Washington State Department of Health

July 2022

DOH PUB 821-156-09

Month of July 2022

COVID-19 Older Adult Behavioral Health Impact Situation Report

Purpose

This report summarizes data analyses conducted by the COVID-19 Behavioral Health Group's Impact & Capacity Assessment Task Force. These analyses assess the likely current impacts of the COVID-19 pandemic on mental health and potential for substance use issues among Washington's older adult population (individuals 65 years and older unless otherwise noted).

Please note this report is based on the most recent available data from various sources. As such, different sections may present information for different reporting periods.

The intended audience for this report includes response planners and any organization that is responding to or helping to mitigate the behavioral health impacts of the COVID-19 pandemic.

As of June 6, 2022, this report has been updated to remove data that are no longer beneficial to the COVID-19 Behavioral Health Group's Impact & Capacity Assessment Task Force. If there is mission critical information that has been removed, please contact Alaine Ziegler at Alaine.Ziegler@doh.wa.gov to address the data.

Key Takeaways

For the most recent reporting period (CDC Week[1] 23 – 26, weeks of June 11 – July 2, 2022) all five syndromic indicators **decreased** from the previous reporting period (CDC weeks 18 – 22). For the current week, psychological distress and suspected drug overdose emergency department (ED) visits are **decreasing**, and suspected suicide attempt, suicidal ideation, and alcohol-related ED visits are **increasing.**

- No statistical alerts or warnings were issued.

Survey data collected by the U.S. Census Bureau for June 1 – 13, 2022, show change in anxiety (7.88%), worrying (45%), lack of interest (14.33%), and depression (-4.72%) among older adults (in this sample, older adults are defined as individuals 60 and older) in Washington.

More adults reported **needing** counseling or therapy but did not receive it (47%) and **more** people reported **receiving** counseling or therapy from a mental health care professional (52%).

[1] https://ndc.services.cdc.gov/wp-content/uploads/W2021-22.pdf

Impact Assessment

Syndromic Surveillance

The Department of Health collects syndromic surveillance data in near real-time from hospitals and clinics across Washington. The data are always subject to updates. Key data elements reported include patient demographic information, chief complaint, and coded diagnoses. This data collection system[2] is the only source of emergency department (ED) data for Washington.

The Behavioral Health Team along with the Rapid Health Information NetwOrk (RHINO) data team have identified discrepancies within the codes used to generate the Behavioral Health Team Situation Report Syndromic graphs. Specifically, individuals who were seen in the Emergency Department (ED) may have been counted more than once during one ED visit based on the individual's diagnosis and how the diagnosis was categorized. For example, if an individual presents to the ED for a Heroin Overdose this visit could be classified as both a CDC Heroin Overdose and a CDC All Drug (overdose) resulting in the same visit being counted twice.

While the overall trend in the data remains the same, the number of visits and therefor the data represented in the graphs may have calculated incorrectly, causing a misrepresentation of what was actually happening. After a careful review of the data, the Behavioral Health Team has decided to use Syndromic graphs generated by the Electronic Surveillance System for the Early Notification of Community-based Epidemics (Essence), which is managed by Johns Hopkins and the CDC.

These graphs better represent the corrected data and remove any discrepancies within the codes. They also allow for increased ease of readability and better identification of long-term trends. Data represented with a blue dot are an expected or normal value. Data represented with a yellow dot are a warning and a red dot is an alert, all of of which are related to how the CDC algorithms detect data.

Statistical warnings and alerts are raised when a CDC algorithm detects a weekly count at least three standard deviations[3] above a 28-day average count, ending three weeks prior to the week with a warning or alert. These warnings or alerts are indicated as needed within each respective syndrome section. Alerts indicate more caution is needed than a warning. Additionally, "average weekly difference" is a measure of the variation in the weekly volume of ED visits across Washington.

Analysis conducted by the Washington State Department of Health and the Northwest Tribal Epidemiology Center found 9,443 misclassified visits in Washington hospitals from May 15 – September 15, 2020. The visits in question should have been classified as American Indian/Alaska Native and represent a 27% misclassification percent during that period.

As of CDC Week 14 of 2021, the total number of ED visits for individuals 65 years or older have increased and have returned to the pre-March 2020 number of ED visits.

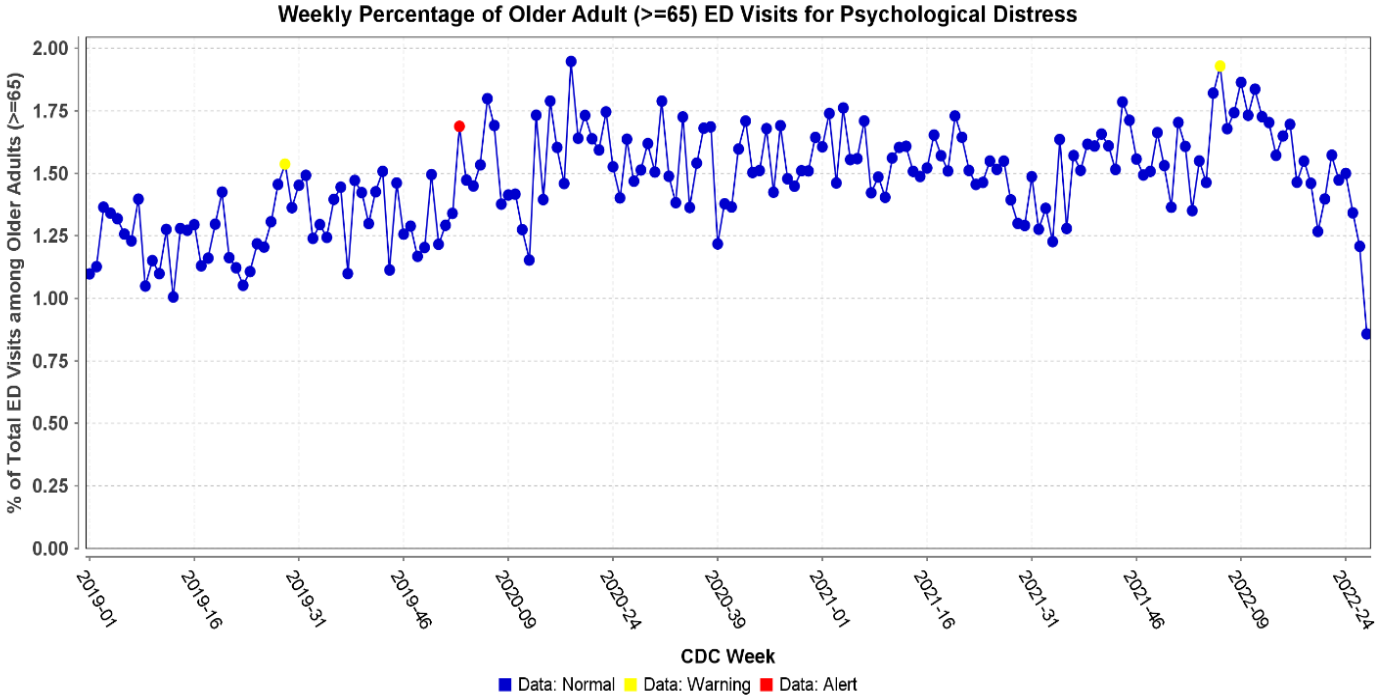
[2] https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/data-exchange-0/syndromic-surveillance-rhino

[3] Standard deviation: A measure of the amount of variation or dispersion of a set of values. Standard deviation is often used to measure the distance of a given value from the average value of a data set.

Psychological Distress

During CDC Weeks 23 – 26 (weeks of June 11 – July 2, 2022), the reported relative ED visits for psychological distress[4] among patients 65 years or older **decreased** from the previous reporting period (CDC weeks 18 – 22), and the current week is **decreasing** (Graph 1). No statistical warnings or alerts were issued**.**

Graph 1: Percent change of ED visits for psychological distress among adults 65 years of age and older in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)

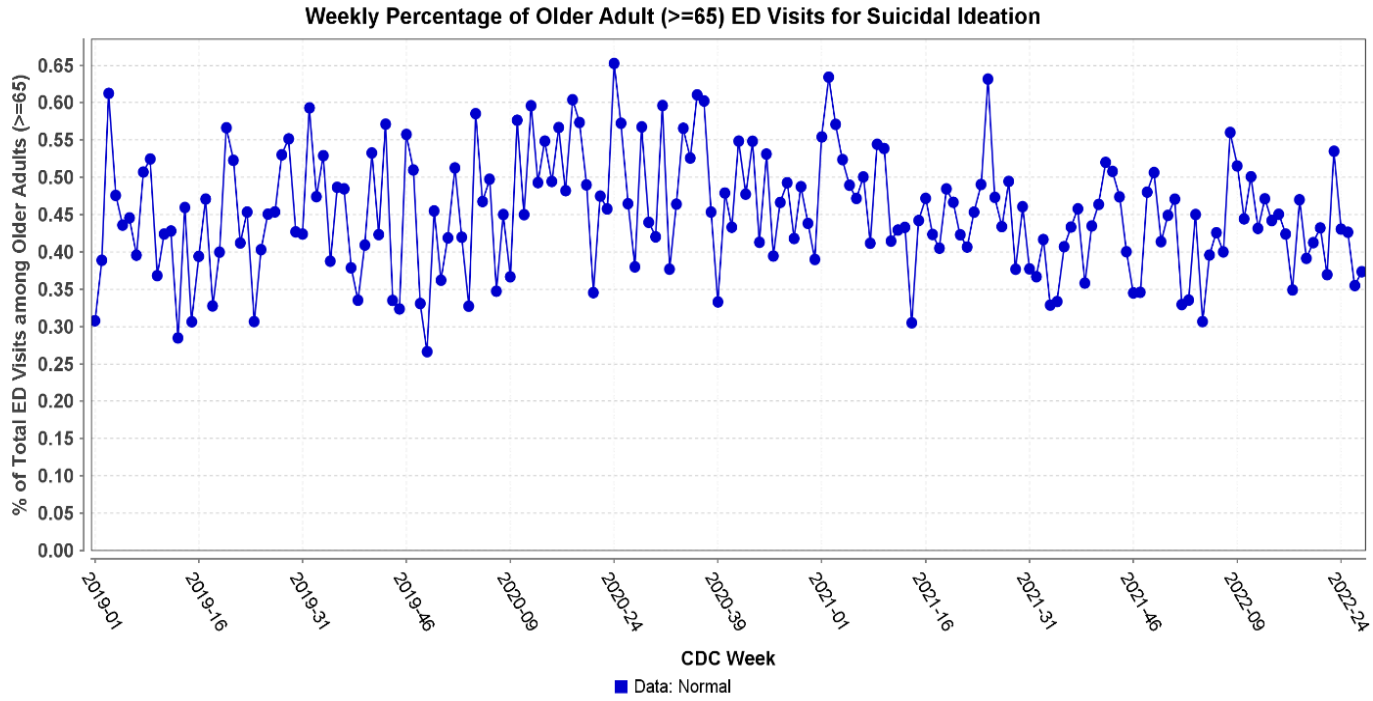


[4] Psychological distress in this context is considered a disaster-related syndrome comprised of panic, stress, and anxiety. It is indexed in the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) platform as Disaster-related Mental Health v1. Full details are available at https://knowledgerepository.syndromicsurveillance.org/disaster-related-mental-health-v1-syndrome-definition-subcommittee.

Suicidal Ideation and Supected Suicide Attempt

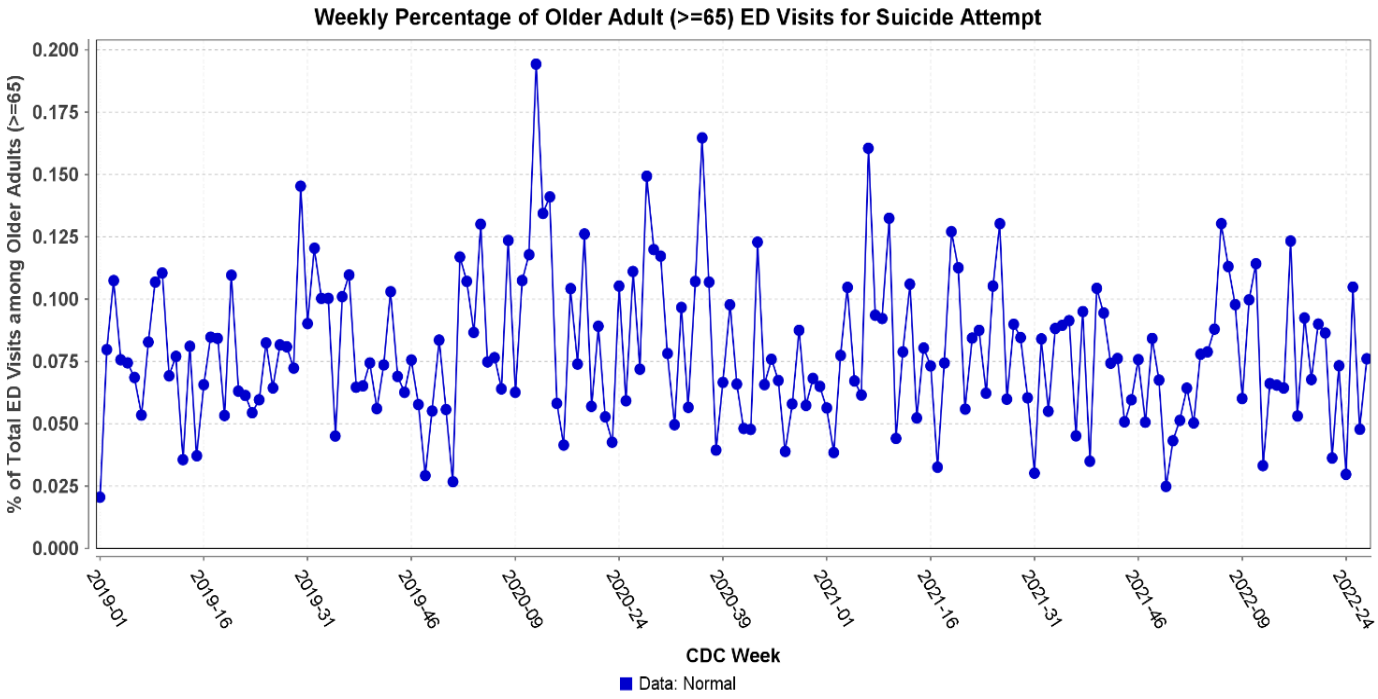
During CDC Weeks 23 – 26 (weeks of June 11 – July 2, 2022) the reported relative percent of ED visits for suicidal ideation among patients 65 years or older **decreased** from the previous reporting period (CDC weeks 18 – 22), but the current week is **increasing** (Graph 2). No statistical warnings or alerts were issued.

Graph 2: Percent change of ED visits for suicidal ideation among adults 65 years of age and older in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



During CDC Weeks 23 – 26 (weeks of June 11 – July 2, 2022) the reported relative percent of ED visits for suspected suicide attempt among patients 65 years or older **decreased** from the previous reporting period (CDC weeks 18 – 22), but the current week is **increasing** (Graph 3). No statistical warnings or alerts were issued.

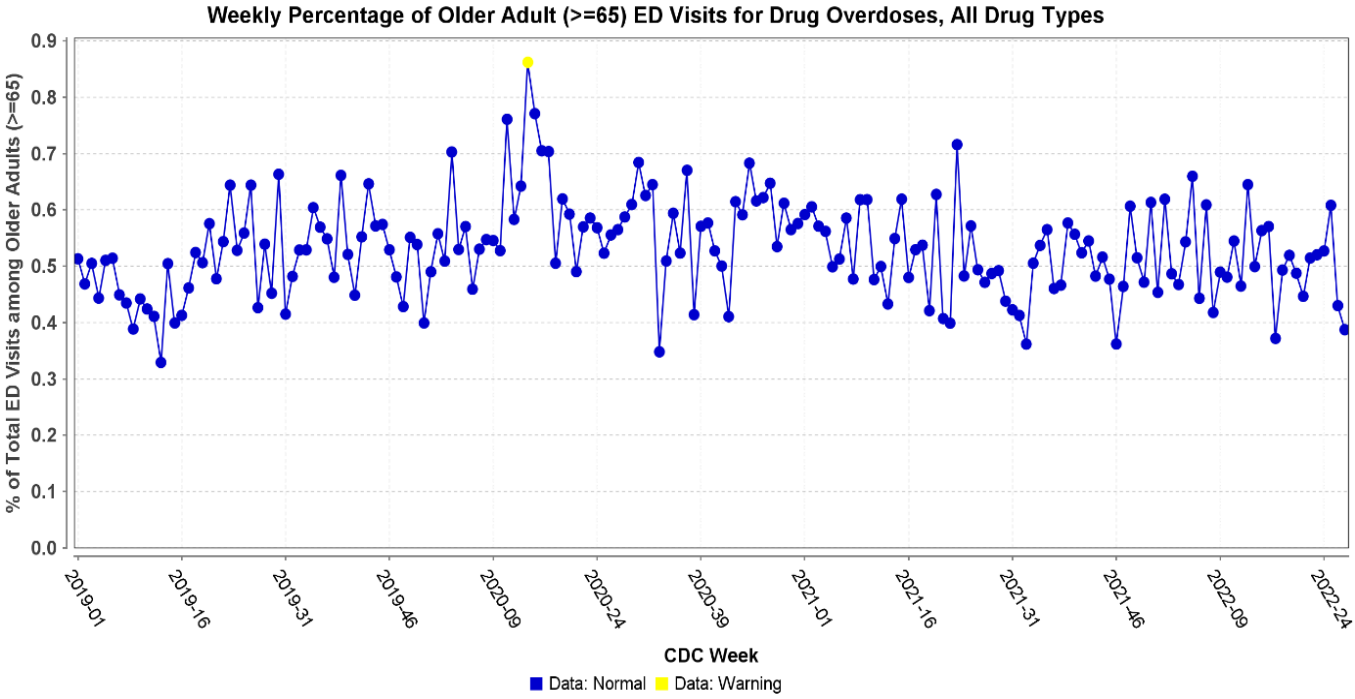
Graph 3: Percent change of ED visits for suspected suicide attempt among adults 65 years of age and older in Washington, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



Substance Use – Suspected Drug Overdose & Alcohol-Related Emergency Visits

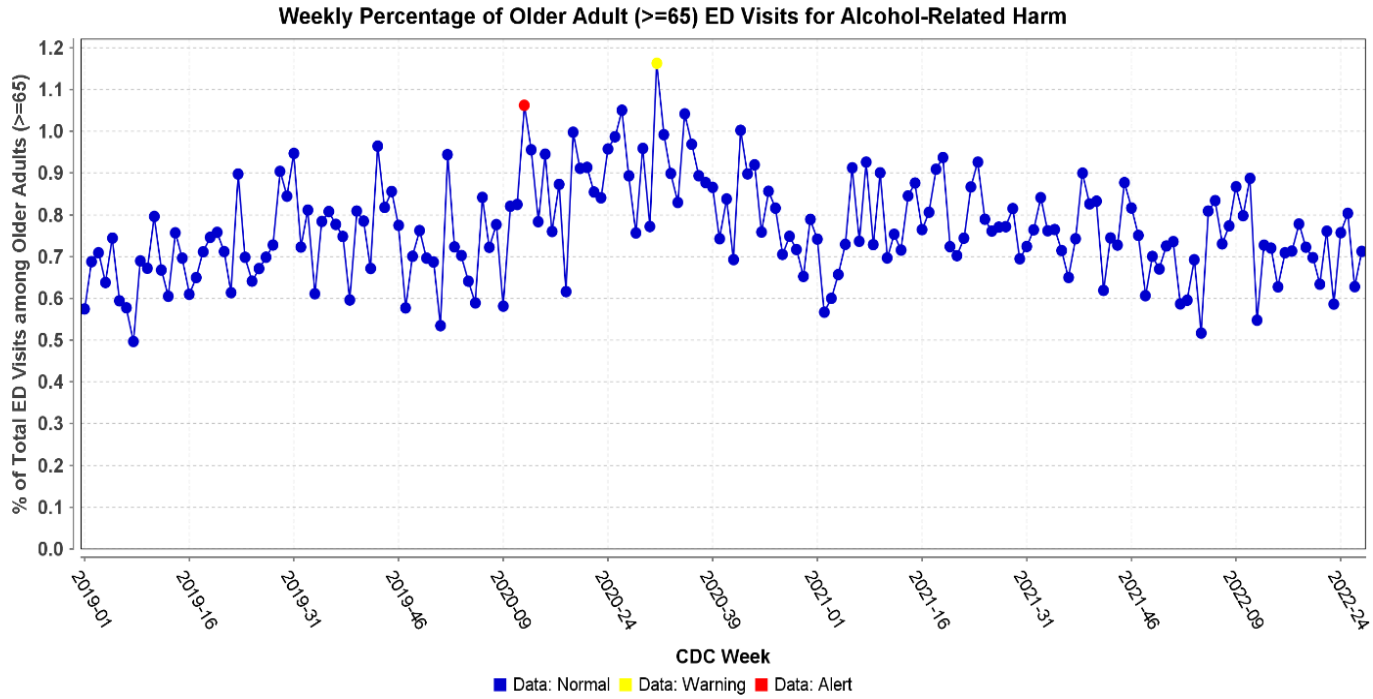
During CDC Weeks 23 – 26 (weeks of June 11 – July 2, 2022) the reported relative percent of ED visits for suspected drug overdose among patients 65 years or older **decreased** from the previous reporting period, (CDC weeks 18 – 22), and the current week is **decreasing** (Graph 4). No statistical warnings or alerts were issued.

Graph 4: ED percent change for all drug-related visits in Washington among adults 65 years of age and older, by week: 2019, 2020, 2021, and 2022 to date (Source: CDC ESSENCE)



During CDC Weeks 23 – 26 (weeks of June 11 – July 2, 2022), the reported relative percent of alcohol-related ED visits **decreased** from the previous reporting period (CDC weeks 18 – 22), but the current week is **increasing** (Graph 5). No statistical warnings or alerts were issued.

Graph 5: ED percent change for alcohol-related visits in Washington for adults 65 years of age and older, by week: 2019, 2020, 2021, and early 2022 (Source: CDC ESSENCE)



Symptoms of Anxiety and Depression

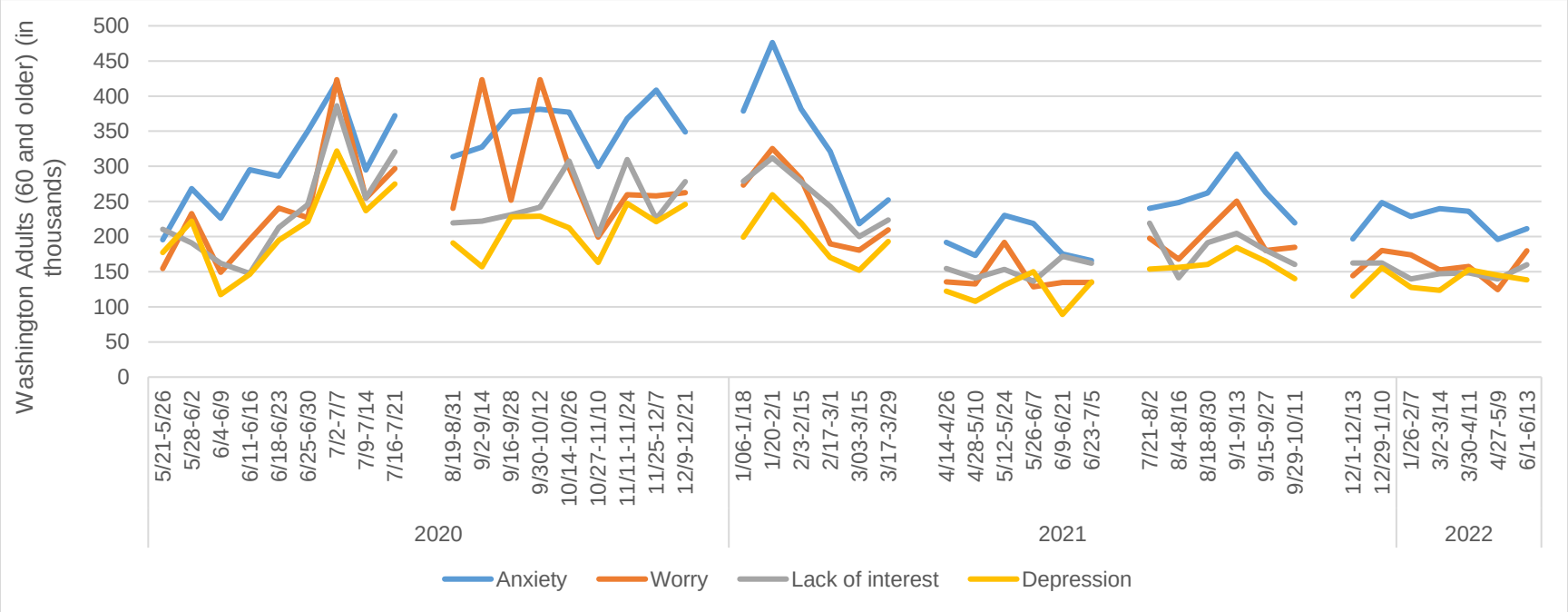
Survey data collected by the U.S. Census Bureau for June 1 – 13, 2022, show changes in anxiety (7.88%), worrying (45%), lack of interest (14.33%), and depression (-4.72%) among older adults (in this sample, older adults are defined as individuals 60 and older) in Washington, compared to the previous reporting period of April 24 – May 9, 2022 (Graph 6).[5]

In the most recent reporting period represented below, approximately 211,200 older adults reported symptoms of **anxiety** on all or most days of the previous week, while approximately 179,800 older adults reported the same frequency of symptoms of **worrying**; approximately 159,800 older adults reported **lack of interest** on all or most days of the previous week, while approximately 138,300 reported the same frequency of symptoms of **depression**.

The same respondent may report symptoms of both anxiety and depression at the same time, and these numbers are not cumulative. This survey data is independent to the data presented in previous sections.

[5] https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm

Graph 6: Estimated number of Washington adults (60 years and older) with feelings of anxiety and depression "at least most days," by week: April 23, 2020 – May 9, 2022 (Source: U.S. Census Bureau)



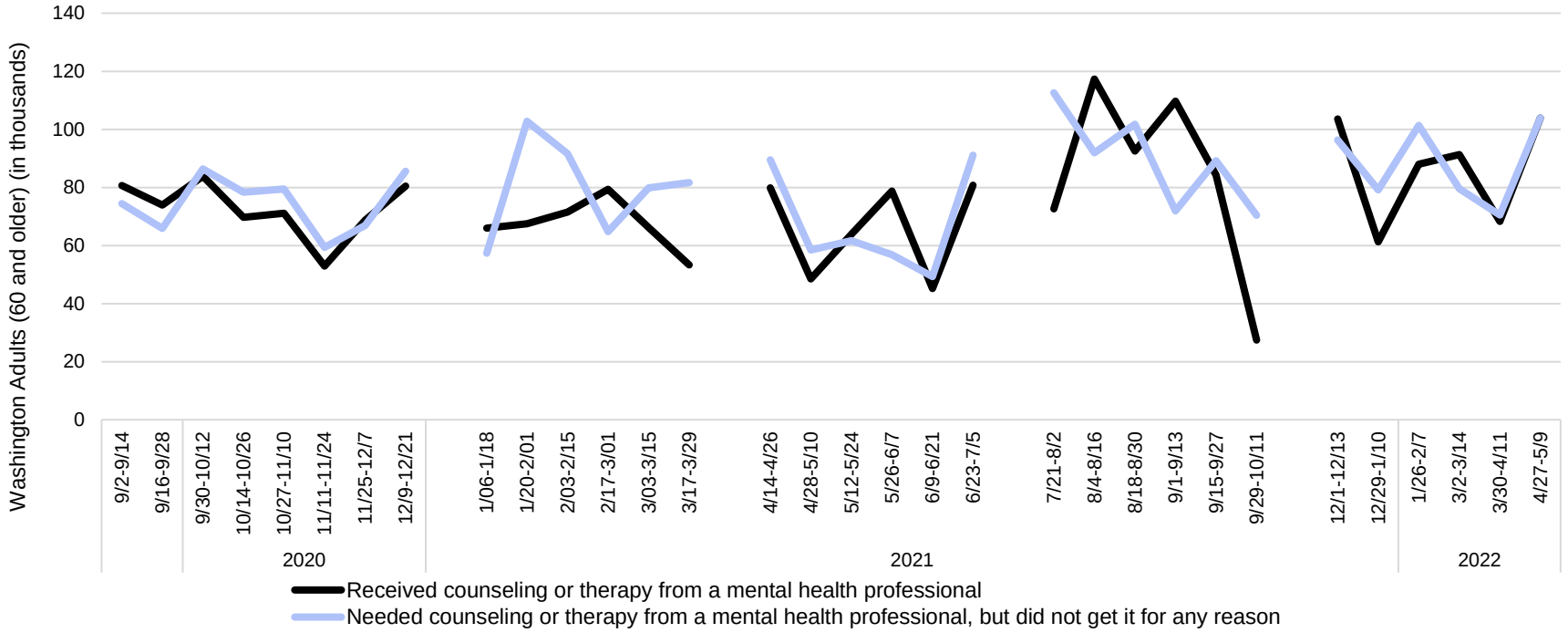
Note: The U.S. Census Bureau briefly paused data collection for the period of December 23, 2020 – January 3, 2021, March 30, 2021 – April 13, 2021, July 6 – 20, 2021, and October 12 – November 31, 2021. Note, for Phase 3.3 has shifted to a two-weeks on, two-weeks off collection and dissemination approach, although previous phases of the survey collected and disseminated data every two weeks.

Care-Seeking Behavior

Survey data collected by the U.S. Census Bureau for April 20 – May 9, 2022, show the number of adults in Washington who received counseling or therapy, as well as the number who delayed or did not receive care (Graph 7). No new data were released for mental health and care-seeking behaviors in the most recent data set.

Compared to the previous reporting period (March 30-April 11, 2022), **more** people reported **needing** counseling or therapy but did not receive it (47%) and **more** people reported **receiving** counseling or therapy from a mental health care professional (52%).

Graph 7: Estimated number of Washington adults (60 years and older) who received or delayed counseling or therapy, by week: August 19, 2020 – May 9, 2022 (Source: U.S. Census Bureau)



Note: The U.S. Census Bureau briefly paused data collection for the period of December 23, 2020 – January 3, 2021, March 30, 2021 – April 13, 2021, July 6 – 20, 2021, and October 12 – November 31, 2021. Note, for Phase 3.3 has shifted to a two-weeks on, two-weeks off collection and dissemination approach, although previous phases of the survey collected and disseminated data every two weeks.

Telehealth Use for Washington Medicaid Clients

Telehealth (phone and videoconferencing) claims use for Washington Medicaid clients is collected by the Washington State Health Care Authority (HCA).

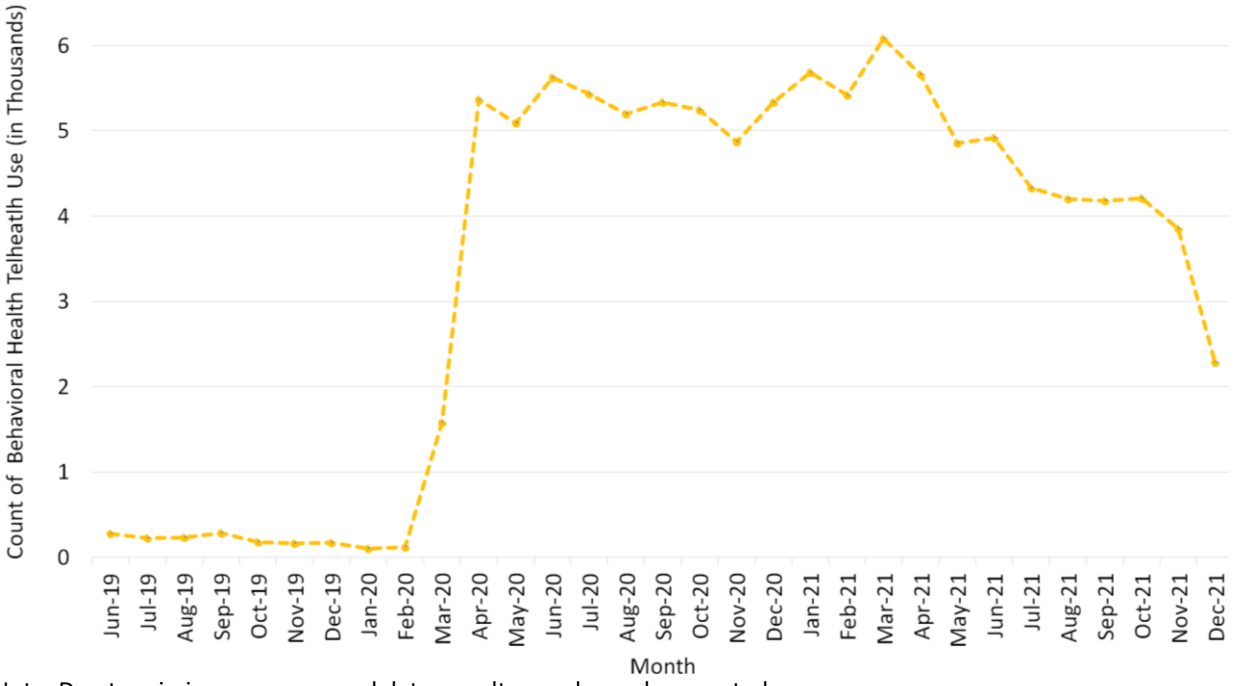
It is important to note the limited use of telehealth in Medicaid clients prior to the COVID-19 pandemic (March 2020), which could explain the significant increase in March and April 2020 (237%) after the implementation of the "Stay Home, Stay Healthy" order in March 2020.

Due to the significant demand for telehealth, several changes were made to policies, coverage, and implementation that could impact this data. Results may be underreported due to missing, changed, or suppressed data.

As these data are limited to **only** Washington Medicaid recipients, overall telehealth use may be underreported as older adult populations may be Medicare beneficiaries.

The most recent reporting period (December 2021) showed a 53% **decrease** of telehealth behavioral health services use (Medicaid) claims for individuals 65 years and older compared to the previous month (Graph 8).

Graph 8: Count of Telehealth Behavioral Health Use Claims for Older Adult Washington Medicaid Clients, by month (Source: HCA)



Note: Due to missing or suppressed data, results may be underreported.

Inpatient and Observational Community Hospital Discharges

Mental, Behavioral, and Neurodevelopmental Disorders

The Comprehensive Hospital Abstract Reporting System (CHARS)[6] collects record level information on inpatient community hospital stays.

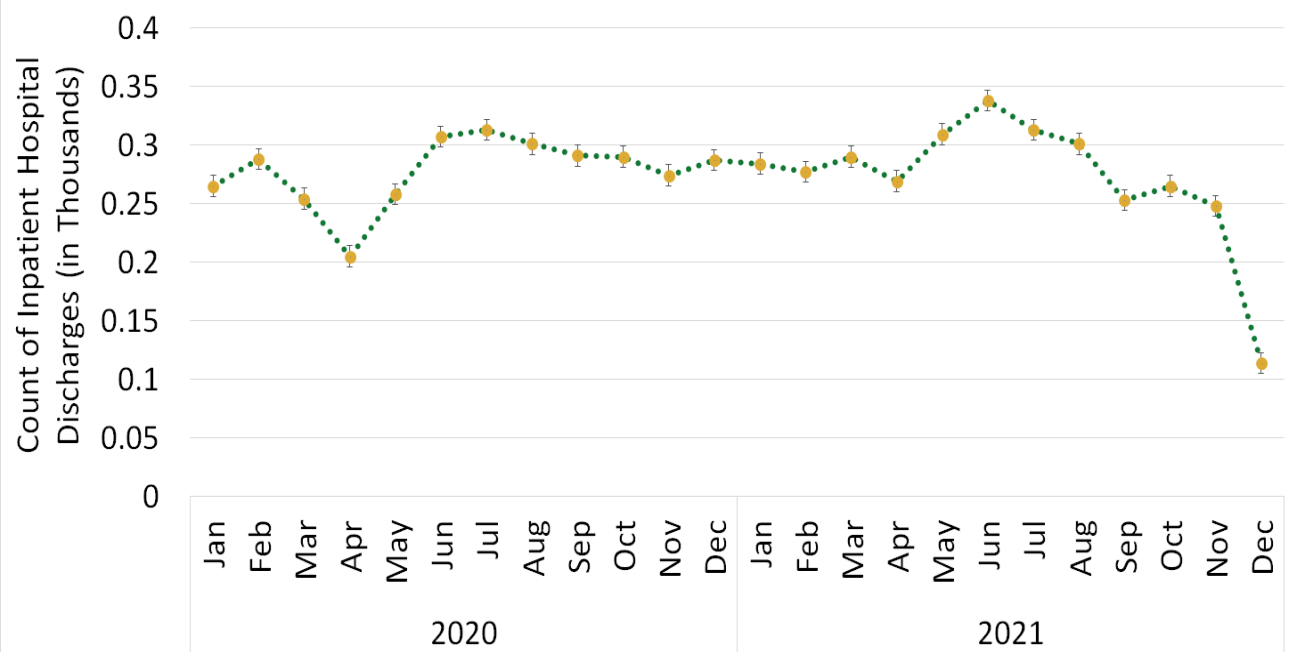
Caution should be taken when reviewing data, as the "Stay Home, Stay Healthy" order (March 2020) may impact hospital discharge data for both inpatient and observation patients. Only mental, behavioral, and neurodevelopmental disorders were evaluated (based on the individual's primary diagnoses included only ICD-10 F-codes)[7] for this report.

Due to time lag, data may not be complete. While non-Washington residents can be discharged from a Washington community hospital, only Washington residents were included in the analysis. Because of low numbers (>10), no further separation was conducted for discharges for specific mental, behavioral, or neurodevelopmental disorders.

The most recent reporting period (December 2021) showed a 54% **decrease** of discharges with a diagnosis of mental, behavioral, and neurodevelopmental disorders for individuals who were 65 years and older as compared to the reporting period.

Graph 9 shows the count of older adult (individuals 65 years and older) inpatient community hospital discharges for mental, behavioral, and neurodevelopmental disorders.

Graph 9: Count of Older Adult Inpatient Community Hospital Discharges for Mental, Behavioral, and Neurodevelopmental Disorders, by month (Source: DOH)

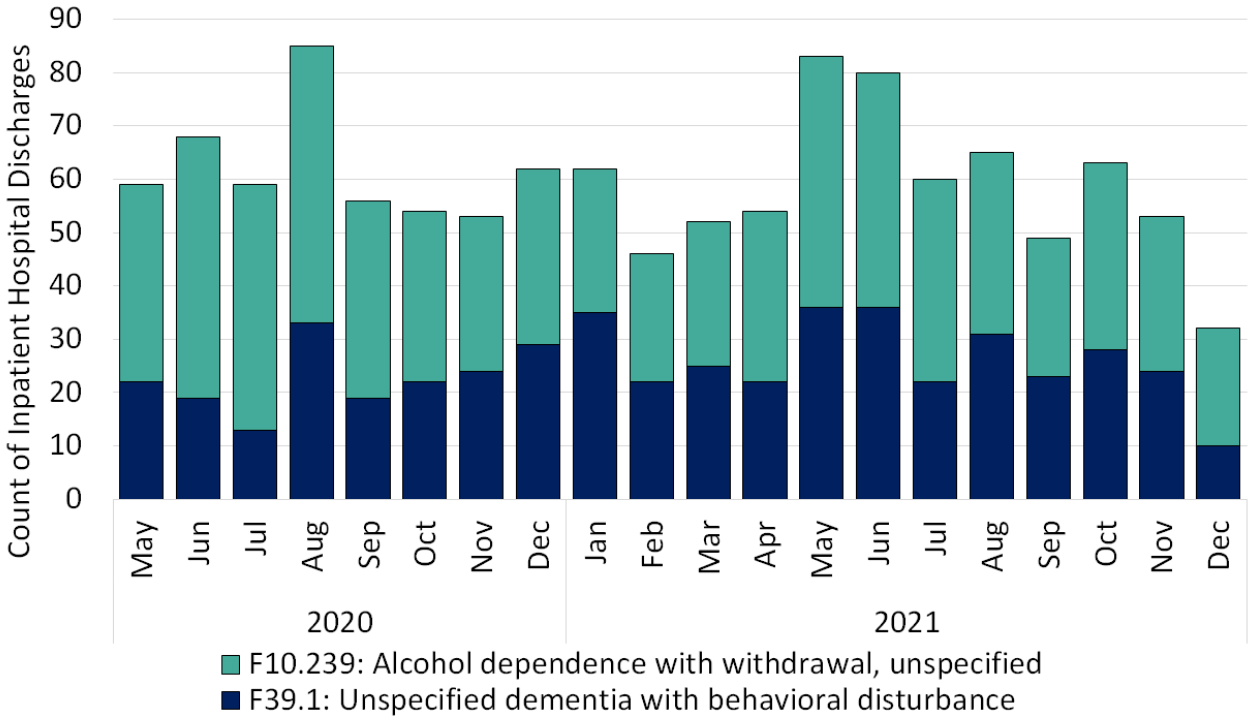


[6]https://www.doh.wa.gov/dataandstatisticalreports/healthcareinwashington/hospitalandpatientdata/hospitaldischargedatachars

[7] ICD-10 is the Tenth Revision of the International Classification of Disease and Related Health Problems published by the World Health Organization (WHO). F-codes are specifically related to mental, behavioral, and neurodevelopmental disorders.

Graph 10 shows the count of the top two mental, behavioral, and neurodevelopmental disorders in terms of inpatient community hospital discharges. The most recent reporting period showed a 58% **decrease** in "unspecified dementia with behavioral disturbance" and 24% **decrease** in "alcohol dependence with withdrawal, unspecified" discharges.

Graph 10: Count of Top Mental, Behavioral, and Neurodevelopmental Disorders for Older Adults (individuals 65 years and older) Inpatient Community Hospital Discharges, by month (Source: DOH)



Fatal and Non-Fatal Falls

Falls are typical in older adults and can result in fatal and non-fatal injuries. Falls have been linked to depression and anxiety suggesting that older people who are more depressed and anxious are more likely to be at risk for greater falls.[8,9]

Due to time lag, data may not be complete. While non-Washington residents can be discharged from a Washington community hospital, only Washington residents (individuals 65 years and older) were included in the analysis. For more information on older adult falls prevention, please visit: www.doh.wa.gov/findingourbalance.

[8] Kvelde, T., Lord, S. R., Close, J. C., Reppermund, S., Kochan, N. A., Sachdev, P., ... & Delbaere, K. (2015). Depressive symptoms increase fall risk in older people, independent of antidepressant use, and reduced executive and physical functioning. *Archives of Gerontology and Geriatrics*, *60*(1), 190-195. https://doi.org/10.1016/j.archger.2014.09.003

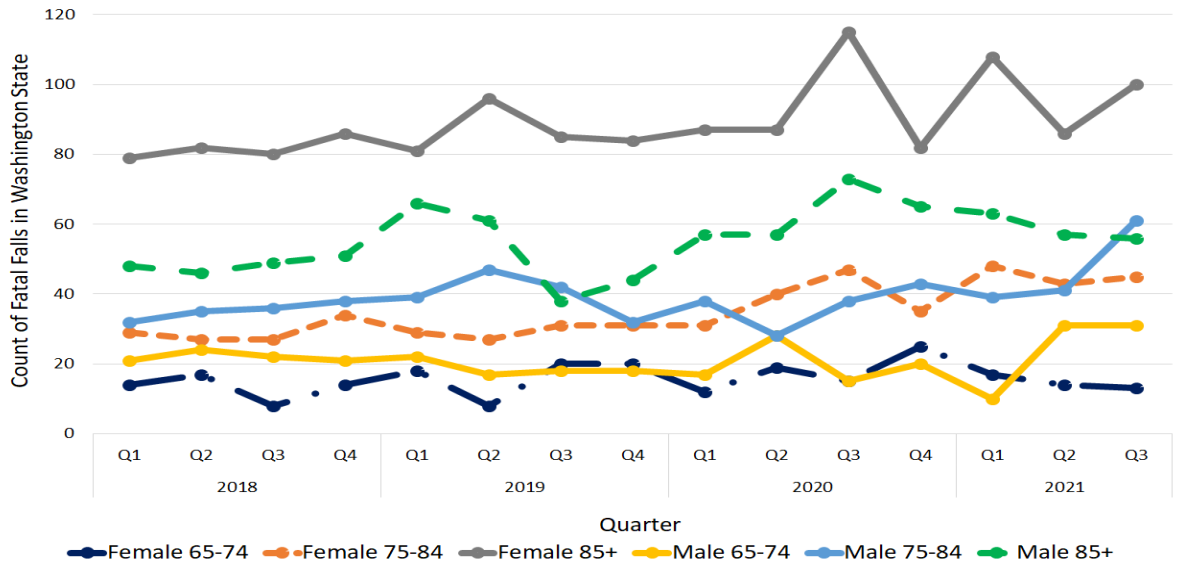
[9] Holloway, K. L., Williams, L. J., Brennan-Olsen, S. L., Morse, A. G., Kotowicz, M. A., Nicholson, G. C., & Pasco, J. A. (2016). Anxiety disorders and falls among older adults. *Journal of Affective Disorders*, *205*, 20-27. https://doi.org/10.1016/j.jad.2016.06.052

Graph 11 shows the count of fatal falls stratified by gender and age. The most recent reporting period (Quarter 3 of 2021) showed a 0.99% **increase** for individuals who were 65 years old and older as compared to the previous year (Quarter 3 of 2020).

Stratified by gender only, the most recent reporting period showed a 10.73% **decrease** for females and 17.45% **increase** for males in fatal falls as compared to the previous year.

Stratified by age only, the most recent reporting period showed a 47% **increase** for older adults ages 65 - 74 , 24.71% **increase** for older adults ages 75 - 84, and 17.02% **decrease** for older adults ages 85 and older in fatal falls as compared to the previous year.

Graph 11: Count of Fatal Falls for Older Adults (aged 65 years and older), by age, gender, and calendar quarter (Source: DOH)

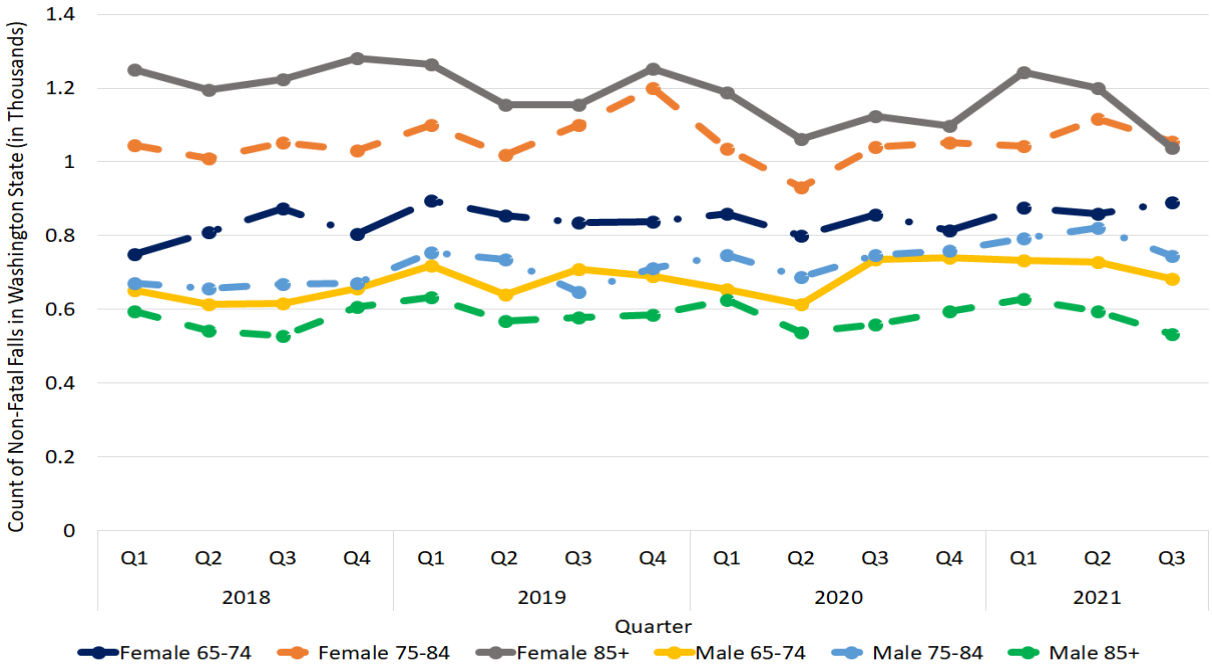


Graph 12 shows the count of non-fatal falls stratified by gender and age. The most recent reporting period (Quarter 3 of 2021) showed a 2.41% **decrease** for individuals who were 65 years old and older as compared to the previous year (Quarter 3 of 2020).

Stratified by gender only, the most recent reporting period showed a 1.36% **decrease** for females and 3.97% **decrease** for males in non-fatal falls as compared to the previous year.

Stratified by age category only, the most recent reporting period showed a 1.19% **decrease** for older adults ages 65 - 74, 0.61% **increase** for older adults ages 75 - 84, and 6.77% **decrease** for older adults ages 85 and older in non-fatal falls as compared to the previous year.

Graph 12: Count of Non-Fatal Falls for Older Adults (aged 65 years and older), by age, gender, and calendar quarter (Source: DOH)



Acknowledgements

This document was developed by the Washington State Department of Health's Behavioral Health Epidemiology Team Lead author is Alaine Ziegler, MPH

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