National Coalition on Mental Health and Aging
Meeting Minutes
November 7, 2011

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 16members present onsite and 8 via conference call. The meeting began with member introductions.

NCMHA Business

The minutes of the June 2011 meeting were adopted.

Today's meeting had a focus on Behavioral Health and Primary Care Integration: Implications for Older Adult Mental Health. Three speakers addressed this topic from three different vantage points.

Promoting the integration of mental and behavioral health in primary care through public policy

First, Diane Elmore, Associate Executive Director, Public Interest Government Relations Office, American Psychological Associationbegan by providing a working definition and basic model of integrated health care from APA's *Blueprint for Change: Integrated Health for an Aging Population*(2008), http://www.apa.org/pi/aging/programs/integrated/integrated-healthcare-report.pdf.Next she reviewed reasons for promoting integrated health care including: improved access, utilization, and quality; positive changes in clinical and functional outcomes, treatment adherence, patient satisfaction, and cost-effectiveness; and reduced health disparities. These models have an increasingly strong evidence base (e.g., IMPACT, PROSPECT, PRISME, VA). In terms of integrated health care policy efforts, she reminded the Coalition of earlier discussions of the OAA Amendments of 2006 that authorized AoA to: designate an employee to be responsible for administration of mental health services; and,make grants to states formental health screening and treatment services, increased public awareness regarding the benefits of prevention and treatment, and to reduce stigma and prejudice. These provisions were based on the Positive Aging Act of 2005 (S. 1116/H.R. 2629). Unfortunately these provisions have yet to receive funding.

The remaining provisions of the Positive Aging Act (S. 525) have been introduced in the Senate by Senators Collins (R-ME) and Mikulski (D-MD). They would make mental health services a part of primary care services and extend them to other settings where older adults reside and receive services. These evidence-based services would be provided by interdisciplinary teams of mental health professionals working in collaboration with other providers of health and social services. The bill would authorize SAMHSA to: 1) support demonstration projects to integrate mental health services in primary care settings; 2) support grants for community-based mental health treatment outreach teams;

3) designate a Deputy Director for Older Adult Mental Health Services in CMHS; and 4) include representatives of older Americans or their families and geriatric mental health professionals on the Advisory Council for CMHS.

In Health Care Reform, integrated care is currently manifested in provisions related to: community health teams to support the patient-centered medical home; co-locating primary and specialty care in the community-based mental health settings; capacity building in primary care; community-based collaborative care networks; and, state option to provide health homes for enrollees with chronic conditions.Also in Health Care Reform are Geriatric Education and Training (Title VII) provisions that: 1) expand Eligibility for Geriatric Academic Career Awards to a variety of new disciplines, including osteopathy, dentistry, nursing, social work, psychology, and pharmacy; 2) authorize a new Geriatric Career Incentive Awards Program to provide financial support to foster greater interest among a variety of health professionals in entering the field of geriatrics; and 3) expand authority for Geriatric Education Centers (GECs) to offer short-term fellowships in geriatrics for faculty members in medical schools and other health professions schools. GECs receiving these grants are required to offer training courses to family caregivers and direct care providers at no charge or minimal cost or incorporate mental health and dementia "best practices" training into their courses.

Specific to psychology, the Graduate Psychology Education (GPE) Program: 1) Provides grants through HRSA to accredited graduate psychology programs (doctoral/post-doctoral and internships) to provide interdisciplinary care to underserved populations (including older adults); 2) Since 2002, 106 GPE grants have been awarded in 32 states (including DC) to university medical centers, primary care clinics, and federally qualified health centers.

Finally, it is very exciting that currently an IOM Study: *Mental Health Workforce for Geriatric Populations* is underway.APA, AAGP, and NASW successfully worked with Reps. DeLauro (D-CT) and Kennedy (D-RI), to designate $900,000 in the report language that accompanied the FY2010 Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act to fund this IOM study. IOM will determine the mental and behavioral health care needs of those over 65 and make policy recommendations for meeting those needs through a competent and well-trained mental health workforce.

In closing, Diane alerted NCMHA to two Coalitions of interest. The Patient Centered Primary Care Collaborative (PCPCC), a coalition of over 900 members from major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, clinicians, and others that works to develop and advance the patient-centered medical home. The Eldercare Workforce Alliance (EWA) is a group of 28 national organizations representing consumers, family caregivers, the direct-care workforce, and healthcare professionals who work together to address the immediate and future workforce crisis in caring for an aging America.

Primary and Behavioral Health Care Integration (PBHCI)

Next in the integrated care discussion, Marian Scheinholtz, Public Health Advisor, Community Support Programs Branch Division of Service and Systems Improvement of the Center for Mental Health Services, SAMHSA began her presentation, "What is being learned from the SAMHSA integration project grants and resources available from the SAMHSA-HRSA Center for Integrated Health Solutions" by highlighting why integration is important to people with serious mental illness (SMI). She then described their Primary and Behavioral Health Care Integration initiative (PBHCI). Its purpose is to improve physical health status of people with SMI served by the public behavioral health system by supporting communities to coordinate and integrate primary care services into publicly funded community-based behavioral health settings. The expected outcome is that grantees will enter into partnerships to develop or expand their offering of primary healthcare services for people with SMI, resulting in improved health status. Eligible

applicants include community behavioral health agencies in partnership with primary care providers.Service delivery in PBHCI: facilitates screening and referral for primary care prevention and treatment needs; provides and/and or ensures that primary care screening, assessment, treatment, and referral be provided in a community-based behavioral health agency; develops a registry/tracking system for all primary care needs and outcomes; offers prevention and wellness support services (>10% of grant funding); and build processes for referral and follow-up for needed treatments that are not appropriately provided in a primary care setting.

PBHCI Performance Outcomes include:health outcome indicators (by individual) such as weight/height/body mass index, blood pressure, blood glucose, or HbA1C, and lipid profile and services. Outcome indicators include: the number of mental health consumers receiving primary care services and the number of mental health consumers screened for: hypertension; obesity; diabetes; co-occurring substance use disorders; and tobacco product use.In collaboration with HHS/Office of the Assistant Secretary for Planning and Evaluation, cross-site evaluations questions are: (1) Does the integration of primary and behavioral health care lead to improvements in the behavioral and physical health of the population with serious mental illness (SMI) and/or substance use disorders served by the grantees' integration models? (2) Is it possible to integrate the services provided by primary care providers and community-based behavioral health agencies (i.e., what are the different structural and clinical approaches to integration being implemented)? and, (3) Which models and/or respective model features of integrated primary and behavioral health care lead to better mental and physical health outcomes?

PBHCI infrastructure development includes: development of interagency coordination mechanisms and partnerships with other service providers; policy development to support needed collaborative service systems improvement, enhanced computer systems, workforce development, and redesigning processes to enhance effectiveness, efficiency and optimal collaboration between primary care and behavioral health provider staff. Potential models of PBHCI Integration will: assure regular screening and registry tracking/outcome measurement at the time of psychiatric visits for all individuals receiving psychotropics; provide routine primary care services in the behavioral health setting via a nurse practitioner or physician out-stationed from the full-scope healthcare home; identify a primary care physician to provide consultation on complex health issues; embed nurse care managers within the primary care team working in the behavioral health setting, to support individuals with health risk factors; and, create wellness programs.

SAMHSA also has a partnership with HHS/HRSA to promote the planning and development of integrated primary and behavioral health care for those with SMI, addiction disorders and/or individuals with SMI and a co-occurring substance use disorder, whether seen in specialty mental health or primary care safety net provider settings across the country. Its purpose is to: serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care and related workforce development; and, provide technical assistance to PBHCI grantees and entities funded through HRSA to address the health care needs of individuals with mental illnesses, substance use and co-occurring disorders. The 2010 Award was to the National Council for Community Behavioral Healthcare. The program has up to $5,350,000 (per year for up to 4 years). It is allocated as: $1.4M—SAMHSA, $350,000—HRSA, $3.6M—Office of the Secretary's Prevention Trust Fund. For more information about this SAMHSA – HRSA Center for Integrated Health Solutions, http://www.integration.samhsa.gov/or (202) 684-7457

Models for Integrated Care: The NYS Geriatric Mental Health Demonstration Projects

The final integrated care presentation was by Kimberly Williams, Geriatric Mental Health Alliance of New York and NCMHA Executive Committee Representative for State and Local Coalitions who discussed the New York experience with integrated care through the geriatric mental health

demonstrations, and opportunities for sustainability in the Affordable Care Act. The Geriatric Mental Health Actof New York established an Interagency Geriatric Mental Health Planning Council and services demonstrations grants ($2 million per year). In the RFP for Integration Programs, the specifications included establishment of program models for co-location of mental health specialists within primary care and other models for improving collaboration between separate providers.Core program elements required included screening, assessment, treatment, priority access, and coordination or integration of systems.Programs are located in a variety of settings including: hospital/medical school health clinics, community mental health agencies or county clinics, private practice, home health, and federally qualified health centers. Six integration of physical health and mental health programs and three community gatekeeper programs were established initially with the grant funds. A total of 22 grants were awarded to integrate physical and behavioral health care in either behavioral health care settings or physical health care settings during the first and second round of the demonstration programs.

Grantees meet via monthly conference calls and via quarterly face-to-face meetings. The goals of this learning collaborative are to provide oversight of grant programs, foster support and learning among grantees, and offer expert technical assistance.In Phase I of the Medicare Optimization Project Process, on-site visits are conducted to understand program model and opportunities to optimize funding are identified. Staff communicates with programs about optimization opportunities.In Phase II of the Medicare Optimization Project process, individualized technical assistance is delivered on: development of viability models, implementation of revenue optimization recommendations, assistance with mounting billing, and identifying additional community partners to assist with sustainability.

Kim concluded her remarks by noting opportunities for sustainability in the Affordable Care Act including Patient Centered Medical Homes, Health Homes, and avoiding hospital readmissions through care coordination.

Patient-Centered Outcomes Research Institute (PCORI): Purpose, Organization and Pilot Projects Grant Program

Gail Hunt, President and CEO of the National Alliance for Caregiving, and member of the Patient-Centered Outcomes Research Institute (PCORI) Board of Governors,presented on the Institute that was fully established in January 2011. The mission of PCORIis to help people make informed health caredecisions – and improve health care delivery andoutcomes – by producing and promoting high integrity,evidence-based information that comesfrom research guided by patients, caregivers (this includes health care providers too)and thebroader health care community including comparative effectiveness research.

The promise of PCORI includes understanding the choices patients face, aligning methods and data with patient needs, and providing patients and clinicians' information for better decisions. There is a lot of evidence-based data and they are looking at both randomized clinical trials and observational studies.

PCORI is comprised of a 21 member Board including patient representatives, caregivers, physicians, nurses and providers, health services researchers, state and federal health officials, pharmaceutical, device and diagnostic manufacturers, private payers and employers. Expert methodologists are advisors. Its core duties are to: establish national research priorities and fund research in these priority areas; establish and carry out a research project agenda; develop and update methodological standards; provide a peer-review process for primary research; and, disseminate research findings. (20% of the funding they have for dissemination will go to AHRQ). The proposed criteria for national priorities are: impact on health, improvability via research, inclusiveness of subpopulations, impact on Health System Performance, gaps in knowledge, variation or disparities in delivery or outcomes,

potential to inform decision-making at point-of-care, responsiveness to expressed needs, advances CER methods, and fits the definition.

The purpose of the PCORI Pilot Projects Grants Programis to: 1) provide information to PCORI that informs future iterations of *national* research priorities for patient-centered outcomes research, 2) support the collection of preliminary data to advance the field of patient-centered outcomes research, providing the platform for an evolving PCORI *research agenda*, and 3) support identification of *research methodologies* that advance patient-centered outcomes research. The first grant announcement is out. Letters of intent are due November 1st and proposals are due December 1st. 1,344 letters of intent were received. They expect to commit approximately $13 million in FY 2012 to support approximately 40 projects. NIH will conduct the merit review process with all other aspects of grant awards and grants management handled by PCORI.

Gail noted the difficulty of securing applications from patients and families to be involved in the grant review process. She also stated that PCORI is not allowed to do research or discuss costs. They can look at quality outcomes for patient and caregivers or hospitalization rate reductions but can't discuss costs.PCORI will be doing more brand awareness efforts and hirea director of patient engagement. More information is on their website, http://www.pcori.org/

State and Local Mental Health & Aging Coalition Survey

Kimberly Williams, Geriatric Mental Health Alliance of New York Representative and NCMHA Executive Committee Representative for State and Local Coalitions provided an update on the recent survey of state and local mental health and aging coalitions. A total of 30 state and regional coalitions in 22 states responded. We would like a higher response rate, so the survey was sent to NASPHD for assistance with dissemination. Technical assistance training needs of state and local coalitions were identified. These include sustainability, advocacy, policy, development of mission. Actions that NCMHA can take to assist them include addressing priority issues in national meeting agendas, offering resources and sharing expertise. GMHA-NY through its National State Based Advocacy Project is working with California, Georgia, Indiana, Pennsylvania, and Oklahoma on developing and carrying out an advocacy plan.For survey results see: http://www.nasmhpd.org/general_files/meeting_presentations/OPD/MH%20and%20Aging%20State%20and%20LocalCoalition%20Survey%20Responses%206-28-1_5.pdf

Policy Updates

James Finley, Director of Public Policy at theAmerican Mental Health Counselors Associationprovided the policy update. He began by stating that the Supreme Court will tell us how we should take up health care reform. Things are very difficult in Appropriations. There are Mega issues around the appropriations process. The "Super Committee" is talking a lot about Medicare. However, the Committee itself is deadlocked. They really need to be able to make concessions but have to ask at the highest levels of their parties to able to make those concessions. By the end of month, they are supposed to make decisionsand have full-blown legislative language ready by December but this seems unlikely.

The Medicare's Sustainable Growth Rate (SGR) cut continues to be an issue but no one on the Hill wants to discuss it until the Super Committee finishes its work. Medicare, Medicaid, and dual eligibles are all on table of the Super Committee. No one expects a solution by the Super Committee and the actual SGR cut should hit in 13 months, so there is that much time to fix it.

A question was raised as to whether we should expect to see funding for any new programs. The answer was "No!" An example of no new money is the recent discontinuation of planning for the

CLASS Act part of the ACA. The actuarial report figures used are in question but no one chose to rewrite the Bill to save it. It is seen as competitive with private long term care plans.

Regarding dual-eligibles, any major discussions and themes are being tightly held on the Hill. There is a better sense of the problems than of the fixes. There is concern that there will be an effort to privatize care which may not be appropriate for this low-income, frail population.

Member Updates

American Mental Health Counselors Association – Jim Finley reported that the American Mental Health Counselors Association is working to secure recognition of mental health counselors under Medicare. Counselors are well represented in rural and underserved areas and are a valuable resource for meeting the mental health needs of rural elders.

American Psychological Association - Deborah DiGilio shared that two webinars were held this fall and are archived and available cost free on the Office on Aging webpage. The first "Mental Health Needs of Family Caregivers: Identifying, Engaging and Assisting" was co-sponsored by the Administration on Aging. Over 360 aging and health service providers participated. Discussed were strategies to identify and engage family caregivers, effective interventions in addressing caregiver stress and burden, and an overview of the wealth of resources available in the *APA's Family Caregivers Briefcase*. http://www.apa.org/pi/about/publications/caregivers/index.aspx. The second webinar, "New Alzheimer's Guidelines: How Will Research and Practice Be Affected?" discussed the new NIA/Alzheimer's Association guidelines.

American Society on Aging –Anita Rosen noted that the dates of the Aging in America Conference will be held here in Washington DC on March 28th - April 1st. Willard Mays reported that three NCMHA sessions were accepted but rather than having a one day coalition track, they scheduled the three sessions on three difference days resulting in conflicts with the Mental Health and Aging Network and Kimberly William's programs. He will speak with them about changing the time.

Geriatric Mental Health Alliance of New York – Kimberly Williams updated the group on the grant that she has working with five state coalitions on effective advocacy and embedding geriatric mental health into primary and managed care.

Illinois Coalition on Mental Health and Aging - Charlotte Kauffman noted that they have a new website, http://www.ilcmha.org/. They had two regional mental health and aging conferences this fall and will also have a mental health track at the Governor's Conference on Aging that will be held December 7th – 9th in Chicago.

Mental Health and Aging Coalition of Eastern Kansas - Sally King discussed the November 4th Mental Health and Aging Regional Conference for social workers. Over 100 individuals attended.

National Alliance for Caregiving – Gail Hunt informed the group that they will be releasing a new study, "Caregiving Costs: Declining Health in the Alzheimer's Caregiver as Dementia Increases in the Care Recipient" at the upcoming Gerontological Society of America meeting. The study specifically examines the use of formal health services in a large sample of Alzheimer's disease caregivers. (Ed. Note: The full report is now available at: http://www.caregiving.org/pdf/research/Alzheimers_Caregiving_Costs_Study_FINAL.pdf

National Association of Social Workers – Chris Herman described plans for the 2012 NASW conference in July. Its theme is "Restoring Hope: The Power of Social Work." The call for proposals is available at: www.professionofhope.com.January 15, 2012 is the deadline for submitting proposals.

A Practice Perspectives article, "Creativity and Aging" was released in September. They also released a report, *Social Services in Cuba*that was based on the two NASW delegations to Cuba in early 2011, www.socialworkers.org/nasw/swan/cubaReport.pdf.

National Association of State Mental Health Program Directors –Marcia Marshall formerly with NASPHD (and now with the Severn Avenue Group) noted that SAMHSA funding for NASPHD's project to help states plan and develop mental health services for older adults was no longer being funded. She mentioned that at a meeting of the National Association of Insurance Commissioners convened to discuss the development of health exchanges, mental health was not mentioned a single time.

National Association of States United forAging and Disabilities - Sara Tribe described their Technical Assistance Support Center (TASC) that assists states and local agencies develop comprehensive Sate and Area Plans on Aging. More information is available on their website, www.nasuad.org (click on TASC Planning Zone). NCMHA and its members can submit resources to be added to the Resource Links section of the webpage.

National Consumer Voice for Quality Long-termCare – Jessica Brill Ortiz reported that they are developing a report on the consumer perspective of quality care. She will send additional information about the project so that it can be sent to member organizations.

National Council on Aging – Emily Watson discussedNCOA's work on sustainability producing a report for SAMHSA called *Lessons Learned on Sustainability of Older Adult Community Behavioral Health Services* that will be available shortly in draft on www.ncoa.org; SAMHSA is considering publication. NCOA has also been working with SAMHSA and AoA as a subcontractor on the Older Adults Behavioral Health Technical Assistance Center preparing plans for upcoming webinars, issue briefs and policy academy regional meetings.

Oklahoma Mental Health and Aging Coalition - Karen Orsi reported that the Coalition has relocated to Oklahoma City because they were asked to do program development in Oklahoma City health homes and wrap around services.

Pennsylvania Behavioral Health and Aging Coalition - Rebecca May-Cole reported that they are working with their Geriatric Education Center on a series of training activities for registered nurses on areas of identified need including mental health. They have conference calls discussing difficult cases and how to meet needs through interdisciplinary teamwork. The PA office of Mental Health and Aging Department joined with them in surveying all nursing homes accepting Medicaid recipients about how they meet the behavioral health needs of their residents, what are the barriers, what staff do they use to meet these needs (social workers vs. psychiatrists, vs. contracting with outside providers, etc.).

Psychologists in Long Term Care – Michael Duffy reported on behalf of Paula Hartman Stein that they have implemented two PEARLS programs in Ohio.

Rhode Island Elder Mental Health and Addiction Coalition – Janet Spinelli reported that she and an elder affairs advocate in the police department conducted a training titled, "First Responders: Drug Abuse and Drug Misuse Among Older Adults." The Power Point presentation is available at: http://docs.google.com/viewer?a=v&q=cache:8JoDX1o0UQgJ:www.dea.ri.gov/Advocates/Presentations/2011%2520Session/First%2520Responders%252010-26-11.ppt+First+Responders:Drug+Abuse+and+Drug+Misuse+Among+Older+Adults&hl=en&gl=us&pid=bl&srcid=ADGEESj0idWO1S775fFm36v9jKKzEfLt1e5Ixshjk5SBKPp3XyKawqQ0XX5m20kq9f1yZcPfdtB5wrQmoh6XUPCF2VlfE4efflgvRsQVotAxaU0sOMNTnxSKSUwbsViq4m-Xws4gsgm2&sig=AHIEtbTHh2K3y-0jVLXKsF6nWPTwdoocxQ

The next NCMHA meeting will be held on March 27th from 2:00 – 4:30 p.m. The meeting is being held the afternoon preceding the Aging in America Conference that will be held also inWashington, DC. We hope that many state and local coalitions attending the conference will also be able to join us, in person, for this next meeting. The NCMHA meeting will be held at the American Psychological Association building, 750 First Street, NE, which is one block from the Union Station Metro stop.

The meeting was adjourned at 12:30 p.m.