National Coalition on Mental Health and Aging
Meeting Minutes
March 27, 2012

Alixe McNeill, Chair of the National Coalition on Mental Health and Aging (NCMHA) and representative of the National Council on Aging (NCOA) called the meeting to order and reviewed the proposed agenda. There were 26 members present onsite and 10 via conference call. The meeting began with member introductions.

NCMHA Business and Announcements

The minutes of the November 2011 meeting were adopted.

Alixe informed the Coalition that the Executive Committee submitted written comments on the National Alzheimer's Draft Plan and Laurie Young delivered oral comment on NCMHA's behalf at the March meeting of the HHS Advisory Council of Alzheimer's Research Care and Services. The comments will be sent to NCMHA members. Deborah DiGilio was thanked for providing the American Psychological Association comments to assist Anita Rosen who drafted NCMHA's comments.

Alixe also alerted the group to the January 2012 AHRQ brief on Integrated Health Care (http://www.ahrq.gov/research/jan12/0112RA1.htm).

Willard Mays, Representative of National Association of PASRR Professionals provided an update on the creation of a new separate group on aging and mental health advocacy. Interested parties met for the first time on February 13th and endorsed the idea of forming the Aging and Mental Health Advocacy Network. Diane Elmore of the American Psychological Association agreed to serve as interim chair during the group's formation. A second meeting of the Network will convene right after this NCMHA meeting to adopt bylaws and determine priorities and next steps.

Policy Update

James Finley, Director of Public Policy at the American Mental Health Counselors Association, provided the policy update. He began by stating that a short term extension for Medicare payment rates until the end of the year seems likely. Then the rates drop 28% at the beginning of 2013. The Psychotherapy payment bump was lost this year and will be back in play. Health Information Technology will also need to be addressed.

Congress may be preparing a pared down version of a Medicare bill soon. Lame duck Congresses usually do stripped bills. A major Medicare bill may be introduced in 2015 but there are radically different perspectives on what "major" would look like.

A big issue in town is the House passed budget. It is a radical budget that caps domestic spending and cuts Medicare/Medicaid spending by $810 billion over 10 years. It will move all dual eligibles under Medicare. A question was raised that if the duals go under Medicare, would it include long term care? The answer will be in the details of the bill.

A concern was raised that older adult mental health and substance abuse might be left out of health reform and other evolving efforts. There is unfortunately not a strong advocate for mental health and aging. Mental health advocates don't often focus on older adults and aging advocates don't often focus on mental health. It is definitely not at the top of any of the lists of issues for health reform. .

2012-2013 NCMHA Priorities: Survey Findings and Executive Committee Recommendations

NCMHA recently conducted a survey of its members to identify priorities for future action. Members were asked to select their top 3 action priorities considering the current interests of their organization, developments in the field,and the needs of older adults,from among the 15 priorities set by the Coalition in 2010. Members were also asked to suggest actionable step(s) or issues that the Coalition and its members should address in 2012-2013.

NCMHA received completed surveys from 29 individuals; 50% from national organizations and 50% from state and local coalitions. The Executive Committee reviewed the findings and recommended at this meeting that the Coalition adopt the four priorities ranked highest by the survey respondents for attention and action in 2012-2013. The Executive Committee also proposed that NCMHA establish working groups for each of the four priorities to review the recommended action steps for each priority issue and develop a plan of action that they will recommend to the Coalition at its next meeting in July 2012. All members were invited to join one of the four groups to help shape the plans and carry out education and related actions.

The four top priorities and chairs for those working groups are:

- Assure access to affordable, comprehensive services - Kim Williams, Geriatric Mental Health Alliance of New York
- Integration of behavioral health into PHC, LTSS, community services - Chair: Anita Rosen, American Society on Aging
- Designation of older adult mental health leader /coordinator in AoA, other HHS and other federal, state and local agencies - Chair: Willard Mays, National Association for PASRR Professionals
- Address severe provider and faculty shortages - Co-Chairs: Deborah DiGilio, American Psychological Association and Gail Hunt, National Alliance for Caregiving

A sign-up list was circulated at the meeting and will be sent electronically to all NCMHA members so that they can join a working group.

Updates from Federal Agencies

Shannon Skowronski, Aging Services Program Specialist, Office of Program Innovation and Demonstration, Administration on Aging

Shannon began her remarks by stating that evidence-based practice is a big focus now and they also do have a focus on mental health issues. Under Title III D, that is not a new program, states receive money to provide health related programs. These programs now have to be evidence-based. Proportionally, the money for mental health is small and more funding is needed for new start-ups. The funded programs need guidance on how to find partners for effective efforts and it is hoped that the Policy Academies will help. It was noted that mentoring would be good component for the Policy Academies (see next item for more information on the Policy Academies). Through Section 30-26 of

ACA, CMS has awarded 30 grants to community agencies to provide coordination of services to dual eligibles as they are transitioning between care settings. Some awardees are Area Agencies on Aging. AOA is working to support them in delivering these programs.

For more information about AOA's Evidence-based Disease and Disability Prevention Program (EBDPP) see http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Evidence_Based/index.aspx
For more information about AOA's mental and behavioral health efforts, see:
http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Behavioral/index.aspx.

Marian Scheinholtz, Public Health Advisor, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

SAMHSA is sponsoring Policy Academies in five HHS regions beginning in 2012 and 2013. In Dallas, they are bringing in administrative level staff representatives from the Departments of Aging, Mental and Behavioral Health and additional folks (4 per state) to address behavioral health needs or the wellness of older adults. The question was raised as to how representatives are chosen. The reply was that they are selected by state agencies. The next one is scheduled for June 17-18 in Kansas City.
For more information about the Policy Academies, see:
http://www.nasuad.org/behavioral_health/older_adults_behavioral_health.html

SAMHSA is also working on the National Alzheimer's Disease Plan.
Mental health is a costly issue in AD – not just the sequelae. Related to the SAMHSA Targeted Capacity Expansion Programs (TCE), 10 programs are currently in their no-cost extension year.

Michele Karel, Program Coordinator, Home-Based Primary Care Mental Health Initiative, Office on Mental Health, Department of Veterans Affairs, VA Central Office, Washington, DC

Michele noted that although she is a staff member of VA Central Office in Washington, DC, she is located in Boston, so could not be present in person at the meeting, She provided an update on three VA programs- Staff Training in Assisted Living Residences(STAR-VA), Cognitive-Behavioral Therapy for Insomnia (CBT-I), and the Home Based Primary Care program (HBPC).

The VA has piloted in the Community Living Center (i.e., nursing home care) setting, an interdisciplinary behavioral approach to managing challenging behaviors related to dementia, called STAR-VA, which is based on Linda Teri and colleague's 2005 Staff Training in Assisted Living Residences (STAR) program. STAR was originally developed for training direct care workers in assisted living residences to improve the care of older adults with dementia by improving their interactions and successfully managing the challenging behaviors commonly exhibited by these residents. STAR-VA was developed by VA mental health program leaders and front-line staff in collaboration with Dr. Linda Teri, as part of a pilot dissemination and implementation initiative within VHA designed to increase the capacity of staff in VA Community Living Centers to improve the care provided to Veteran residents. In the intervention, doctoral-level mental health providers serve as behavioral coordinators working closely with other members of the interdisciplinary team. CLC Mental Health Providers at pilot sites received specialized training and weekly expert consultation in the intervention over a six-month period. Initial evaluation of training and patient outcomes are very promising, and VA is considering broader implementation. All VA CLCs have psychologists as part of the team.

As part of the extensive VA evidence-based psychotherapy national training and implementation program, CBT-I is now being rolled out nationally. VA professionals will be trained to use CBT-I, which has excellent support for the treatment of insomnia, a common problem among older adults – which can also help to reduce the use of pharmacological interventions for sleep problems.

The VA Home Based Primary Care program continues to grow; in HBPC, an interdisciplinary team provides in-home health care to mostly older veterans who are unable to access clinic-based services. In 2007-2008, Mental Health Providers, Psychologists and/or Psychiatrists, were added to into every HBPC team nationally, so that mental and behavioral healthcare could be integrated into team-based care for Veterans and families, including offering support to strained family caregivers. As programs grow in size, in terms of numbers of Veterans served, a number of local sites are hiring additional mental health staff.

Joan Weiss, Chief, Geriatrics and Allied Health Branch, Division of Public Health and Interdisciplinary Education, Geriatrics and Allied Health Branch, Health Resources and Services Administration (HRSA)

Joan provided an overview of HRSA's Geriatrics and Allied Health Grant Programs. They have four geriatric and two mental health programs. The Comprehensive Geriatric Education Program (CGEP) funds schools and training programs to train individuals in providing geriatric care, develop and disseminate curricula relating to the treatment of the health problems of older adults, train faculty members in geriatrics, or provide continuing education to individuals who provide geriatric care. It has a behavioral health piece.

The Geriatric Academic Career Award (GACA) funds the career development of geriatric specialists. ACA expanded eligible disciplines and now includes physicians, nurses, social workers, psychologists, dentists, pharmacists, and allied health professionals in academia to provide training in clinical geriatrics including on interdisciplinary teams of health professionals. This program award provides a financial incentive for junior faculty. There are current 66 active GACA awards – 64 physicians, one psychologist and one physical therapist. The next competition will be in 2015. They are working to solicit a better response from the newly eligible disciplines.

The Geriatric Education Centers (GEC) funds health professions schools to provide interprofessional/interdisciplinary education and training including continuing education to health professions students, faculty, and practitioners in the diagnosis, treatment, and prevention of disease, disability, and other health problems of older adults.There are currently 45 Geriatric Education Centers (GEC). Mental Health is a component in all. There will be $2 million in non-competitive supplemental grants for GECs in FY 2012 and $4 million in FY2013 to fund revision and dissemination of curricula for training of professionals in care for individuals with Alzheimer's and related dementias.

The Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Providers (GTPD)funds schools of medicine, osteopathic medicine, teaching hospitals, and graduate medical education to provide support for geriatric training projects to train physicians, dentists and behavioral and mental health professionals who plan to teach geriatric medicine, geriatric dentistry, or geriatric behavioral or mental health.

The Graduate Psychology Education Program (GPE) provides internship support in doctoral programs, in psychology. There is $2.9 million allocated. The current GPE cycle lasts through 2013.

Joan stated that a new source of grant fundingis expected to be announced in early April. $10 million in already appropriated Fiscal Year 2012 funds will be used to initiate a new program authorized in Sec. 756 of the recent healthcare reform law. Its aim will be to help close the gap in access to mental and behavioral health care services by increasing the number of adequately prepared mental and behavioral health providers for underserved populations (including older adults returning veterans, etc.). All grants will be peer-reviewed and awarded before the end of the current fiscal year on September 30th, so there will be a very compressed submission window. Psychology and social work programs will be eligible. Awards will be $10,000 per student.

The Institute of Medicine contacted HRSA as part of its data collection activities for its current Geriatric Mental Health Workforce Study for information on health disciplines. HRSA provided data for 2007 – 2011. Data they provided included:

- 93,616 individuals were trained in mental health and behavioral health in 21 disciplines. This includes 82,000 in mental health and 11,000 in substance abuse.
- More individuals were trained in 2010 than in 2007. There was a 90% increase in mental health and trainees and a 251% increase in substance abuse trainees

Overall, growth is slow but they are moving in the right direction.

Daniel Timmel, Policy Analyst, Centers for Medicare and Medicaid Services(CMS)

Daniel works in the Medicaid section of CMS. His section is currently writing the rules for implementation of ACA for 2014-2016. Another of their foci is a project on inappropriate antipsychotrophics in nursing homes. They have also been working with Housing and Urban Development (HUD) on a community living initiative doing what they can under their legislative authority.

Their general business is to adjudicate state requests for amending their State plans to do less. States are moving into managed care. They are completing 1115 demonstration waivers to move Medicaid into different existing operations.

Related to Preadmission Screening and Resident Review (PASRR), they have analyzed the program designs of all State PASRR programs for comprehensiveness. They have determined that 6 are comprehensive; 6 less than 20% compliant, and the rest are somewhere in between. A letter will go to State Medicaid, Aging and Health Departments reporting on their state and the national results. A table with states grouped by quartile of compliance are being released out soon.

As of October 2010, nursing homes are required to explore a resident's desire to return to the community. The requirement is in MDS 3.0 Section Q. There are a variety of resources on this topic includingpresentations from the MDS 3.0 Section Q Training held on March 7 and March 9, 2012, and reports, point of contact charts, and reference materials designed to assist with Section Q implementation: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html

Katie Maslow, Scholar in Resident, Institute of Medicine

Katie reported that Institute of Medicine Report, *Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* is about be sent out for external review. The scheduled release date will be in the middle of June. It is a completely confidential process. Information about the study can be found at: http://www.iom.edu/Activities/MentalHealth/GeriatricMentalHealth.aspx.

Reports of Successful State/Local Coalition Sustainability Strategies

Rebecca May Cole, Pennsylvania Behavioral Health and Aging Coalition (**www.OlderPA.org**) - The Coalition became a 501C3 in 2005. They have a $340,000 budget with the majority of funding from State aging and public welfare programs. They receive $130,000 for their behavioral health connection which is affiliated with the State Mental Health Improvement Plan. They also have a contract with the Department of Aging. They offer forums on promising practices in mental health and substance abuse. They do suicide prevention training and others on meeting the mental health and behavioral health needs of older adults. They also work with the Pennsylvania Geriatric Education Center on training geriatric resource nurses in the community. They made $15,000 by

charging for this training. It included understanding dementia and effective behavioral management techniques.

Bernie Seifert, New Hampshire Coalition on Substance Abuse, Mental Health and Aging

Training and learning was very important for building their successful coalition. The NASPHD training in coalition building and the SAMHSA training in Las Vegas were so important to their effectiveness and they would like to see it occur again. They currently collaborate with the Massachusetts Aging and Mental Health Coalition

***Karen Orsi, Oklahoma Mental Health and Aging Coalition*(www.omhac.com)**

She began her work with the Coalition in 2006 on a volunteer basis and benefited immensely from the help of Bob Rawlings. They were sustained over the last two years with Oklahoma Transformation funds, but this ended abruptly. The Coalition survived because of #7 NCMHA priority that is, by collaborating with aging, health, mental health and substance abuse and consumer organizations. They now receive block grant funding and funds from multiple other sources to keep funding intact. The Oklahoma Department of Mental Health has the Coalition's resources on their website and uses them.

They have a Geriatric Depression Screening Program to chip away at the stigma where they are right next to nurses doing blood pressure screenings so depression screening is viewed as one component of a general health screening. They are also involved in the Advocacy project with Kim Williams and are very involved with senior Health and Wellness issues including mental health, caregivers, and suicide prevention in assisted living facilities, and a Medicare Optimization project.

Charlotte Kaufman, NASPHD Older Persons Division

Charlotte noted that they are using SAMHSA's Treatment of Depression in Older Adults Evidence-Based Practices (EBP) KIT as a resource in their efforts. http://store.samhsa.gov/product/Treatment-of-Depression-in-Older-Adults-Evidence-Based-Practices-EBP-KIT/SMA11-4631CD-DVD

Prior to adjournment of the meeting, the recent CMS coverage decision on depression was mentioned. CMS will now cover costs for an annual screening for depression for Medicare beneficiaries in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. For more information on the coverage decision see: https://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?&NcaName=Screening%20for%20Depression%20in%20Adults&bc=ACAAAAAAIAAA&NCAId=251.

The next NCMHA meeting will be held on Monday, July 23 from 10-12:30pm at APA Central Office, 750 First Street, Washington, DC, 6th floor Board Room.