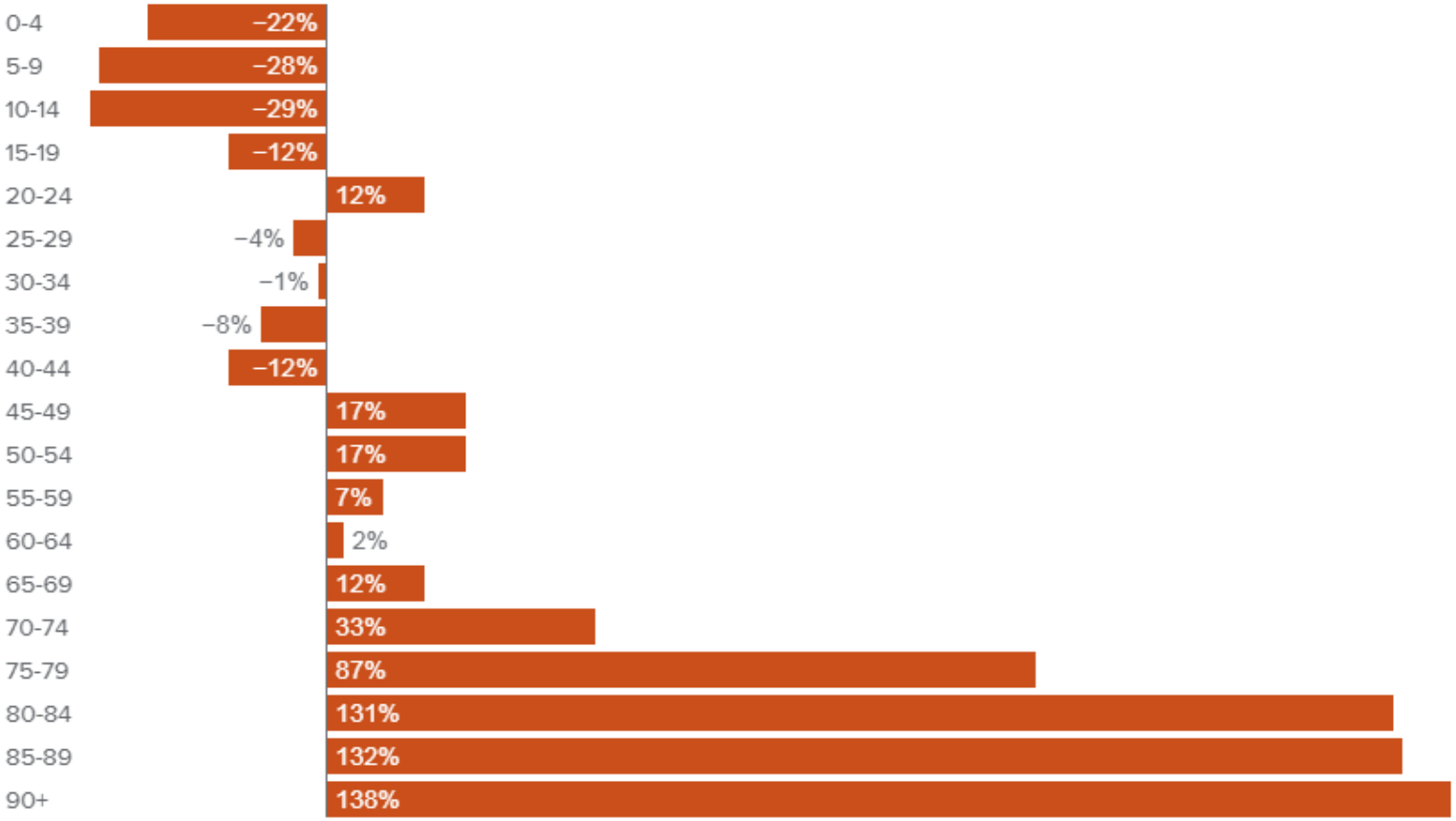
1. Framing the challenge
    - Aging population in California
2. Mental disorders affecting older adults
    - Access to care
3. Mental health workforce
    - Scope and composition
4. Workforce stressors and system gaps
5. Policy Opportunities and Levers



Framing the challenge

Older Adults on the Rise

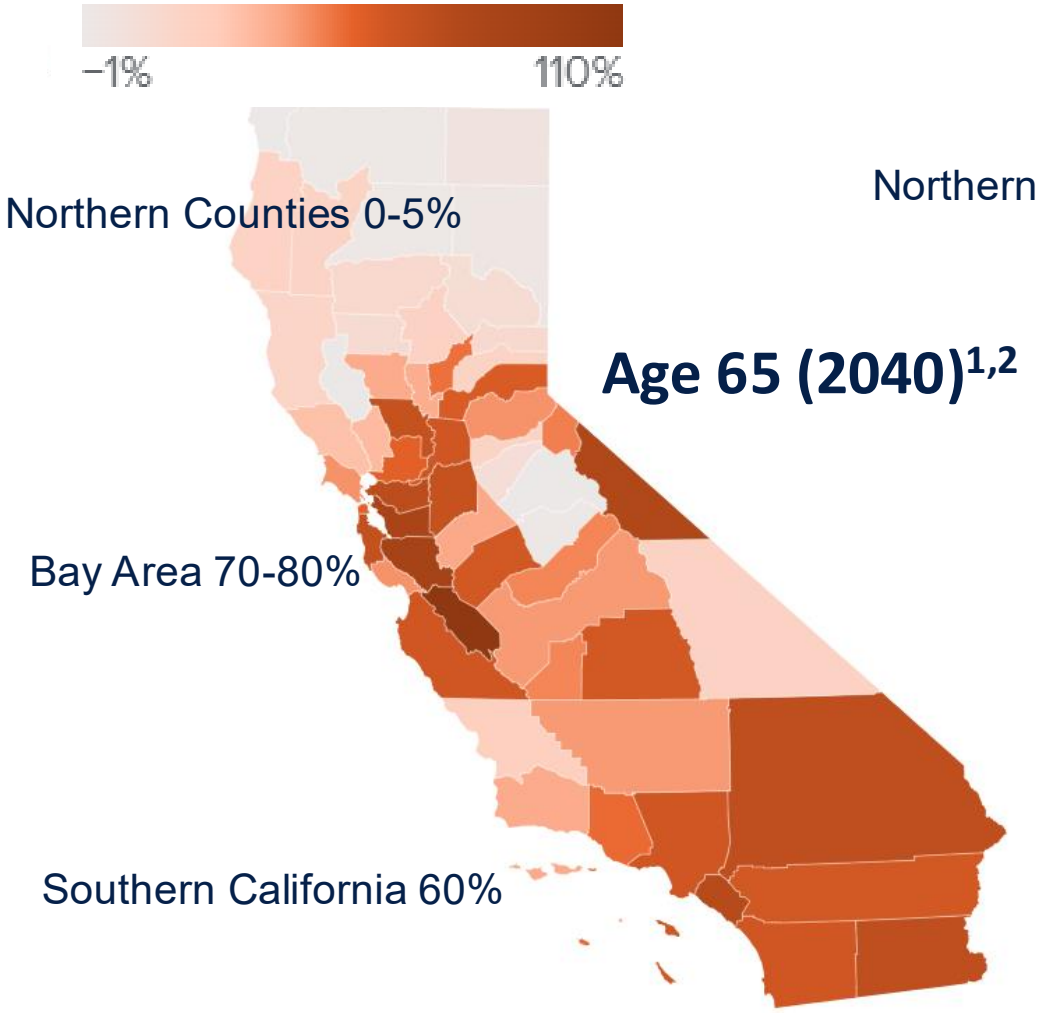
- In 2000 – 1 in 7 Californian's were older adults[1,2]
- By 2040 - 1 in 4 Californians will be over 60
- Increase of 142% from 2000-2040
- Working age (20-64) growth is 3%



SOURCE: California Department of Finance, Population Projections, Vintage September 2024.

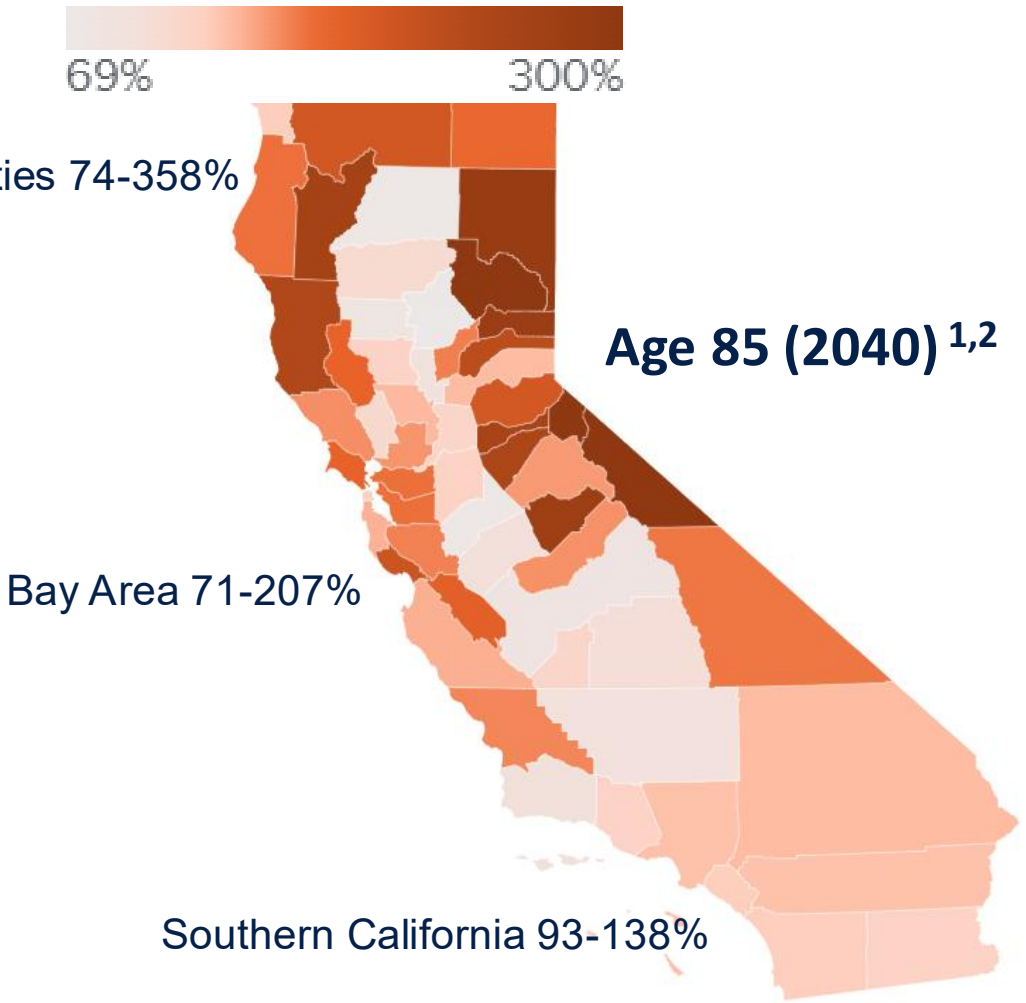
Public Policy Institute of California https://www.ppic.org/publication/californias-aging-population/
California Department of Finance https://dof.ca.gov/forecasting/demographics/projections/

Aging Is Uneven Across California Counties: A look at 2040



Age 65 (2040)[1,2]

SOURCE: California Department of Finance, Population Projections, Vintage September 2024.

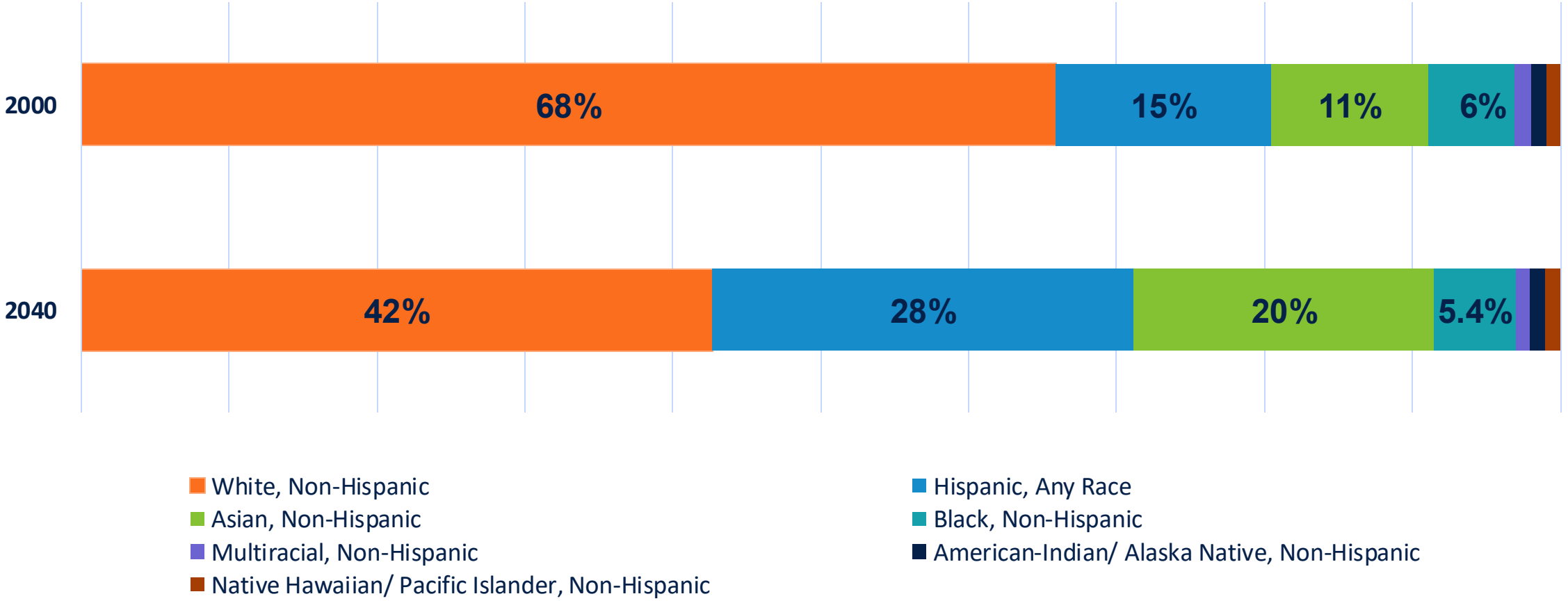


Age 85 (2040) [1,2]

SOURCE: California Department of Finance, Population Projections, Vintage September 2024.

Racial and Ethnic Diversity of Older Adults in California

Older Adults by Race/ Ethnicity 2000-2040[3]



California Department of Aging https://aging.ca.gov/

Diversity and Mental Health Disparities

- By 2030 about 5% of older adults in California will identify as LGBTQIA+
- LGBTQIA+ → Higher risk and rates of suicide, exposure to violence, and trauma
  - California Department of Aging LGBTQIA+ 2024 survey[4]
    - Lack of access to care, social support, and mistrust in providers
    - Need for provider training, increased assess to gender affirming behavioral health care
  - LGBTQ+ Aging Focus Group Project (2024)[5]
    - Agism, invisibility, declining health, and grief
    - Community, resilience, chosen family
- Black and Latinx Older Adults → Higher rates of psychological distress, financial strain, untreated chronic conditions, and lower rates of mental health utilization[6]

Income, Housing, and Health Insurance

- By 2033 – 89% over 75 will not have resources to pay for care[7]
- 1:4 are projected to live **in or near poverty** by 2040[1]
- 70% of older adults projected to be homeowners by 2040[1]
  - Housing stability at a cost – "**housing rich, income poor**"
  - 30%+ may not be able to afford a mortgage in retirement
- Rise in older adults experiencing homelessness in California[6,7]
  - 166% increase from 2017-2022
  - **Adults over 50 make up 48%** of states homeless population (2022)
    - 41% of those had first incident of homelessness after the age of 50
- The **"overlooked middle"** – Medicare but no Medi-Cal

Older Adults in the Workforce 2020-2040 projections

- **Older adults are extending work life**
  - Longer lifespans, delayed retirement, rising living costs
  - Insufficient retirement savings or gaps in social security
- Labor force participation **on the rise** for 65–74-year-olds[1]
  - In 2020 **~30%** of 65–74-year-olds are in the workforce - projected to rise **~ 40% by 2040**
  - Low/ no increase in those 75 and up
  - Growth strongest among women and people of color
  - Recent AARP study: 75% of women ages 40 to 89 - menopause symptoms interfere with their lives; 1 in 10 say it is debilitating[30]
- **Aging care workforce**
  - ~60% of personal care / home health workers in CA are over age 40; ~40 % over age 55
- **Workplace barriers** include:
  - Health and functional limitations, digital skill gaps
  - Lack of accommodations or flexible roles
  - Ageism and limited pathways for retraining or advancement

Social Determinants of Mental Health[8]

- Social determinants of health (SDoH)
  - Non-medical factors that influence health outcomes and health inequality
- Social determinants of mental health (SDoMH)
  - SDoH + **stigma** of mental illness, mental health **disparities**, flawed criminal **justice** system, and **homelessness**
- Social determinants of mental health in older adults
  - SDoMH + **ageism**, **mentalism**, **ableism**, social **isolation**, & workforce shortages
    - Major role transitions, grief, and loss
    - Stereotypes, prejudice, and discrimination based on age, mental health, and ability
    - Protective factors: Wisdom, resilience, meaning, and community[9]

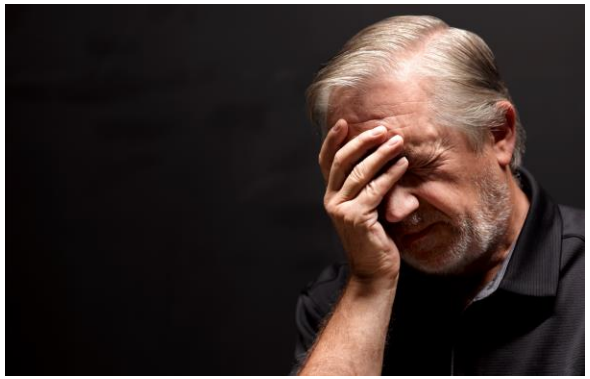
Mental disorders affecting older adults

Older Adults with Mental Illness in California

- 2021 California Commission on Aging Data[10]
  - 11.5% of adults 65+ (805,000) met diagnostic criteria for any mental illness (AMI)
  - 1% (70,000) met criteria for serious mental illness (SMI)
  - 8% of older Californians had a substance use disorder (SUD) in the past year (560,000)
  - 21% of suicide deaths in California were older adults (highest in men over 85 years)
- Elder Abuse +200,000 cases per year via Adult Protective Services and rising
- Adults and Access to Care (2017-2019)[11]
  - 63% did not receive mental health care in California
  - 4% with SUD received addiction treatment alone

Mental disorders affecting older adults

- **Major Depressive Disorder:** Chronic depression vs late life onset depression[9]
  - 14.6% of people +65 carry a diagnosis of MDD in California[12]
  - 25% higher risk of death by suicide - Men +75 highest risk, 2nd leading cause of disability worldwide
  - 2023 California Community Assessment Survey of Older Adults
    - 43% depressed, 50% dealing with loss or grief, 40% lonely[13]
  - Bipolar Disorder – depressive episodes more common in older adults, 20% of people living with bipolar are over the age of 60[14]
- **Psychiatric Symptoms**: Anhedonia, anergia, anorexia, insomnia



Mental disorders affecting older adults

- **Neurocognitive Disorders:** Neurodegenerative disorders leading to cognitive impairment - exists on a spectrum associated with loss of functional capacity
  - 1:10 older adults +65 have dementia and ~1:5 have mild neurocognitive impairment in the US[15]
    - Black, Hispanic, and those with low education are disproportionately affected in the US
  - **California Data- DHCS All Claims Data 2021[16]**
    - 18.1% Medicare FFS (dual eligible only) have Alzheimer's Dementia (AD)
    - 6.8% Medi-Cal only beneficiaries have AD diagnosis
      - 19.7% of Medi-Cal beneficiaries receiving IHSS services have AD diagnosis
- **Neuropsychiatric Symptoms**: Significant cognitive decline, interferes with daily life, requiring help with IADLs+, w/ or w/out *behavioral disturbances* – agitation, aggression, psychosis, mood changes, sleep disruptions, etc.
  - Most common associated symptoms: Apathy, Depression, Agitation → Isolation → Institutionalization[9]

Mental disorders affecting older adults

- **Schizophrenia and Other Psychotic Disorders:** A spectrum of psychotic disorders that impact insight, cognition, and functional capacity
  - Risk of suicide is 8.5 times that of the general public[9]
  - Late Onset (40-60) and Very Late Onset (+60) with symptoms present for more than 6 months
    - 20% of cases diagnosed +40, 3% after 60
    - Women 1.6x risk[17]
- **Comorbid Conditions:** Neurocognitive disorders/ dementia, cardio/cerebrovascular disease, stroke, menopause, depression, substance use disorders
  - 70% of those with schizophrenia over 80 yrs have comorbid diagnosis of dementia (Medicare)[18]

Co-occurring Mental disorders affecting older adults

- **Co-morbid Medical and Psychiatric Conditions:** Cardiovascular disease, COPD, depression, neurocognitive decline[9]
- **Substance Use Disorders:** Alcohol use, cannabis use, prescription drug misuse (opiate, benzodiazepine), and illicit stimulants are most prevalent substance use disorders in older adults [19]
  - ~8% of older adults in California with SUD
  - Overdose rates on the rise
  - Social isolation, fractures, falls, memory loss, sleep disruption, anxiety, depression
  - Loss of housing and or homelessness
- **Trauma Related Disorders and PTSD:** Chronic vs. late life exposure to trauma and new onset
  - Prevalence decreases with age; characterized by stoicism, disengagement, and co-morbid pain (VA data)[20]

Accessing Mental Health Care in California

- **Barriers**: Cost, agism, stigma, fragmentation, transportation, lack of dual diagnosis programs, medical multimorbidity, and cognitive impairments[21]
- **Lack of Access :** Screening, diagnosis, treatment, and ongoing care for mental illness
  - Black and Latinx – trust, fear, stigma, lack of culturally affirming care
  - LGBTQIA – isolation, fear, stigma, lack of gender affirming care
  - Immigrant older adults – language barriers, isolation, cultural stigma
- **Geographic Disparities**: Variation in # of services per year per Medi-Cal beneficiary
  - Madera: 1.05 (lowest) → Mendocino 3.49 (highest)[22]

Mental Health Workforce

Defining the Geriatric Mental Health Workforce[11]

- **Informal Caregivers (~1:1)**
  - Family member, friend, neighbor – *play many roles*
- **In-Home Support Service Specialists- IHSS (variable 4-7:1,000)[23]**
  - Consumer Directed Personal Care Assistance, 70% are family caregivers, $16.50-22.50/hr
  - December 2024: **823,300** Medi-Cal beneficiaries, **727,787** IHSS providers, average 117hrs/ month[24]
  - **Roles:** Medication reminders, medical appointments, in-home support and care
- **Unlicensed Professionals/ Paraprofessionals (unknown #'s)**
  - Mental Health Rehabilitation Specialists, Peer Specialist (Uncertified and Medi-Cal Certified), Community Health Worker, Non-licensed Substance Use Counselors and Technicians, Home Health Aides and Nursing Assistants.
  - **Roles:** Counseling, coaching, service linkage, case management, in-home care support, medication support
- **Licensed Primary Care Providers (90:100,000)**
  - Physicians, Nurse Practitioners, Physician Assistants, Geriatricians
  - **Roles:** Screening, assessment, diagnosis, and treatment

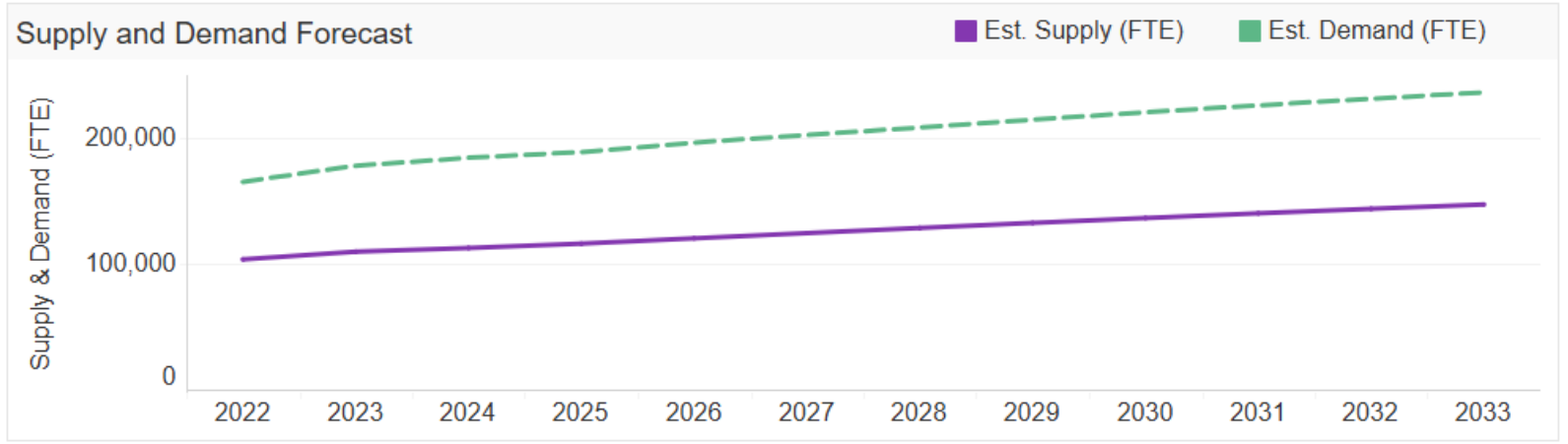
Defining the Geriatric Mental Health Workforce[11]

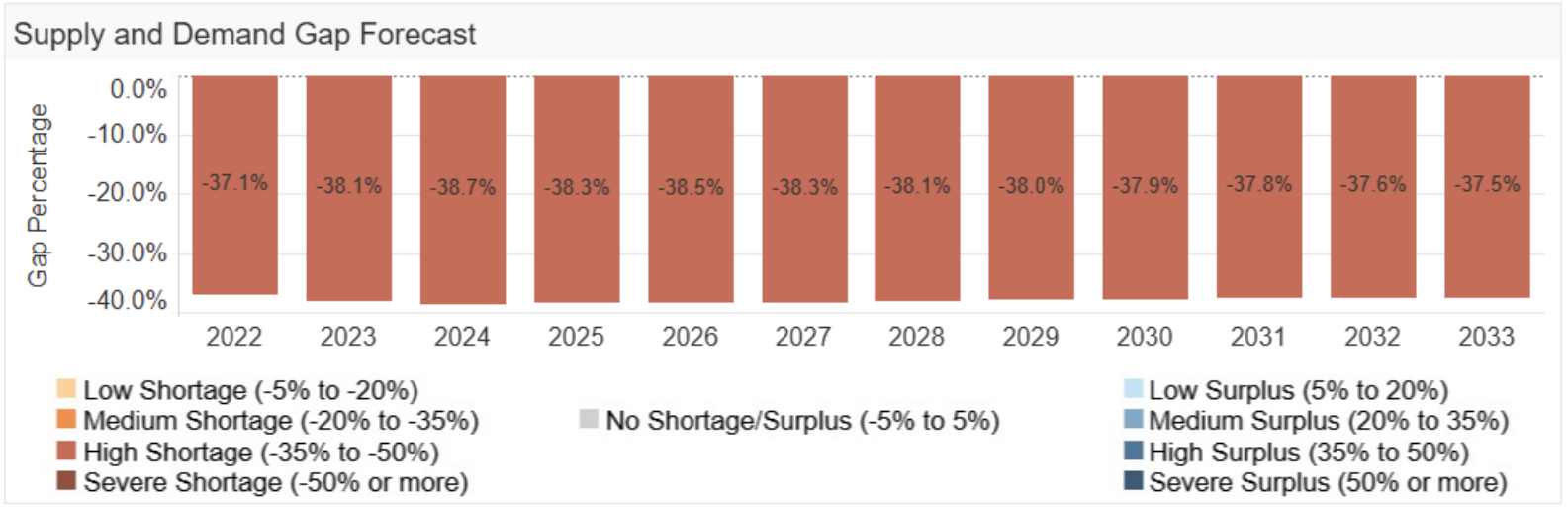
- **Unlicensed Associate Behavioral Health Professionals (unknown #'s)**
  - Associate Social Worker, Associate Marriage and Family Therapist, Associate Professional Clinical Counselor
  - **Roles:** Screening, counseling, case management, care coordination, treatment planning with supervision
- **Licensed Behavioral Health Professionals (variable 5-100:100,000)**
  - **Non-Prescribing:** Clinical Psychologists, Clinical Social Workers, Professional Clinical Counselors, Marriage and Family Therapists, Psychiatric Technicians, Vocational Nurses, Occupational Therapists, Pharmacist, Registered Nurse, Certified Clinical Nurse Specialist,
  - **Prescribing:** Psychiatric Mental Health Nurse Practitioners, Physician Assistants; Psychiatrists, Addiction Psychiatrists, and Addiction Medicine Physicians
  - **Roles:** Screening, assessment, diagnosis, and treatment – therapy, medications, other somatic interventions

Workforce Stressors and System Gaps

Supply Will Not Meet Demand[25]

HCAI: Supply and Demand Modeling for California's Behavioral Health Workforce

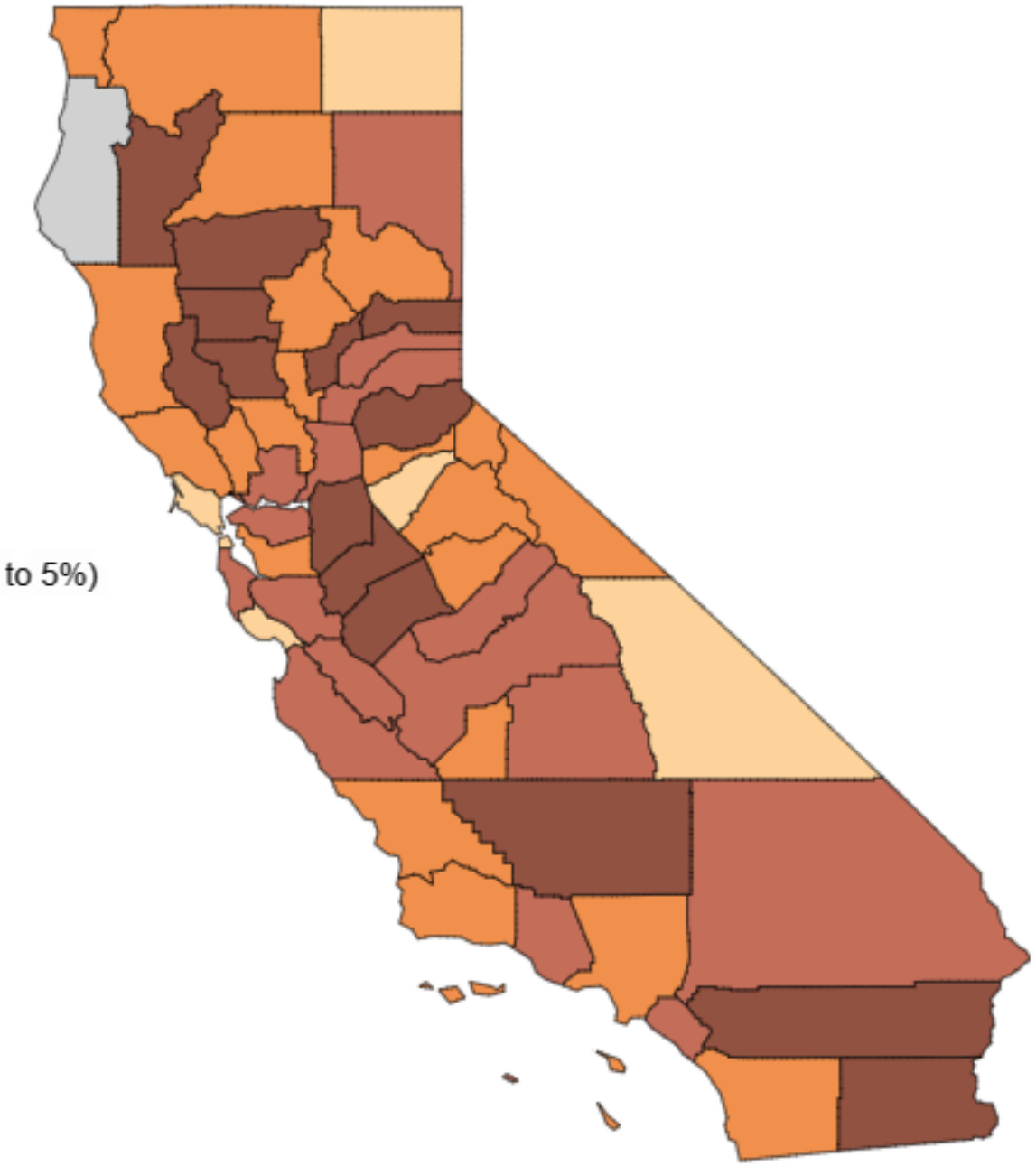




HCAI Supply and Demand Modeling for California's Behavioral Health Workforce

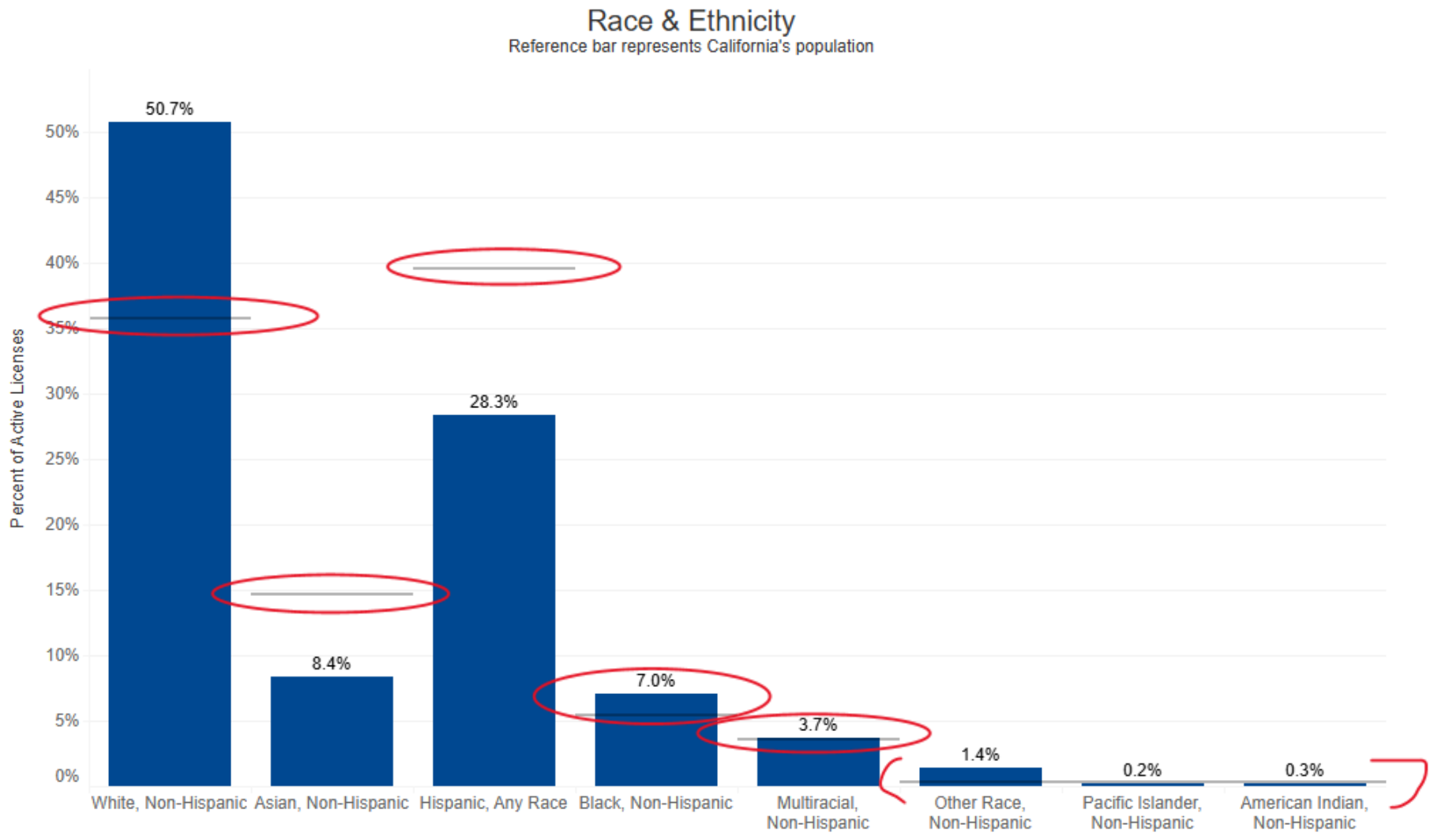
Shortage By County 2033[25]

- Low Shortage (-5% to -20%)
- Medium Shortage (-20% to -35%)
- High Shortage (-35% to -50%)
- Severe Shortage (-50% or more)
- No Shortage/Surplus (-5% to 5%)



HCAI Supply and Demand Modeling for California's Behavioral Health Workforce

Race and Ethnicity of Behavioral Health Workforce: *Does Not Meet the Needs of the Population*[25]



HCAI Supply and Demand Modeling for California's Behavioral Health Workforce

Geriatric Mental Health Workforce Challenges

- **Informal Caregivers**
  - Loss of wages, burnout, familial stress, financial strain, lack of formal supports, lack of respite care, and low-income families disproportionately affected
- **In-Home Support Service Specialists- IHSS**
  - Low wages, lack of mental health training, supervision, integration into a clinical team, excluded from formal systems of recognition, and lack of professional development[23]
  - Part-time work, lack of benefits, majority in the safety-net[24]
- **Unlicensed Professionals/ Paraprofessionals[25]**
  - Low wages ($15.60/hr), limited clinical supervision and training, role ambiguity, disproportionately affects low income, Black and Latinx, females, lower education, and non-citizens
  - **Aging workforce** - 40% are over the age of 50.
  - Lack of/ narrowed training pipelines – graduates of SUD counseling programs fell +20% from 2015-2020
  - Dementia Home Care & Nursing Assistants +60% without health insurance, +40% enrolled in safety-net

Geriatric Mental Health Workforce Challenges[26]

- **Licensed Primary Care Providers**
  - Workload, burnout, pay, unmet SDoMH, burden of mental illness in primary care
  - Lack of geriatric behavioral health training/ support
  - **Aging workforce** – in 2022 25% over age 65
- **Unlicensed Associate Behavioral Health Professionals -** Lack of supervision, low wages, high-cost of training, decline in enrollment
- **Licensed Behavioral Health Professionals**
  - Workload, competitive pay, burnout, lack of geriatric training, scope of practice restrictions, reimbursement issues
  - **Aging workforce-** 31% psychiatrists and 27% counseling psychologists are +65
  - 90% of counites reported difficulty with recruitment and retention of LCSW, LMFT, Psychiatrists, and SUD counselors.
    - Barriers: Rural, competitive pay, long hiring process, and cost of living/ housing affordability
  - Lack of diversity in the workforce → incongruence with patients served and affects training and mentorship
  - Unknown number of licensed geriatric behavioral health professionals in California
- **Older Adults in the Workforce** report positive impact on health and well-being, however, lack support for increased health needs, disability, and time off for mental health care[31]

Major Systemic Challenges[26,27]

- **Pay and benefits –** Across all roles
  - **SB 525 –** minimum wage for care workers 2023 – 5 schedules – $15-25 / hour
  - **Collective Bargaining -** AB 1672 for IHSS – failed to advance
  - **State and Federal Government Role –** CALAIM BH Payment Reform + new rate schedule → will this translate to higher pay and better benefits?
- **Training Pipeline** – Certificate, Associates, Bachelors, Masters, and Doctoral Training
  - Cost of training, loss of wages during training, housing stability, supervision
- **Current Workforce Training Gaps**
  - Intersection of mental illness, dementia, and behavior dysregulation
  - Polypharmacy and lack geriatric pharmacology training
- **Payment Reform for Behavioral Health Services –** Medicare Medi-Cal Dual Eligible, Medicare, Private
  - Payment reform aims to increase enrollment – supply and demand challenges and downstream effects on current workers
- **Worker Social Determinants of Health** — housing, transportation, and food insecurity especially relevant to unlicensed/ paraprofessional, IHSS, and informal caregivers

Policy Opportunities and Levers

California's Commitment to Behavioral Health Care

- **CalAIM –** California Advancing and Innovating Medi-Cal
  - **$12B Investment in Reforms:** Behavioral Health, Long Term Care, Enhanced Care Management, PATH programs, and Integrated Care for Dual Eligible
    - Medi-Cal Peer Support Specialist - +5,000 trained and certified
    - Long Term Care and Care Management improvements with goal of increased enrollment
    - PATH Program- $1.85B to support community capacity to address complex needs of Medi-Cal beneficiaries (2025-2030)
- **BH-CONNECT** - Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
  - **$1.9B Workforce Initiative:** Training, recruitment, and retention of the Medi-Cal BH Workforce (2025-2030)
  - Supports unlicensed and paraprofessionals, associates, and other community health / peer provider groups
  - Medi-Cal Behavioral Health: Loan Repayment, Scholarship Program, Recruitment and Retention Program, Community-Based Provider Training, and Residency Training Program.
- **PACE** - Program of All-Inclusive Care for the Elderly- 27 counties, full-service community-based care for those who would otherwise be in a nursing home

California's Commitment to Older Adults

- **CalAIM Dual Eligible Special Needs Plan (D-SNP)[28]**
- **D-SNPs** are exclusively aligned county administered Medicare Advantage Plans contracted with DHCS and state Medicaid, replaces Cal MediConnect
  - Medicare is payer for acute and post-acute, Medi-Cal wraps around to cover premiums, cost sharing, LTSS, other community-based care
  - Plan provides unified and integrated care coordination
  - Voluntary enrollment, significant variability across counties
- **Eligible:** 1.7 million dual eligible in California, rolling out 2024-2026 – 41/58 counties
- **Requirements:** D-SNP must have collaborative contracts with Behavioral Health, IHSS, Home and Community Services, and Medi-Cal Dental
  - Ensure care coordination, wrap around services, long term care services, caregiver support, LTSS assessment, palliative care, management of specialty "carve out" referrals, dental, and SDoH assessment and support

CalAIM Dual Eligible Special Needs Plan (D-SNP)[28]

- **Expanded Reimbursement and Revenue:** Quality bonuses, care coordination incentives, ICM
  - Expand and change payment for behavioral health (BH) services → cost-based to **fee-for-service**
- **Focus on Quality**: Measures rely on required staffing ratios and 4:12 metrics are behavioral health
  - **Whole person care & Integrated Care:** Improve member experience, Closed Loop Referrals, Address SDoH, etc.
  - **Required Screening, linkage to care:** Yearly Assessments- Mental Health, Cognitive, LTSS, Caregiver
  - **BH Documentation Reform:** active and ongoing problem list, progress notes, and other documentation reflecting the care given and billing codes
  - **Data Sharing**: Planned integration across service settings
- **Early Implementation Challenges**[29]
  - New roles, new workflows, training on new program
  - Coordination of services and teams (clinical team and plan based care coordinators not in-sync)
  - Information sharing a challenge
  - Evidence of prior authorization denials

Future Opportunities

- **Invest in geriatric behavioral health training across all workforce tiers**
  - Integration of **geriatric mental health content**, prioritize interprofessional learning, and expand offerings across roles and levels
  - New **pipeline pathways** linking K-12, community colleges, and state university training programs with community-based apprenticeships aimed at building a geriatric workforce while supporting financial wellbeing, career advancement, and on-the job training.
- **Fund innovations in formal and informal caregiver support**
  - Provide stipends, structured training, and expand access to high-quality respite care as a critical tool for family caregivers
  - Create accessible training curricula and opportunities which meet the needs of older adults in or entering the caregiving workforce
- **Embed Behavioral Health into Aging Services Infrastructure**
  - Co-locate BH services in senior centers, skilled nursing facilities, adult day centers, and PACE programs
- **Fund Innovative Models of Integrated Care**
  - Integrate licensed clinicians, paraprofessionals, and informal caregivers emphasizing diversity, rurality, and underserved communities in team-based care implementation
- **Invest in infrastructure for data sharing and care coordination**
  - Single EMR integrating behavioral, community-based, and informal care documentation across lifespan services

Healthforce Center at UCSF

Thank you

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