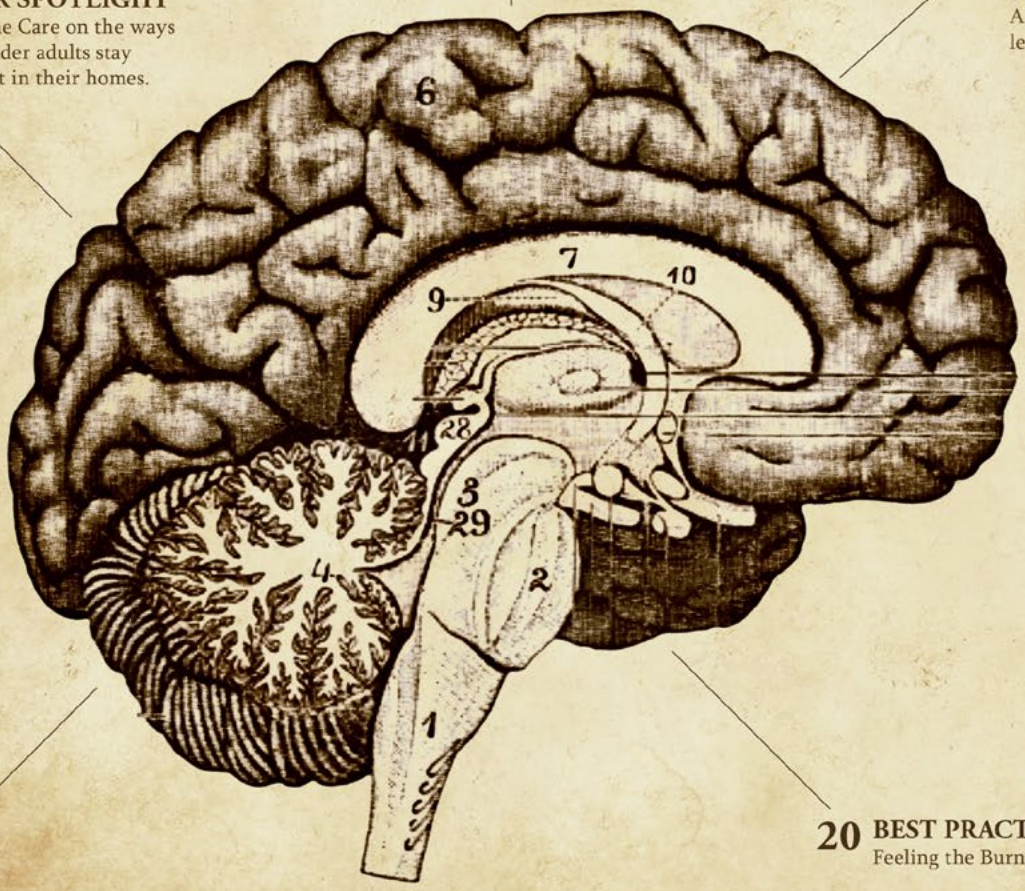
LEADINGAGE CALIFORNIA FALL 2019

ENGAGE™

BEHAVIORAL HEALTH AMONG OLDER ADULTS:

What Is It? Who Provides the Care?



LeadingAge California

inspire...serve...advocate

Founded in 1961, LeadingAge California is the state's leading advocate for quality, non-profit senior living and care. The association's advocacy, educational programs and public relations help its members best serve the needs of more than 120,000 of the state's older adults. LeadingAge California represents over 625 nonprofit providers of senior living and care – including affordable housing, life plan communities, assisted living, skilled nursing, and home and community-based care; as well as our business partners and residents.

LEADINGAGE CALIFORNIA
ENGAGE

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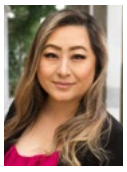

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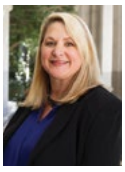

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Changing the conversation about mental health

Welcome to the Fall issue of *Engage Magazine*! For this issue we focus on the behavioral health needs of older adults. Undetected and undiagnosed mental health issues can have a tremendous impact on older adults and their families. Encouraging healthy communication and recognizing mental health care as an important part of whole-person care continues to change the way we approach discussing these issues and reduces the stigma surrounding this topic.

Our feature article comes to us from Dr. Patrick Arbore, founder and director of the Center for Elderly Suicide Prevention & Grief-Related Services at Institute on Aging. In "Behavioral Health: What Is It? Who Provides the Care?" Dr. Arbore defines and discusses what geriatric behavioral health is and why expanding and training the future workforce is so critical.

We welcome new member Alegre Home Care in our Member Spotlight; our own Brenda Klutz gives us the latest on behavioral health requirements for skilled nursing and assisted living facilities; and LeadingAge California COO Eric Dowdy gives us a look back on the legislative year.

In our People in Focus section, Casa de Modesto Executive Director Curt Willems offers tips for providers on starting a dialogue with residents about mental and emotional health. Simon Fox, executive director of the Adventures in Caring Foundation, discusses recognizing signs of caregiver burnout and what employers can do to help. UCLA research scientists Drs. Kathryn Kietzman and Janet Frank round out this issue with a discussion on the future of the geriatric behavioral health workforce and how to meet the increasing demand for services.

We hope you enjoy this issue! As always, we welcome your suggestions and feedback. Please email me at rdouglas@leadingageca.org.

Enjoy the upcoming holiday season!

Robin Douglas
Editor-in-Chief

A NOTE FROM THE

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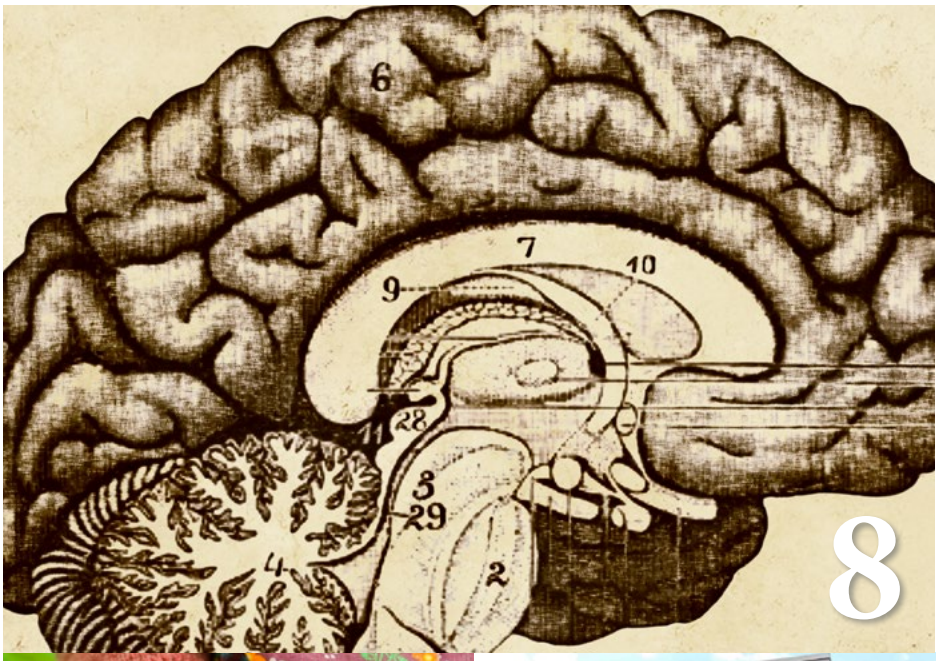
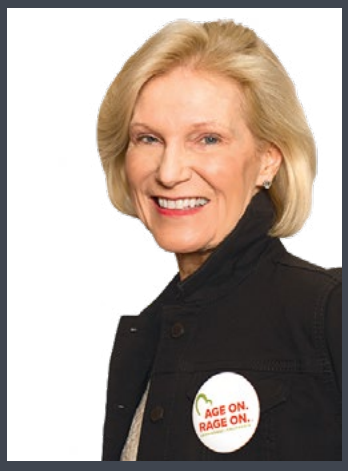


Preparing for Change

FROM THE
CEO



Jeannee Parker Martin
President and CEO

For some parts of the U.S., fall is the most colorful time of the year, with images of trees changing colors, kids back in school, Halloween, and the holidays not too far ahead. In California, the fall represents all those things plus a drier season, fires and other climate-related disasters. We enjoy the upsides of fall and have taken strides to prepare for these emergencies, including tailoring disaster preparedness programs to individual communities.

Fall also represents cooler, wetter weather and images of people without housing on the street, many of whom have serious behavioral health issues. Just as nearly 1 in 5 adults in California are over 65, nearly 1 in 5 over 55 have mental health issues. And this number will nearly double by 2030. This issue of *Engage* can help you prepare for these demographic and health changes with information and guidance on how to address behavioral issues in your community.

As an association, fall represents a busy time of the year – conferences, member engagement, budgeting, readying for 2020 conferences, education, policy and public awareness. As we look ahead to 2020, we hope you and your community will join others and take the Age On. Rage On. Challenge! The Age On. Rage On. Challenge is easy – get a group of friends, residents, and staff together, and take a photo or video of them talking about what Age On. Rage On. means to them. Check out our social media sites to see examples from TELACU, Pilgrim Place, and others with their messages for the Age On. Rage On. Challenge. Post these to social media with #AgeOnRageOn!

AGE ON.
RAGE ON.™
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Governor Newsom's Executive Order for the Master Plan for Aging called for the establishment of a Stakeholder Advisory Committee. The Stakeholder Advisory Committee is helping to develop components of the Master Plan for Aging. Fortunately, I have been selected to sit on this committee to represent our voice. Contact me with your thoughts and suggestions regarding the plan which will address a wide range of topics, including housing, care and services for older adults, and issues related to behavioral health and wellness.

For information about the Master Plan for Aging, visit https://www.chhs.ca.gov/home/master-plan-for-aging.

HAVE YOU HEARD

Christian Church Homes (CCH) announced Syd Najeeb was appointed as the new president and chief executive officer, effective January 2020. Najeeb had served as CCH Chief Operating Officer and Chief Financial Officer for over three years.

Pilgrim Place announced Ronald Bolding as its new Chief Executive Officer in October.

HumanGood CEO John Cochrane was featured in the "Transform" podcast series from *Senior Housing News* in September about the growing demand for middle-market senior housing.

Gold Country Retirement Community was voted #1 Skilled Nursing in El Dorado County in *Style Magazine*'s 2019 Readers' Choice Awards.

Canterbury Woods, a Covia community, received the Award of Excellence for Food Safety from the Environmental Health Bureau of the Monterey County Health Department.

RHF's Rotary Village was featured in the *Delano Record* in October in "Harold Olson Rotary Village Celebrates 55 Years." Happy anniversary!

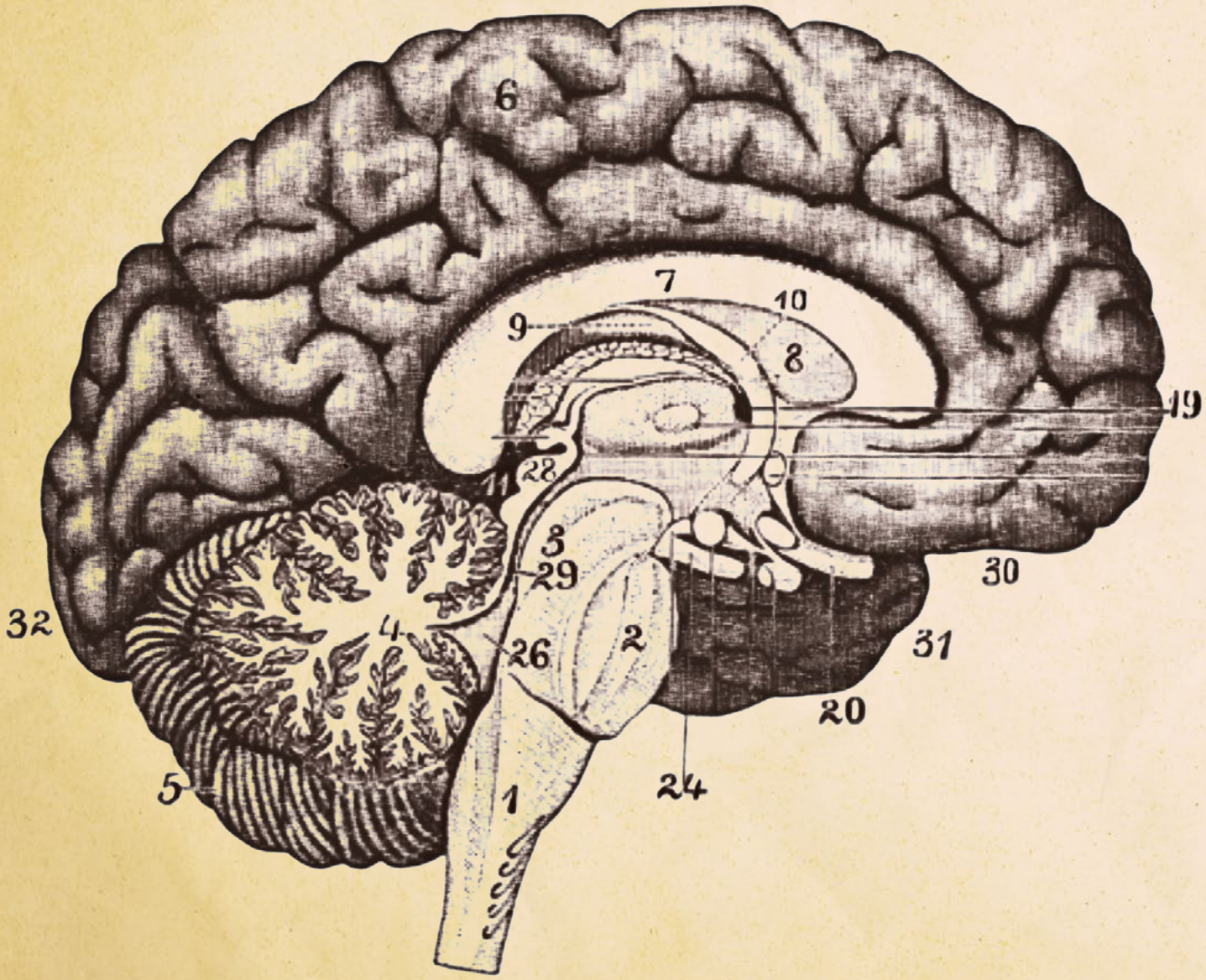
Want to be featured in Have You Heard?

Send your news items to info@leadingageca.org

BEHAVIORAL HEALTH AMONG OLDER ADULTS:

WHAT IS IT? WHO PROVIDES THE CARE?

by Patrick Arbore, Ed.D., founder and director, Center for Elderly Suicide Prevention & Grief Related Services, Institute on Aging



What Is Behavioral Health?

As defined by Duke University School of Medicine, Geriatric Behavioral Health is a field of medicine dedicated to the diagnosis and treatment of mental disorders in older adults. Geriatric psychiatrists and psychologists have training in specialized areas that include the physical, emotional, and social needs of older patients. The disorders in which these practitioners specialize include dementia, depression, anxiety, sleep disorders, and late life schizophrenia. Geriatric practitioners work with other healthcare professionals, the older patient, and the older patient's families to develop caring approaches to treatment.

Most of us are more familiar with the term "mental health" rather than behavioral health. The term "behavioral health" encompasses all contributions to mental wellness including substances and their abuse, behavior, habits, and other external forces.

Scope of the Problem

According to Sorkin et al (2018), a significant number of older adults have serious mental health needs that are not a normal part of aging. It is estimated that one in five people aged 55 and older have some type of mental health issue, and 4.7 percent of community-dwelling older adults have had serious psychological distress in the past year. By 2030, the number of older adults with major psychiatric illnesses will more than double, from an estimated 7 million to more than 15 million individuals.

Untreated mental health problems in older adults are associated with poor health outcomes, high healthcare use and costs, complexity of the course and prognosis of many mental and physical illnesses, functional disability and cognitive impairment, compromised quality of life, and mortality, including higher risk of suicide.

Research suggests that, despite the growing burden of mental health need in this older adult population, older adults, and in particular racially and ethnically diverse older adults, underuse mental health services or do not seek mental healthcare. Older adults are the most underserved population in mental health services.

Diversity in the Elderly Population

More effort is needed to identify diverse groups of older adults and engage them in behavioral health services if we are going to prevent and/or intervene effectively with mental health issues.

The prevalence of behavioral health conditions, according to the Administration on Aging and the Substance Abuse and Mental Health Services Administration, differs across and within racial and cultural groups of older adults. Differences may be explained by factors such as immigration status, gender, education, life events, and other stressful factors.

Stigma as a Barrier to Behavioral Health Care

The negative stigma attached to issues of behavioral and mental health is the product of a long history of misunderstanding, exaggeration, and ignorance. In today's world, many people believe that behavioral health issues, even extremely common ones like anxiety or depression, are somehow a sign of weakness. Other sources of stigma include societal factors like the idea that asking for help is a sign of weakness, and that people who can "take care of themselves" are somehow stronger.

A barrier to seeking help includes public stigma, which refers to the negative beliefs, attitudes, and conceptions about mental illness held by the general population. This public stigma leads to stereotyping, prejudice, and discrimination against individuals with mental health problems. Internalized stigma refers to devaluation, shame, secrecy, and social withdrawal, which are triggered by applying the negative stereotypes associated with mental illness to oneself.

A scenario I have heard many times over the years is this: An 80-year old adult with whom I have worked

told me that he had been "fired" by his primary care physician due to his cancellation of appointments. He received a nice letter indicating that he would no longer be seen by this physician. Because this individual lives alone, has multiple physical health, mental health, and social concerns, he was devastated by this situation.

As he attempted to reach out to other physicians, he found it increasingly challenging to find someone who would see him within a reasonable distance from his place of residence. As he has no family within the area, he became very discouraged. When he needed medical care, he started going to the emergency room because he had no primary care physician. Sadly, I am hearing this scenario being played out over and over again. Some older adults have found another primary care physician who has stated that they will be seen on a yearly basis. The question is: Who will take care of the increasing number of older adults, especially those 85 years of age and older, who have more complex behavioral health needs?

Aging Work Force

While the need for geriatrics-trained physicians and other professionals has been known for many years, it appears that future physicians have little interest in geriatrics. Although the field of geriatrics is guided by the principles of patient-centered care, management of chronic illness and attention to a patient's goals and functioning, it has not met current and future demands for geriatric practitioners despite those highly valued statements. According to the John A. Hartford Foundation, geriatric social work ranks as one of the top 20 careers in terms of growth potential. Employment in the field of geriatric social work is expected to increase faster than the average of all other occupations due in part to shorter hospital stays and the need for care coordination at hospital discharge.

Unfortunately, too few social workers are stepping up to meet this demand. Close to 50 percent of master's level social work students state they have little or no interest in working with older adults after graduation. To complicate matters, geriatric social workers are older (median age of 50 years) than practitioners in other fields and are nearing retirement.

As mentioned, the number of adults age 65 and older is going to soar to almost 72 million by 2030. This is an increase of almost 32 million older people since 2010. Along with this increase in the numbers of older adults, there is also an increase in mental health and substance abuse problems. At least 5.6 million to 8 million older adults have one or more mental health and/or substance abuse conditions. These behavioral health concerns present unique challenges for the practitioner who is caring for them.

Across the workforce of those who are caring for these individuals in our communities, there is little, if any, training in gerontology or geriatrics. Because I teach and facilitate trainings on aging related issues, I encounter hundreds of professionals and students who may know a lot depending upon their experiences. However, when I ask how much training in aging they receive, they state that they didn't get very much. For example, I hear from older people that they are prescribed sleep medication or antidepressants after the death of a spouse. When I ask the person if they mentioned to their doctor, nurse practitioner, psychologist, or social worker, that their spouse died suddenly, they say "No. No one asked me and I didn't say anything." Differentiating between major depression and grief in an older person is often difficult. Cognitive, functional, and sensory deficits may complicate detection and appropriate diagnosis of the situation. However, a geriatrician or another professional trained in aging would ask questions of an older person that would be more relevant so that a proper assessment would occur.

Strategies to Engage Older Adults in Mental Health Treatment

If we are going to engage older adults in mental health treatment, it will be necessary to identify strategies to reduce the stigma of receiving treatment. First, however, we need to overcome barriers to identifying older adults who are suffering from depression, anxiety, suicidal ideation, personality disorders, trauma, and other mental health disorders.

To do this we will need to increase and educate the aging workforce regarding behavioral problems that affect an aging population. Additional research is needed to study the interrelationships among perceived

public stigma, internalized stigma, and attitudes about seeking treatment for mental health issues.

Second, we need to include individuals 85+ into our research studies since this population is the fastest growing age population in the United States.

Third, implement and evaluate community-based health education campaigns and interventions to reduce mental illness stigma and to increase the utilization of mental health services for all older adults regardless of age, gender, race, culture and/or sexual orientation. With the rising rates of suicide among people of all ages, and especially in those people aged 85+, there is an urgent need to identify vulnerable older adults in our families, communities, and clinics.

Aging is a fact of life, and it is important for us to focus on healthy aging, including behavioral health issues – not only in May, which is both Older Americans Month and Mental Health Awareness Month, but throughout the year.

Awareness of the problem is the first step.

Learn more about Institute on Aging at www.ioaging.org

Further Reading

Office of Minority Health. (2016, October 18). Mental health and American Indians/Alaska Natives. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=39

Substance Abuse and Mental Health Services Administration. (2014, October 9). Health disparities. http://www.samhsa.gov/health-disparities

Office of Minority Health. (2016, October 19). Mental health and Asian Americans. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=54

Older Adult Behavioral Health Profiles by Region https://www.acl.gov/programs/health-wellness/behavioral-health

Substance Abuse and Mental Health Services Administration. (2017). CBHSQ Report- Opioid misuse increases among older adults: National Surveys on Drug Use and Health (NSDUH), 2002 to 2014. https://www.samhsa.gov/data/sites/default/files/report_3186/Spotlight-3186.html

United States Government Accountability Office. (2015). Antipsychotic Drug Use: HHS Has Initiatives to Reduce Use among Older Adults in Nursing Homes, but Should Expand Efforts to Other Settings. 2015. https://www.gao.gov/ products/GAO-15-211

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For more information, please contact: **Chad Tittle** at **916-469-3369** or **ctittle@leadingageca.org**

LeadingAge California PAC

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- Jeannee Parker Martin, LeadingAge California

SILVER LEVEL

- David Reimer, Palm Village Retirement Community
- Debbie Herbert, Monte Vista Grove Homes
- Todd Murch, Eskaton
- Mel Matsumoto, Channing House
- Sheri Peifer, Eskaton

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- Rhonda Bekkedahl, Channing House
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- Eric Dowdy, LeadingAge California
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LeadingAge CA

Podcast: Depression and Anxiety in Geriatric Patients

This 2019 podcast from Psychiatry Today features Dr. Carolina Osorio, who runs a special program at Loma Linda University Health that treats elderly people with depression and anxiety.

https://psychiatrypodcast.com/psychiatry-psychotherapy-podcast/2019/2/20/depression-and-anxiety-in-geriatric-patients

Report: Reducing the Cost and Risk of Dementia

This report recently released by the Milken Institute offers new ideas on reducing the cost and risk of dementia.

https://milkeninstitute.org/reports/reducing-cost-and-risk-dementia

Online: LeadingAge Learning Hub – Mental Health

This video training series was developed to mirror an in-person training covering the topics included in the written guide, including role playing examples of situations commonly encountered by staff that can be applied across a variety of aging services settings.

https://www.leadingage.org/mental-health

MEMBER SPOTLIGHT - Alegre Home Care

Home care was born in the late 1980s, as the AIDS epidemic shifted the focus of caregiving to providing grief counseling and hospice care to an ailing, aging population unable to rely on family members for support. The sandwich generation was born with a need for outside support and Charles Symes, II answered the call.

A NEED FOR HOME SUPPORT

Alegre Home Care founder Symes opened his first home care service in San Francisco's Castro District in the spring of 1993. The need for home support in that area was particularly strong, and care at that time was designed to maintain or restore health and safety in a residential environment. Skilled nursing visits, ordered by doctors and funded by insurance and Medicare, were available on a short-term basis. Long-term care was an up-and-coming field. Shift care in the home on a one-to-one basis was a service not covered by insurance and considered "custodial care."

Thirty years later, home care changed to focus on prevention and keeping people well with general support services, including memory care, recovery services and companionship.

Alegre's Quality Compliance and Risk Manager, Linda

Harrison, shared stories about the people Alegre serves and all the ways their caregivers connect and engage with them. "We support a Vietnam veteran, and our home care aide engages him in card games, working puzzles, and art projects. We have a client who loves music, and our aides encourage her to keep playing and sing along with her. We've also paired an aide who enjoys hiking with a very physically fit client who loves to hike the hills."

"Our agency has migrated through many changes over the past 30 years as the needs of our clients and seniors have changed," said Harrison. "From initial support to hospice and home health agencies, to preventive caregiving for those who need not only care, but socialization and engagement, we have adapted and continued to grow our workforce."

Alegre believes the biggest challenge facing home care in the future is the growing baby boomer population and the increasing need for services. Hiring qualified caregivers and keeping them is an ongoing challenge. Alegre Home Care is proud of its low 15 percent turnover rate in the industry; they continue to look for new ways to encourage individuals to enter the career of caregiving and meet the needs of a new generation of elders.

"We are proud to be a first year member of LeadingAge California," said Symes. " and to join the over 450 non-profit senior communities in serving the joint mission of serving, inspiring and advocating for aging services in California. "

FAST FACTS ABOUT ALEGRE HOME CARE

- Today Alegre Home Care has over 450 employees, covering 11 Bay Area counties and growing.
- Alegre is the first LGBTQ (and the only certified) home care agency in the Bay Area;
- Since 2016 they have had five state-licensed home care organizations under the Home Care Services Consumer Protection Act;
- They are community-based, supporting events like the Annual "Seniors on the Move" in San Mateo, participating in community outreach at Senior Fairs and working with local hospitals and senior communities.
- Monthly "Lunch and Learn" sessions are provided to all staff to discuss caregiving strategies and engage in online training on a variety of topics, from how to communicate with families about their loved ones with dementia to preventing dehydration.

Dear Brenda

Brenda Klütz has 30 years of experience in California state service; with over eight years of working in the Legislature as a consultant on Aging and Long-Term Care issues and 15 years with the Department of Health Services serving as the Assistant Deputy Director and Deputy Director. Currently, she provides LeadingAge California members technical support on issues related to reimbursement, licensing, and regulation interpretation.

Behavioral Health Requirements for Skilled Nursing and Assisted Living Facilities

Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. [42 CFR 483.40]

Meeting the behavioral health needs of residents in our communities can mean covering a wide spectrum of needs and conditions. These can vary from experiencing an emotional challenge (which any of us might have); special needs of residents with dementias who may be withdrawn or exhibit triggered behaviors; or a condition with a formal diagnosis. Helping residents to find the joy or recapture overall well-being is the responsibility of all staffs. Pleasure in dining, participating in meaningful activities, helping residents to recall fond memories and favorite music, and the feeling of continued contribution are all a part of an individual's well-being.

The focus of this column provides information on the minimum regulatory expectations for skilled nursing facilities (SNFs) and assisted living facilities (ALFs) related to providing behavioral health services to residents. The Centers for Medicare and Medicaid Services updated the federal behavioral health requirements for SNFs in November 2017.

Behavioral health requirement for SNFs and ALFs have common elements:

- Providing care and treatment appropriate to a resident's level of care;
- Preventing/managing behaviors that might present a danger to the resident, other residents, staff and visitors, and;
- Conducting thorough assessments of residents to identify possible behavioral health needs, identify triggering events, and developing effective care plans to address needs.

Visit leadingageca.org/engage-magazine to download:

- A PowerPoint presentation on the behavioral health related requirements for SNFs and ALFs;
- A side-by-side comparison of requirements; and
- A copy of the CMS Critical Pathway for Behavioral Health.

As always, if you should have any questions or concerns, please don't hesitate to contact me at: bklutz@leadingageca.org or (916) 469-3377.

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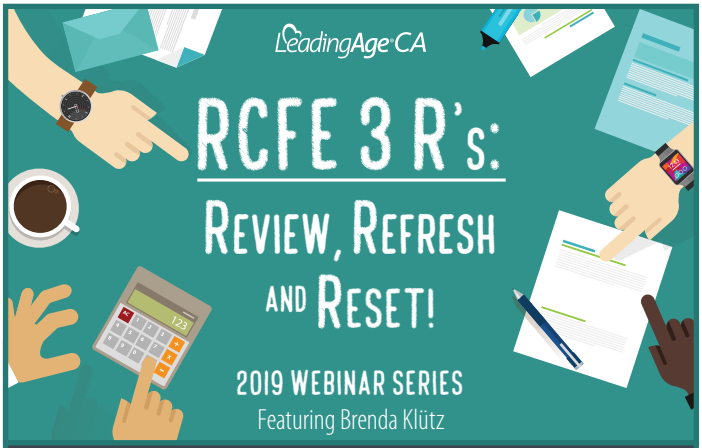

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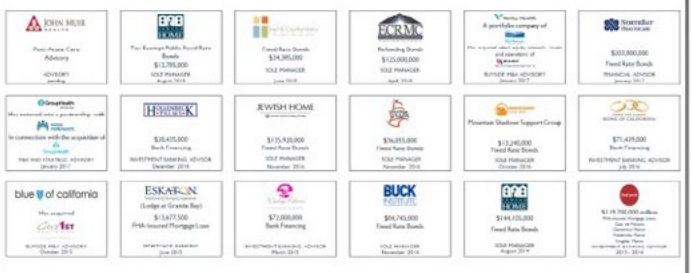
- Knowledge of California marketplace with senior bankers located in San Francisco and Long Beach



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A Conversation with Curt Willems, Executive Director of Casa de Modesto

Learn more about Casa de Modesto: casademodesto.org

Curt, can you share a little bit about your background and what motivated you to join the aging services field?

I have over 30 years in mental health services. In my practice as well as in my own life evaluation, I realized we all age and must come to terms with the aging process.

Working within the senior retirement community has given me a new avenue to develop the healing process for people and an opportunity to help people face their own mortality concerns. This allows me the ability to address mental health support, processes, and services that we provide as an organization to an aging population and the residents that we serve here at Casa de Modesto.

How has your experience working in the mental health field influenced the way you approach your work at Casa de Modesto?

We all have mental health issues that get in the way with how we think, act, work, develop relationships, and create or deal with memories…the mind obviously influences all that we do and say. Mental health issues can create barriers to how we process life on any given day and I try to understand people before making a snap judgement about them. Everyone has a history that causes him or her to respond in particular ways to different situations.

The conversation around mental health issues has opened up in recent years. Why do you think a stigma still exists for older adults when it comes to discussing these issues?

More than 20 percent of seniors suffer from a mental health issue. Most people will accept that a physical illness is factual and impacts a person's life, and is reason and rationale for how they exist and respond to life at the time of their illness.

Mental illness is something that is seen through symptomology but not always able to substantiate the diagnosis with factual evidence. We're all vulnerable to feeling judged by others around us, and that means that we will often work hard to avoid behaving in ways that are stigmatized. It can be easier to make a doctor's appointment for a sore throat than it is for a suffering spirit.

When it comes to mental health, shyness, culture, family belief systems – all these things prevent many people from opening up and talking to others about their emotional well-being.

What should providers keep in mind if they see a resident (or staff member) who appears to be struggling or in crisis?

Try to determine what the crisis is all about. Is it a real or perceived crisis, or issue of concern for the person? It may be able to be resolved by rationally talking through the situation with the person. The same issues that we struggle with when we are younger affect us when we are older as well, only they are amplified quite often by our limitations to self-resolve as we age.

Understand that mental healthcare is health care. The first and best thing you can do to help older adults access the mental health treatment that they may need, is to think through your own attitudes about mental health. How do you see mental illness? How have mental health issues been a part of your life and affected you, a friend or family member?

Learn how to become a listener - to ourselves and to others. One of the best ways to open the door to healing is to have someone care enough about them to listen openly without judgement. Our minds are as important to our health as our physical bodies; we all deserve care that helps us be our best selves.

ADVICE FOR PROVIDERS

Talk openly about your own feelings. "Fine" and "pretty good" don't have to be the end of the conversation on how you're doing. If we demonstrate that we are afraid to talk about mental illness ourselves, people won't feel comfortable talking with us about their health issues. If we are able to demonstrate a comfort level and acceptance for the topic, it will open the doors for seniors to be okay talking about it with you, as something in common and safe.

ASK FOR SUPPORT FROM HEALTH CARE PROVIDERS AND OTHERS.

Primary care physicians can often provide resources on how to talk to older adults about maintaining a healthy mind, and they can always help broach the topic. Mental health specialists like counselors, social workers, psychologists, psychiatrists, and clergy all have experience talking with individuals about emotional/psychological struggles. Some struggles are environmentally induced issues of concern, some are biochemical imbalances within a person's system, and others are trauma-based issues from the past that continue to come up and create pain and suffering in one's life.

RECOGNIZE SOCIAL ISOLATION AND DEPRESSION IN THE ELDERLY.

If you notice changes in behavior in an older adult, like reduced appetite or increased sleep, don't be afraid to ask how they're doing. They may be willing to open up, especially if you avoid using phrases like "mental illness" and focus instead on listening to how they describe their experiences. It may feel disrespectful to pry, but ignoring symptoms won't make them go away. With your help, seniors can change the conversation about mental illness and begin to talk about their own crippling emotional/psychological needs.

*(Adapted from: **PhillyVoice**, Feb.21, 2019)*

BEST PRACTICES

Feeling the Burn?

WHAT IS BURNOUT EXACTLY?

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."

– Rachel Naomi Remen, MD, University of California San Francisco Medical School

One of the big myths about burnout among caregivers is that frequent exposure to human suffering has no long-term effects. This is absurd. Witnessing the suffering of others is cumulative, and much exposure over time changes us. Those who care for people in chronic pain, or with severe disabilities, or who are nearing the end of life, often have deep relationships with their patients and are deeply affected by these experiences. This cannot simply be dismissed by condescending remarks about toughening up.

Researchers have yet to fully agree on definitions, but for all practical purposes, there are six different types of hazards facing caregivers that are associated with the term "burnout," recognized by "compassion fatigue" expert Françoise Mathieu. These occupational hazards are encountered by those individuals who are "immersed in suffering and loss daily" in professions including include doctors, nurses, nurse assistants, therapists, social workers, and first responders. Less obvious is the impact these hazards have on the activity directors, housekeepers, cafeteria workers, family members, and secretaries who often witness loss and suffering as well.

THE SIX HAZARDS ARE OUTLINED AS ...

1. **Burnout:** exhaustion from poor working conditions or continual overwhelming workload. Burnout is all about the workplace.
2. **Compassion Fatigue:** emotional exhaustion from constantly giving to, and relating with, people who are desperately in need. Compassion fatigue is all about the relationships.
3. **Moral Distress:** exhaustion that comes from an ethical conflict, when your job regularly demands you do something your conscience is fighting.
4. **Secondary Trauma:** indelible memories of hearing tragic stories that haunt you.
5. **Vicarious Trauma:** the accumulation of hundreds of tragic stories you heard, that cause a lasting disturbance and reshaping of your view of the world.
6. **Primary Trauma:** direct exposure to overwhelming events – when you are in danger or the trauma happens to you.

These six hazards can be grouped into two categories: exhaustion and traumatization. When a person is hit by both – and most caregivers are – the threat levels multiply to a devastating effect. This double-whammy is why burnout for caregivers is so much more dangerous than for most other occupations.

WHAT ARE THE WARNING SIGNS?

The most insidious thing about burnout of all types is that it is isolating. Those who are suffering from it begin to withdraw – from their clients, co-workers, families and friends. The warning signs are a lack of communication, participation, and presence. Speech patterns and behavior become more distant, less personal, and less hopeful. For example, those who are burning out often do only the tasks they are told to do, don't engage with others, avoid meetings or sit in the back and don't say anything. Some call it "presenteeism" – like absenteeism, but even though the body is present, nothing else is.

On the other hand, some people go to the opposite extreme and attack the problem, burying themselves in their work. For example, compassion fatigue hits your most caring and dedicated employees first and hardest. The first sign of it is working harder and longer, ever determined to do more and more with less and less – which is ultimately unsustainable. So also keep a look out for those who are running on fumes and sacrificing their well-being for others.

WHAT'S THE PROBLEM WITH PEOPLE WORKING HARDER? WHY WOULD YOU WANT TO FIX THAT?

Burned out caregivers make mistakes and people get hurt. Medical errors are now the third leading cause of death in the U.S. Miscommunication, misunderstanding, poor decisions, and shortcuts taken due to burnout are a key factor.

Another myth is that compassionate people cannot run out of compassion. Yes, they can. And it often results in suicide because the contrast between feeling naturally full of compassion and the utter desolation of having nothing left to give, is deeply troubling. Your lifelong core identity—that you are a kind, compassionate person – is threatened because you no longer feel that way. So, who are you now? This is the empty anguish of compassion fatigue.

The biggest mistake is to tell people what they should do. Giving talks on best practices – which just about everyone knows and almost no one does – is mostly a waste of time. (More New Year's resolutions anyone?)

SO, WHAT CAN YOU DO?

You can welcome people. Burnout is isolating, so the healing of it begins with community, communication and kindness. Different roles and responsibilities wrestle with different forms of stress, but we are all in this together. It helps everyone to understand what others are struggling with, and to realize that you are not alone.

This builds community – and something else. In any given room of people, there is a lot of wisdom waiting to be tapped. Everyone has a piece of the answer. The answers are found, as Carl Jung noted, not in the ideals that no one lives up to, but in the secrets of our own private experiences. The opportunity to share our own discoveries is precious, and a vital affirmation of the value and lessons to be found in our subjective experiences.

Winston Churchill pointed out that most people stumble over truth at some point in their lives, but then they get up, brush it off and carry on as if nothing happened. This is why people burn out – by ignoring the lessons of experience, ignoring the voice of intuition, ignoring common sense, ignoring warning signs, and carrying on as if nothing has happened.

Compassion fatigue makes a demand of us. The demand is that our compassion must become wiser.

The single greatest thing you can do as a leader to combat burnout is to encourage people to learn from experience, to share their discoveries with one another, and to grow in wisdom together.

This can be accomplished in small group dialogue with clear guidelines on what is expected of participants in a reflective conversation. By small, I mean a group big enough to have a good conversation (six or more) but small enough for everyone to have a voice in the conversation (sixteen or less).

The guidelines for facilitating conversations that build a deeper sense of connectedness and meaning (the antidotes to burnout) are listed at the Adventures in Caring website: Guidelines for Reflective Conversations. Such conversations are the foundation stones of a culture of compassion. They are the way we can gather the uncommon common sense, the wisdom in our communities—to sustain our compassion, nourish our relationships, and enrich our lives.

Simon Fox is Executive Director of the Adventures in Caring Foundation. He is author of the new online course: Oxygen for Caregivers: Your Toolkit to Guard Against Burnout, Build Resilience and Sustain Compassion.

adventuresincaring.org/oxygen-for-caregivers

Come on and Take a Free Ride

by Robin Douglas, LeadingAge California

Life can be challenging without safe reliable transportation - relying on other people for rides, spending hours navigating public transit - now just imagine you're an older adult with a chronic illness who needs to run errands and get to medical appointments. In a recently published study, researchers at the University of Southern California Center for Body Computing partnered with ridesharing giant Lyft to show how "networked transportation" options can remove those barriers for older adults to accessing medical care, reducing social isolation and improve overall quality of life.

For three months, researchers gave unlimited Lyft rides to a group of 150 adults with chronic illnesses who lived in and around Los Angeles County. And they certainly used them. Participants spent an average of $20 per ride - averaging around $500 a month - going to doctor's appointments, running errands, visiting friends, and other social activities. Most had heard of services like Lyft and Uber, but few had used it on a regular basis, wary of financial scams or identity theft.

The participants were trained on how to use the Lyft app while those without a smartphone were instructed on how to use a call-in service. Technology support provided throughout the study also helped ensure continued engagement.

Perhaps not surprisingly, 92 percent reported improved quality of daily life at the end of the study. "This research underscores how ride-sharing platforms can provide a significant benefit to the well-being of older adults," says Leslie Saxon, MD, executive director of the USC Center for Body Computing and lead investigator of the study. Participants reported enjoying the feeling of independence and control over their day - proving that transportation is about much more than getting from point A to point B, regardless of age.

Nationally, seniors are increasingly using ridesharing, especially as they become more comfortable with smartphone technology. Study participants overwhelmingly chose to order Lyft rides using their app (86 percent), while a small percentage used the call-in option. Promisingly, 80 percent of participants said they would continue to use ridesharing after the pilot ended. "Improving people's lives with the world's best transportation is Lyft's mission," says Tommy Hayes, Senior Manager of Public Policy at Lyft. "This innovative study illustrates the great potential we have to positively impact the lives of older adults through reliable, affordable transportation."

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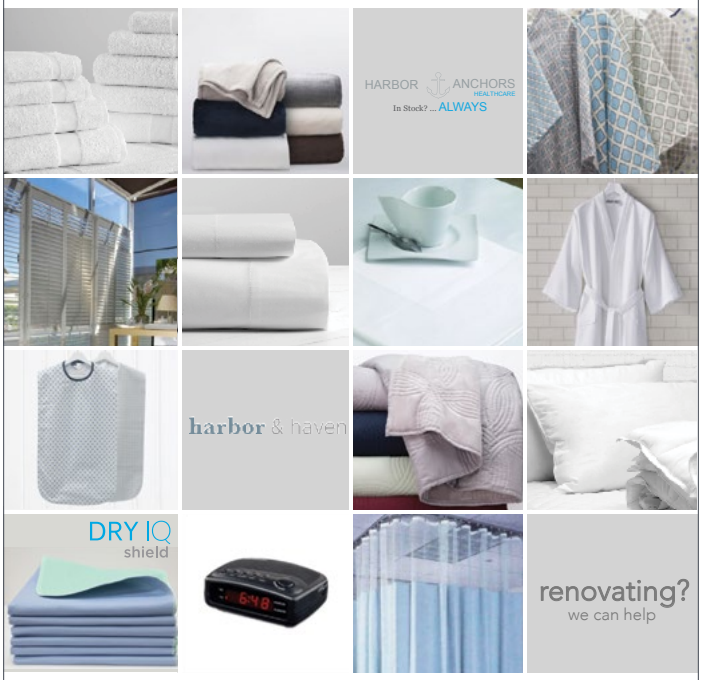

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1 The EMERGE class of 2020 visited the Senior Wellness Center to volunteer and serve meals to the seniors.

2 President and CEO of Washington D.C.-based hunger policy group Bread for the World, David Beckman, supporting Age On. Rage On.!

3 Bruce Udelf, Executive Director at Baywood Court, taught a class on DISC Training-Communication Skills during a Golden Gate Regional meeting.

4 Local residents came out to the support LeadingAge California during the Successful Aging Expo on November 2nd in Irvine, CA.

4

5 Unidine showcasing some of their top chefs from around the country.

6 Jack York, Owner and President at It's Never Too Late (IN2L) with his cross country crew.

7 Lola Rain and Carrie Shaw with Embodied Labs.

8 Some of the LeadingAge California team posing along with members Deborah Herbert, Monte Vista Grove Homes (far left) and Roberta Jacobsen, Front Porch (third from left).

9 The beach vacation booth of Value First set up a camera for visitors to snap photos together.

A LOOK BACK ON THE LEGISLATIVE YEAR

We are happy to report another successful legislative year with some big wins in the affordable housing and Long-Term Services and Supports (LTSS) financing space, as well as the establishment of the Master Plan for Aging. The end of the 2019 Legislative year saw the first test of the Newsom administration, which had to act on over 3,000 bills with 39 percent of the bills becoming law and vetoing 5.6 percent. Approximately 1,700 bills remained in the Legislature with some eligible to be re-heard in 2020. Some of our key accomplishments for 2019 are outlined below.

LeadingAge California a Key Player in Developing the Master Plan for Aging

The Governor's executive order earlier this year set the tone for the focus on aging policy in Sacramento. We are proud to be represented by LeadingAge California President and CEO Jeannee Parker Martin, on the Stakeholder Advisory Committee and the Research Subcommittee. The stakeholder group has met and the work to develop a plan by the end of 2020 is already underway. Our big priorities for the plan include a focus on workforce, affordable senior housing, and LTSS financing system for California.

LeadingAge California Delivers on Housing Legislation

Three bills were introduced this year sponsored by LeadingAge California on affordable senior housing issues. Two of the three bills LeadingAge California sponsored became law. SB 623 (Jackson, D-Santa Barbara) requires HCD to use more recent census data to determine allocations in the multi-family housing program. The second bill (SJR 15, Bloom, D-Santa Monica) calls on Congress to fully fund the HUD 202 supportive housing for the elderly program.

LeadingAge California Awarded Grant to Deliver IN2L to California SNFs

The association has been in collaboration with It's Never 2 Late (IN2L) to bring their devices to 60 nursing homes over a three-year period. The $2.6 million grant is expected to begin recruiting interested nursing homes early next year.

CCRC Data Publication to be Released

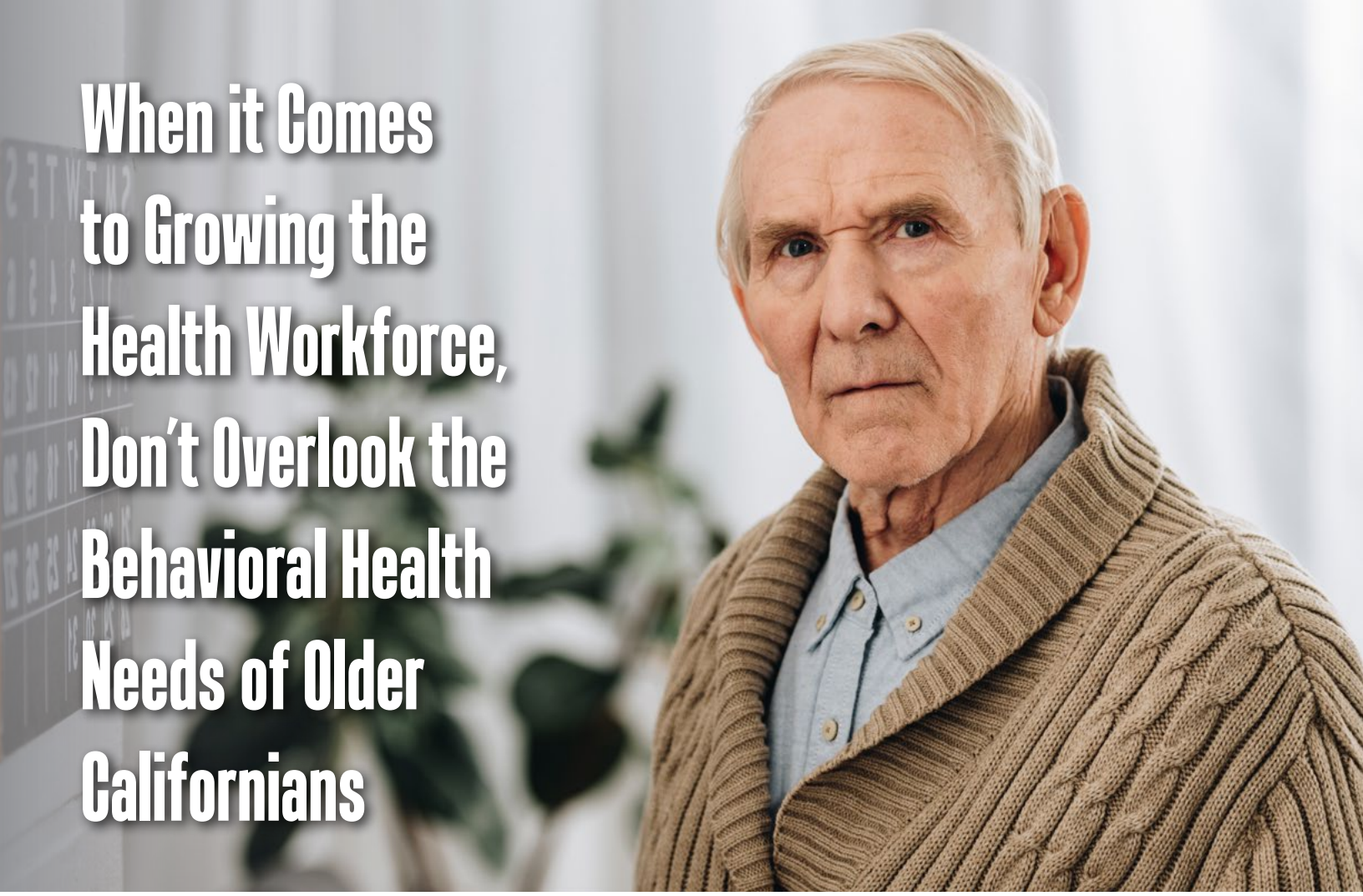
The finishing touches are being put on a comprehensive look at California's continuing care retirement communities (CCRCs). By compiling all CCRCs' Key Indicator Reports from the most recent reporting period, a dataset was developed to look at the demographic and financial dynamics of the state's communities. A report on the key outcomes will be available to members by the end of the year.

We thank our members and partners who worked so closely with us to help us achieve so much this year. We look forward to an exciting and rewarding 2020!

Questions?

Contact Eric Dowdy, Chief Operating Officer, LeadingAge California at edowdy@leadingageca.org

When it Comes to Growing the Health Workforce, Don't Overlook the Behavioral Health Needs of Older Californians



by Kathryn G. Kietzman, PhD, MSW and Janet C. Frank, DrPH, MSG

It is great news indeed that the Governor is investing 300 million dollars in the 2019-2020 budget to strengthen the health workforce pipeline in California! These funds set the stage for implementing the recent recommendations of the Future Health Care Workforce Commission. Over the past two years, this group of experts has worked diligently to assess California's health workforce deficits and to craft solutions to recruit, train, and deploy a new cadre of health workers. While the Commission includes a subcommittee on healthy aging and a subcommittee on behavioral health, more attention to the intersection of these two service arenas is needed. Why? Because the current capacity of the workforce to meet the present and growing demand for geriatric behavioral health services is far from sufficient.

Prevalence of Behavioral Health Conditions among Older Adults

An estimated 15 percent of older adults have ongoing behavioral health needs. Between 1.4 and 4.8 percent of older adults are living with a serious mental illness (SMI) such as bipolar disorder or schizophrenia. Suicide rates are high among older adults; individuals 65 years of age and older account for 17.9 percent of all suicide deaths, and older white men are especially at risk. Despite these stark statistics, less than one third of older adults with mental health disorders seek and receive appropriate treatment.

Effective treatment of an individual's mental health conditions can help prevent the onset, ease symptoms, and/or slow the progression of other diseases. Older adults with SMI tend to have higher rates of physical health conditions that are associated with disability and early mortality such as heart disease, lung disease, and diabetes. Their physical and psychosocial functioning and overall quality of life may be further complicated by the co-occurrence of cognitive impairment or substance use disorders. At the same time, individuals who are living with chronic physical health conditions are more likely than the general population to experience depression and anxiety. For older adults, the late

life onset of a mental health condition may be a first-time experience and come as somewhat of a shock, leaving the affected individual not knowing what to do or who to turn to.

Geriatric Behavioral Health Workforce: Deficits and Training Needs

Recent studies have noted significant deficits in the behavioral health workforce in California. A number of factors are attributed to these shortages including the "aging out" of the workforce, with insufficient numbers in the pipeline being "trained up" to assume these positions. Beyond the generalist workforce concerns, even fewer students are pursuing training in geriatric behavioral health specialties across professional disciplines. Also of concern is that people of color are grossly underrepresented in the mental health professions, and efforts to recruit and train providers that reflect the cultural, ethnic, and linguistic makeup of local communities are not keeping pace with the growing diversity of California. In addition, there are significant behavioral health provider shortages in rural geographies across the state, creating yet another layer of disparities in access to care.

The composition of the workforce necessary to effectively address geriatric behavioral health needs spans the continuum of health and social care providers, from licensed and professional providers and clinicians – e.g., psychiatrists, nurses, physicians, psychologists, and social workers – to unlicensed paraprofessionals – e.g., direct care workers, case managers, and lay and peer support workers. Irrespective of provider type, addressing the complex needs of older adults with behavioral health conditions requires specialized training. By and large, the workforce that currently has the most interaction with older adults is not trained to recognize or respond to their behavioral health needs.

While there have been recent efforts to identify and develop discipline-specific curricula that provides core competencies and guidelines for working with older adults with SMI, there has been little cross-training across disciplines of geriatrics and mental health. And while interdisciplinary teams have proven to be very effective in addressing the mental/behavioral health needs of older adults, related curricula and standardized training in this area is sparse. Furthermore, the availability of cross-disciplinary training materials that are tailored for an increasingly diverse older adult population with respect to generational cohort, culture, language, gender identification, and sexual orientation is negligible.

Opportunities to Take Action

In a recent study we conducted to assess the delivery of public mental health services to older adults in California, concerns about workforce deficits emerged repeatedly. We learned that providers often get overwhelmed by the complexity of serving older adults with multiple and co-occurring conditions, particularly when they lack training in geriatrics and/or in differential diagnosis. We learned that consumers want more providers who look like them, who speak their language, who are responsive to their specific cultural and generational backgrounds.

While moving towards solutions for the overall health workforce, California must not overlook the behavioral health needs of older adults. The workforce capacity to serve this specific population can be advanced by providing (at a minimum) standardized geriatric training at all provider levels, both upstream (i.e., through the traditional academic professional pipeline) and downstream (through in-service, on-the- job training). Community college certificate, career technical education, and peer education programs are especially promising as they develop and promote curricula that explicitly link graduates to available jobs.

Stipend and loan forgiveness programs – with slots specifically allocated for geriatric training – will be needed to support and sustain efforts to attract and retain more students and mid-career providers to get core geriatric training. Peer training and geriatric specialist certification programs have also proven to be quite successful at the county level, providing the skills and knowledge needed to more effectively outreach and serve older adults. Finally, there are ongoing opportunities at the state policy level to ensure that the behavioral health needs of older adults are represented. We hope that you will give careful consideration to the behavioral health needs of the populations you serve, and lend your voice and expertise to the discussions currently underway to develop a Master Plan for Aging in California (by executive order of the Governor and as recently signed into law by way of SB 228). It may be your voice at the table that makes the difference.

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