SAMHSA
Substance Abuse and Mental Health Services Administration

Strengthening Service Coordination for Older Adults with Serious Mental Illness

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WELCOME

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Nearly 50 million Americans are over the age of 65 years and will be closer to 80 million by 2050. Late adulthood can be a time of great satisfaction. Yet, when lifelong struggles with serious mental illnesses (SMI) continue and are often coupled with physical and social losses, it can also be a time of despair. Change and loss in later life may contribute to new episodes of depression, substance use, and other serious behavioral health issues.

SAMHSA's 2016 National Survey on Drug Use and Health (NSDUH) estimated that by 2016, 13.1 million adults ages 50 or older would have mental illness, with an estimated 3 million having SMI. In addition to mental health conditions, NSDUH data also suggests that as many as 5.7 million people aged 50 and over will have a diagnosable substance use disorder by 2020, and over 1 million of this population will be age of 65 and older. Older adults are not immune to the opioid crisis and losses suffered by families and communities across this country.

The NSDUH data reveal a 90 percent increase in opioid use among older Americans compared to data from 2002 and 2014. Further, over 7,000 of the 44,000 people who died from opioid overdose in 2016 were over the age of 50, a 13 percent increase. Compounding the issue, mental health and substance use disorders often present concurrently. In 2016, 1.7 million adults over the age of 50 experienced a mental illness and substance use disorder in the last year.

In June 2016, the Center for Disease Control (CDC) reported staggering increases in suicide across all states regardless of gender or age. Tragically, suicide is a particularly urgent problem among older adults, with higher rates among older men and men aged 75 and older having the highest rate of any group in the country. Further, suicide attempts among older adults are much more likely to result in death compared to younger persons. In 2016, older adults made up 15 percent of our population, but accounted for 18 percent of the suicides, meaning one

older adult dies by suicide every hour. Therefore, it is critical to find ways to address the needs of the older adult population in relationship to SMI and substance use disorders.

The charge given to the expert panel is to share innovative and practical ideas for improving service delivery, professional training, and guidance about funding issues and other challenges in serving the needs of older adults.

Introduction of the Principal Deputy Assistant Secretary

Mr. Owens welcomed everyone participating in the expert panel. Mr. Owens noted from experience how he supports the work of the expert panel - from 2006 to 2008, he was a senior advisor at SAMHSA after his tenure at the Virginia Department of Behavioral Health. He then returned to Virginia's Department of Health Professions, which addresses regulatory issues pertaining to practitioners. As part of the Senate staff, he had the opportunity to help draft the 21st Century Cures Act. Following that posting, Mr. Owens worked with Senator Bob Corker on the Special Committee on Aging, learning much about the work happening across the nation with older Americans.

Overview of Mission and Purpose of ADRC and SAMHSA MHBG

Tison Thomas, Branch Chief, CMHS, SAMHSA; Lori Gerhard, Director, Office of Consumer Access & Self-Determination, U.S. Administration for Community Living (ACL)

According to the CDC, by 2030 there will be 71 million older adults, accounting for roughly 20 percent of the United States population. The vast majority of these individuals will have at least one chronic health condition while the number of older adults with major psychiatric illness is projected to reach 15 million. Experts predict the nation's healthcare spending will also increase by 25 percent during this timeframe. Due to fixed incomes, many older adults are forced to make difficult choices between paying the mortgage and buying medications.

The CDC reports that some aspects of mental health improve with age, but many older adults still suffer with mental distress associated with limitations in daily activities, physical impairments, grief following loss of loved ones, caregiving and challenging living situations, or untreated mental illness, such as depression or substance use. Further, about 25 percent of adults aged 65 years or older have some type of mental health problem, such as a mood disorder, not associated with normal aging. Although social ties are one of the strongest predictors of well-being, about 12 percent of adults aged 65 or older report they are rarely or never receive the social and emotional support they need.

The NSDUH indicated opioid misuse is increasing among those 50 and older. In 2016, over 44,000 Americans died from opioid overdose and more than 7,000 were aged 55 and older. Further, 43 percent of the 4,846 rural opioid deaths in 2016 occurred among adults aged 45 and older. Opioid misuse among 65 and older increased from 1.1 percent in 2002 to 2 percent in 2014, and is predicted to increase to 3.1 percent, or 5.7 million, by 2020.

In a 2007 report on the state of aging and health in America, the CDC reported that smoking, poor diet, and physical inactivity were the root causes of almost 35 percent of all deaths in the United States. The situation of people with SMI is especially dire with a life expectancy of about 25 years less than the general population. More importantly, individuals with mental illness die with treatable medical conditions caused by modifiable risk factors including smoking, obesity, substance use disorder, and inadequate access to medical care.

Encouraging the adoption of healthier behaviors and regular health screenings will improve the health of older adults. These activities can reduce the risk of many chronic diseases, help decrease health disparities, and lower healthcare costs by integrating the provision of mental health and general healthcare services. Currently the majority of the older adults who receive mental health services are treated by their primary care physicians. Extensive research has shown that the integrated treatment models achieve significant reduction in depression, supports close follow-up of individuals, and is very cost-effective.

An estimated 8,618 older Americans ages 60-plus died from suicide in 2010. Although the rate of suicide of women typically declines in older age, older men die by suicide more than seven times the rate of older women. The incidence of suicide is particularly high among white males, 30.3 suicide per 100,000. Notably, the rate of suicide in the oldest group of white males, ages 85-plus, is over four times higher than the nation's overall rate of suicide. Suicide attempts by older adults are much more likely to result in death than among younger persons. Sadly, 58 percent of those who die by suicide have seen their primary care practitioner in the last month of their life. However, mental illness is not a normal part of aging.

Indicators of healthy aging and well-being include increased social support, social connectedness and engagement. However, older adults with mental health conditions are socially excluded increasing the likelihood of significant psychological distress and psychiatric illness, including substance use. Conversely, social inclusion means:

- Confronting the poverty that cripples opportunities and worsens health conditions for many older adults with mental health issues
- Promoting employment when it is desirable to an older adult person
- Encouraging volunteerism
- Offering meaningful activities for older adults with mental illness
- Reducing the inadequate or inequitable distribution of healthcare resources,
- Eliminating the discrimination, fear, and bias that keep older adults with mental health conditions at the margins of the society.

To promote mental health and prevent mental illness among this population, the significant workforce shortage in both mental health and geriatric health must be addressed by increasing the number of providers and enhancing the skills of those who serve older adults with mental health needs. Further, services must be provided in a person-centered, recovery-oriented, evidence-based, and quality-driven system.

When Congress enacted the mental health program and legislation, older adults were highlighted as a special population requiring the states' attention. As part of their application for SAMHSA's Community Services Mental Health Block Grant, states are required to describe the services and support they would provide to older adults. The largest mental health focused grant program within SAMHSA at approximately $772 million, this grant is a flexible set of funds that states can use for services and supports for older adults. However, grant funds cannot supplant or supplement services that are not covered under other insurances or state funds.

In closing, Mr. Thomas encouraged the panel to believe in their ability to make a positive impact in the lives of the older adults and never fear that the goals are too difficult to achieve.

Mr. Weakly introduced Lori Gerhard, Director of the Office of Consumer Access and Self-Determination in the Center for Integrated Programs at the Administration for Community Living (ACL). Before ACL, Ms. Gerhard served as a consultant in long-term services and support and was the acting director of the Pennsylvania Department of Aging Services.

The ACL funds a nationwide network that helps all populations, regardless of payer source or age, to connect to long-term services and supports in the community. ACL's work ranges from developing policy to evaluating program outcomes, and the information from this panel will inform and guide both SAMHSA and ACL's singular and combined efforts to address the behavioral health needs of older adults.

The “No Wrong Door” perspective of the ACL is to provide the right long-term services and supports, which is often difficult due to currently fragmented systems and processes. ACL, the Centers for Medicare and Medicaid Services (CMS), and the Veterans Health Administration have partnered for several years to support states' efforts to develop coordinated systems of access enabling people of all ages to learn about and access services through the Aging and Disability Resource Centers (ADRCs) and the Veteran-Directed Care Program.

The “No Wrong Door” system is a robust network of agencies and organizations designed to support individuals needing long-term care, regardless of age, income, or disability. The system focuses on state and governance administration, public outreach and coordination, and person-centered counseling and practices to streamline eligibility for public programs. Currently, 56 states and territories participate in “No Wrong Door” activities. Providing more than 1,322 access points across the country, programs are staffed and run by people living in the community who are familiar with the culture of that local community.

As states continue to develop “No Wrong Door” systems, the importance of and need for strong, coordinated governance and administration is very apparent. Notably, ADRC funds about $8 million annually in transformative grants to help provide technical assistance and facilitate peer learning across the states. ACL also provides technical assistance to help states with Medicaid administrative claiming. Any state applying for an ADRC “No Wrong Door” system grant needs to have a governance structure that includes the agency that administers their mental health and substance abuse services, their state unit on aging, the agencies that administer programs to people with physical and intellectual and developmental disabilities,

their Medicaid agency, and governor. They are also encouraged, but not required, to have their state department of military and veterans' affairs involved in the process.

Another important aspect of the "No Wrong Door" systems is person-centered practices. Because every individual is unique, the system must be able to respond with flexibility to the individual's situation, strengths, needs, and preferences. Person-centered counseling also allows individuals to be engaged in the decision-making process about their options, preferences, values, and financial resources. For instance, the Veteran-Directed Program developed a benefit to provide veterans with the opportunity to customize their care, including hiring family, friends, and neighbors. ACL has been supporting states' efforts to develop person-centered counseling and a trusted access system, as well.

ADRC's "No Wrong Door" system can also play a crucial and vital role in the integration of health and mental health services. For instance, through the hub-and-spoke model implemented by the Veteran Directed program that crosses state and county lines, a central agency is responsible for the contractual arrangement with the VA and the delivery of the program, and then creates subcontracts with other entities to provide services ensuring that services continue despite program changes that would otherwise leave veterans without care.

ACL has numerous programs and efforts to support states in transforming long-term service access functions. Though states are at different stages, they use ADRC grants to integrate "No Wrong Door" access points, which is key to delivering person-centered care, and include school systems, centers for independent living, and Area Agencies on Aging.

University of Connecticut Report Overview: Older Adult Behavioral Health Asset Mapping Study, Part One

Kate Kellett, Ph.D., Project Coordinator, University of Connecticut, Center on Aging

Multiple factors contribute to the crisis of unmet behavioral health needs for older adults. Nationally, there is unprecedented growth in the older adult population, a very diverse group experiencing behavioral health disorders and an underutilization of behavioral health services. These factors, along with unmet needs, can result in a decreased quality of life, increased utilization of health care services and costs, higher mortality rates, and unnecessary institutionalization.

As a result of the 2012 Policy Academy Regional Meeting (PARM), the Connecticut team reconvened the Older Adult Behavioral Health Workgroup with the mission of improving access and delivery of behavioral health services to older adults, defined as age 55 and older, in their state. Through a partnership with the Department of Mental Health and Addiction Services (DMHAS) and the state Department of Aging, they used ADRC funding from the Options Counseling Grant to develop a yearlong asset mapping project that began in the summer of 2014.

The goals of the project were to review and map community assets that benefit older adults with behavioral health needs, review the resources, barriers, and gaps that impact

implementation of programs and services, identify potential areas where coordination and collaboration could benefit older adults with behavioral health needs, and make recommendations for future action steps.

Ten focus groups, two per DMHAS region, were convened from July through September 2014 with 63 participants who were providers, referral specialists, or both. Ten key informant interviews were planned to supplement the focus groups; however, 17 were conducted with psychiatrists, psychologists, licensed social workers, other clinicians, advanced practice registered nurses, and behavioral health directors throughout the state. Five community forums, one per region, took place April through May 2015 in community settings with approximately 27 participants. Librarians were particularly helpful since they interface with the SMI population who often spend a great deal of time using their computers and their facilities.

A statewide electronic survey was fielded mid-February to mid-May 2015, as the last phase of the project, with 858 respondents. Organizations initially contacted were through the Wheeler Connecticut Clearinghouse database, which was not up to date. The Research Electronic Data Capture (REDCap) tool, a secure web-based application housed at the University of Connecticut (UConn), was used for the survey.

The analysis utilized 1) descriptive statistical methods, 2) bivariate analyses to identify patterns, note trends, and draw conclusions, 3) basic descriptive statistics for the statewide data, and 4) the regional analysis was done by ZIP code. Further, a plethora of qualitative data from the focus groups, community forums, and key informant interviews were analyzed through the constant comparative method.

The UConn library's Map and Geographic Information Center, known as MAGIC, created an online dashboard based on the geographical identifiers by using ZIP codes and various categorical data to create maps and graphs depicting the number of respondents and types of services provided. Users can filter by addiction or mental health issues as well as co-occurring issues.

Community assets were grouped into traditional behavioral health services, education, screening tools, and ancillary services. Some communities were underserved with a shortage of geriatric behavioral health services, lack of services in certain regions, and inadequate transportation due to the many rural areas in Connecticut. Further, uneven quality of care was characterized by a reliance on inadequately trained primary care physicians and emergency room staff who feel very inadequate to treat people with behavioral health. However, UConn's emergency department has now expanded and includes an excellent psychiatric emergency unit. Care was also uneven because of the failure to use evidence-based practices and the inadequate recognition of substance abuse and misuse issues.

Resource challenges include integrating behavioral health, physical health, and aging services, developing an adequate workforce, lack of supported housing, and financial barriers. Potential areas of coordination and collaboration include the use of recognized care models, having

regular provider meetings, and the need for consistent formal networking with professionals in various fields.

Recommendations encompass:

- Develop education and awareness through cross-training opportunities for the current workforce
- Provide training on the needs of older adults while addressing the common myths of aging
- Encourage an extensive utilization of integrated models
- Implement co-location of primary care and behavioral health services in community mental health centers.
- Incentivize workforce development through scholarships or career ladders to increase interest in gerontology
- Strengthen community assets by linking existing clearinghouses and web-based databases through increased collaboration
- Promote and expand warmlines, (i.e., peer-to-peer help and support)
- Develop partnerships and improve the translation of research into practice through policy advocacy and additional research

University of Connecticut Report Overview: Older Adult Behavioral Health Asset Mapping Study, Part Two

Patricia Richardson, Department of Rehabilitation Services, State Unit on Aging; Erin Leavitt-Smith, MA, LPC, Director of Long-Term Services and Supports, Connecticut Department of Mental Health and Addictions Services, Department of Mental Health and Addiction Services (DMHAS)

To share the data from the asset mapping, the Older Adult Behavioral Health Work Group produced an infographic and executive summary for legislators and others to aid in discussions about the needs of older adults. A press event at the state capital allowed the workgroup to meet with legislators, the older adult behavioral health committee, and the two commissioners of the state agencies. Afterward, a strategic plan was developed based on the recommendations and priorities.

The Senior Outreach Engagement Program was combined with a gatekeeper program that lost state funding a couple of years ago. Taking the best of both programs, the Senior Outreach Engagement is now in each of the five DMHAS regions, and any older adult with any substance use or mental health issue can be referred to this program. Case managers go into the community and match people with needed treatment options. Length of treatment is flexible. A nursing home diversion and transition program provides nurses in each region through a statewide collaborative process. Lastly, an older adult conference to be held in March 2019 will help strengthen regional teams. The subcommittee developed a curriculum that could be used to cross-train individuals working in Medicaid waivers, as well as providers working on health

agencies. Further, person-centered counseling curriculum is available on the "No Wrong Door" website, My Place CT.

PANEL 1: Service and Treatment: Access and Service Coordination and Family Caregivers

Facilitator: Kathleen Cameron, Senior Director, Center for Healthy Aging from the National Council on Aging.

ERICKA OKONSKY, "NO WRONG DOOR" EXPANSION SPECIALIST AND SPECIAL PROJECTS COORDINATOR

Virginia's strengths and challenges with the "No Wrong Door" program are many. From the beginning, the effort was a public/private initiative with the Department of Aging and Rehabilitative Services and Virginia Navigator. A statewide nonprofit, Virginia Navigator has a resource database of more than 26,000 public and private resources for those seeking services and supports utilized in conjunction with "No Wrong Door" technologies. One challenge, however, is that the 25 Area Agencies on Aging across Virginia already have a workflow they are committed to using, while the "No Wrong Door" introduces a more collaborative framework. Before launching a massive marketing campaign in 2017, they dealt with the challenges of finding and perfecting the right technology. Once perfected, they educated the public to look for a "No Wrong Door" seal.

Through a narrower collaboration with the Department of Behavioral Health and Rehabilitative Services, "No Wrong Door" workers field calls and use the "No Wrong Door" technology to make referrals and capture the information on clients through the CRIA model - communication, referral, information, and assistance. Other modules include care coordination, transportation, among others. One key data element addresses their desired living setting and connects them to services and supports in the state.

A statewide "No Wrong Door" advisory council includes Secretary of Health and Human services, DBHDS, DMHAS, the Virginia Hospital and Healthcare Association, the Virginia Housing Authority, the Department of Aging and Rehabilitative Services, and Virginia Navigator. Local advisory councils, often led by the area agency on aging, engage partners and encourage the existing relationships to identify effective practices and areas that need attention, which the "No Wrong Door" team can help them address. Though there is federal and state funding, private partners can pay to participate, which spreads the burden of sustainability.

With a successful statewide standard for person-centered options counseling, 155 professionals completed the certification in 2017. "No Wrong Door" has also worked with a statewide hospital system as well as local universities on research projects. Some topics include intervention and prevention measures with social determinants of health and early intervention around social isolation, which may be as simple as helping them identify an emergency contact. They also work with accountable health communities and with the Department of Behavioral Health to strengthen the database.

Currently out of 26,000 resources in Virginia, about 2,000 are related to mental health services, with a smaller portion of that related to substance abuse. Challenges include marketing the "No

Wrong Door" program to help people understand what it offers; however, calls from organizations wanting to partner are ever increasing. Other states are also inquiring about the program. Another challenge has been having a single intake form, process or platform where multiple health and human resources agencies can provide some of their information on a client, specifically around payers in the Medicaid and Medicare. Translating policy to practice has also been daunting, especially with technology.

NIRMALA DHAR, M.S.W., LCSW, OLDER ADULT BEHAVIORAL HEALTH COORDINATOR HEALTH SYSTEMS DIVISION, OREGON HEALTH AUTHORITY

In 2014, Oregon received $10 million through the work of senior advocates to create an older adult behavioral health initiative in Oregon. Part of the money was given to Portland State University Institute of Aging to do a needs assessment, which found fragmented systems with different funding priorities, eligibility requirements, knowledge base, and none with a focus on the older adult population. Oregon then hired a statewide project director, along with 24 older adult behavioral health specialists, most with master's degrees. Specialists have three core job functions: 1) facilitating coordination and collaboration among multiple systems, 2) complex case consultation and promotion of evidence-based best practices, and 3) workforce development through the offering of a variety of training to build core competencies in geriatric behavioral health and community awareness and education.

The Oregon Health Authority has allowed a contract for program evaluation with Portland State University Institute of Aging, which is in its third year of the initiative evaluation process. The evaluation data comes from quarterly reports submitted directly to PSU from the specialists through Qualtrics, an electronic platform, about complex case consultations, trends, post-training evaluation, impact evaluations, and stakeholder surveys. Using the LOGIC model, they assess gaps in services, strategies, and actions to mitigate those gaps, system and consumer outcomes. The five-year goal for consumer outcomes includes:

- Recognize older adults as a priority population
- Have timely access to services that have demonstrated effectiveness
- Have their signs and symptoms recognized as behavioral health needs
- Receive help from knowledgeable and skilled providers of all types
- Seek help to understand signs and symptoms
- Have information and tools to promote mental health wellbeing
- Experience reduced lengths of stays whether in institutions, hospitals or EDs
- Rarely experience evictions
- Experience successful resolution of issues through complex case consultation

Data reveal that the gaps in services encompass the following: access, availability, affordability, acceptability, and coordination. Specifically the data revealed gaps in transportation, provider availability and providers accepting Medicare, lack of knowledgeable providers, providers without expertise in older adult behavioral health, lack of approved credentials, affordability and availability of housing, and restricted eligibility especially for those experiencing SMI and

cognitive decline, need for wraparound services, lack of service availability, especially in long-term care settings and in-home services, prevention and wellness, long waitlists and poor coordination, integration, and communication.

Recommendations include having a focus on consumer outcomes; greater access to services; more knowledgeable workforce; receive appropriate support; systems change to reduce siloes; meaningful changes in the way that services for people with complex needs are conceptualized, funded, and implemented, (i.e., person-centered care as opposed to eligibility-centered care); policy changes to promote interagency efforts, understanding of HIPAA and HIPAA processes, and also memorandums of remit; strengthen behavioral health infrastructure; and continue workforce development.

Sita Diehl, National Alliance on Mental Illness

The National Alliance for Mental Illness (NAMI) is a volunteer organization in over 1,000 communities across the country. Increasingly, the service system is inadequate for this population that hopes to age gracefully with support from friends and families. When the system and the treatment fail, it is the natural support system, if one is in place, that comes to the aid of the individual in crisis.

The National Alliance for Caregiving made up of over 50 organizations nationwide, conducted a study in partnership with Mental Health America (MHA) and NAMI, focused on caregiving across disease states and conditions. Quantitative online interviews held in 2015 with over 1,600 caregivers revealed that the most vulnerable group was mental health caregivers. Because it was not a scientific sampling, the findings of the study likely underestimate the challenges faced by caregivers since the participants were more educated and financially stable than the general population. The National Alliance estimates that 8.4 million Americans are caregivers of adults with mental illness with a duration of care lasting 8.7 years, which is over twice as long as for caregivers overall. Regarding the intensity of care, mental health caregivers devoted 32 hours per week on average to caregiving versus the 24 hours a week for caregivers overall. Half of the individuals in this study that required care were entirely or partially financially dependent, on their caregivers. However, only one-third of the parents had a succession plan for when they could no longer provide care, and only 35 percent of caregivers could rely on other family members to help.

Participants reported a decidedly negative impact of caregiving on their physical and mental health; 62 percent said that they were far less healthy because of their caregiver responsibilities and 50 percent stated there was no one to talk to about these issues, which led to high emotional stress.

Another challenge for caregivers was finding the right diagnosis, which took on average, 11.8 years and 40 percent still were not satisfied with the diagnosis. Fifty-five percent felt excluded by some or all providers, which is marked in the behavioral health system, causing needless heartache and compromised care. Further, 70 percent who had a loved one hospitalized felt that the discharged was premature.

The nationwide provider shortage, particularly in dealing with older adults with SMI, cannot be overstated and insurance barriers are significant. Arrest, homelessness, and stigma are part of the story as well. Lastly, the never-ending fear of the loved one causing self-harm or dying by suicide were extremely burdensome, hence entitling the report on the study*"On Pins and Needles*."

Study respondents consistently asked for a roadmap, which brought about the creation of a toolkit to educate caregivers on issues they will face, ways to provide self-care, and resources in the formal system. The issue of communicating with health professionals and being excluded from care systems is one such area addressed in the toolkit. Caregivers receive education on creating a communication plan in collaboration with the individual who is receiving care and taking the communication plan to the provider with the consent or engagement of the person in care. The plan is then developed to include logistical considerations, preserving dignity, and recordkeeping. Another example is planning for the time when the caregiver can no longer fulfill that role, which requires legal and financial expertise and can be very emotional for everyone involved.

Debbie Webster, Mental Health Program Manager, North Carolina Department of Health and Human Services, Division of MH/DD/SA Services, Community Mental Health Section

Historically, North Carolina has not focused on older adults. However, in 2014, the Institute of Medicine and the Department of Health and Human Services created a task force on mental health and substance use with Senator Angela Bryant and Representative Josh Dobson filling two of the chair positions. The purpose of the task force was to increase and promote community-based and evidence-informed prevention, treatment, and referral to services. Three subgroups were formed to address issues of mental health and substance use issues regardless of age. With 67 members from across the state, the task force represented an array of organizations and included legislators, state and local agency representatives, service providers, advocates, and most importantly, older adults and caregivers. The subgroup found that the state lacked a coordinated statewide approach to meeting the needs of the older population and that no state agency was tasked with ensuring the needs of this population were met. Of the many recommendations, establishing a statewide coordinating leadership, education and training, and increasing the capacity for primary care to screen, treat, and refer to behavioral health were highlighted.

A long-lasting relationship between the Division of Mental Health, the Division of Aging and Adult Services, and Division of Medical Assistance enabled the development and implementation of many initiatives, even though fragmentation still exists. For example, the Strategic Alliance for Elders in Long-term Care Committee strives to improve the safety for residents living in long-term care. The task force on Alzheimer's disease and related dementias created helpful recommendations, some of which received funding, and included a stakeholder group, which is the Dementia Alliance of North Carolina. Rethinking Guardianship is another initiative that identifies strategies to help adults regain decision-making authority.

Another significant collaboration is the development of a North Carolina mental health, substance use, and aging coalition compromised of a diverse membership that includes peers. Though there is no consistent funding associated with the coalition, the Reynolds Foundation provided some funding enabling the coalition to hold regional training on mental health and substance use, as well as two mental health and aging summits. Further, some members of the coalition are now members of the task force on mental health and substance use. Recommendations from the collaboration include: funding specific to older adults; promoting evidence-based practices like Healthy IDEAS, SBIRT (Screening, Brief Intervention, Referral to Treatment), IMPACT; and for the mental health block grant to have a carve-out requirement for serving older adults.

Discussion

Dr. Zubritsky broached the reality of the Olmstead Supreme Court decision, which is managed by the Department of Justice (DOJ), that states people must have the opportunity to live in the least restrictive environment possible. Currently, 26 states have consent decrees across a variety of populations and many states face repeated lawsuits. Efforts are focused on bringing people back into the community. Also, older adults need wraparound services, which are currently only available for children and youth.

Presenters were asked to comment on the use of home- and community-based service waivers. Ms. Leavitt-Smith explained that a lawsuit against the state of Connecticut for warehousing mental health clients in nursing homes resulted in a program diverting people from an institutional level of care. Working with their senior outreach and engagement people, they look at providing wraparound services and various waivers, (e.g., mental health waivers, elder waiver, PCA). Connecticut's Department of Mental Health and Department of Social Services has a mental health waiver specifically for adults 22 and older, with most of the people being 45 to 50 years old. The senior outreach position and regional teams are made possible through state funding with multi-year contracts.

Presenters also discussed the following housing waivers:

- Connecticut has a housing and living subsidy, complete with set-up and including furniture that encompasses the brain injury waiver while being administered through the mental health waiver and covers individuals at any age.
- The District of Columbia Medicaid program expanded its waiver to be able to provide services for individuals that had comorbidities. The difficulty, however, is a disconnect between the expansion of services to cover the population versus the services that are available. Further, Olmstead complicated matters because of the requirement for a consent decree.
- New York had an increase in supported housing availability through numerous state subsidies, but the needs of an aging population, such as being handicap accessible, must be considered in the design.

- North Carolina is under a DOJ settlement that older adults are benefiting from as long-term care, especially adult care homes/family care homes, are being used to house people with mental health issues. Those who are eligible receive startup funding to purchase needed housing items, skills training to maintain housing, Assertive Community Treatment (ACT) services, peer support, and supportive employment. Those with the highest risk, such as the homeless population, are prioritized for housing. However, having enough affordable housing and vouchers is a significant issue.
- The Oregon Health Authority has partnered with Aging Services for those individuals who are "aging service eligible" with SMI to provide housing and wraparound mental health services through a demonstration project. Oregon is also looking at other housing models such as co-housing and The Villages model from Boston. However, a more robust infrastructure is needed to help people live in the community.

The Money Follows the Person program (2010 to 2016) provided money to almost every state, many of which focused on older adult, mental health, and community-based services. Ohio, for instance, followed 12,000 older adults that were de-institutionalized for five years. Panelists were encouraged to contact the states listed on the website to discuss their phenomenal work.

Regarding housing, any homeless veteran qualifies for HUD-VASH services. Also, for veterans that have SMI or medical issues, homeless domiciliary is available for some months, before graduating to the HUD-VASH program.

The wording "social determinants of health" versus "wraparound services" was clarified. In behavioral health, wraparound services are the strategy to address the social determinants of health. A collaborative approach with the consumer that includes a comprehensive geriatric assessment and social determinants will focus on function rather than disease in older adult behavioral health or health in general.

PANEL #2: Presentation: Professional Training and Development: Training, Cultural Intelligence in Service Delivery and Treatment and Preparing Practitioners to Serve Special Populations: Older Adults with Co-Occurring disorders [SMI and Substance Use Disorder (Opioid Addiction) and Older Veterans]

Facilitator: Kim Williams, President and CEO, Mental Health Association of New York City; Co-founder, Geriatric Mental Health Alliance of New York

Workforce and workforce development is perhaps the greatest challenge in serving the older adult population. The National Academies of Science, formerly known as the Institute of Medicine report entitled, *In Whose Hands,* explicitly focused on the mental health and substance use workforce for older adults. The report noted there must be a focused, coordinated effort to address the needs of this population and recommended the creation of a federal entity to combine and coordinate efforts around addressing the workforce needs of this population.

Resident service coordinators working in subsidized housing have daily contact with the older adult population and need to be included in training events.

Robert Walker, External Consumer Engagement Liaison, Massachusetts Department of Mental Health (MADMH), Office of Recovery and Empowerment; Rachel Weiner, Director, Massachusetts Options Counseling Program, Massachusetts Executive Office of Elder Affairs

The Massachusetts "No Wrong Door" network has many participants, but the Options Counselors, the majority of whom do not have specialized mental health training, are the key to the "No Wrong Door" system. These counselors asked for training since they often felt frustrated and sometimes unsafe in situations with someone with an SMI. Through a grant in 2010 with Boston University, an options counseling mental health course was developed through a collaboration. The process strengthened the ADRC network at the state and local levels. The course focused more on behavior than diagnosis, included a section on self-care, and had a generalist approach, looking at the multiple factors contributing to a person's current situation, while highlighting the person's strengths.

Implemented through multiple funding streams, basic mental health training for housing and community-based staff and volunteers focused on social bullying, aging, and behavioral health certificate training for staff with direct client involvement, (i.e., case managers and first responders). They also funded the Home Health Care Aide Foundation through a PCORI grant to look at how to train home healthcare aides around behavioral health. A three-day workshop called *"Buried in Treasures,"* taught people how to facilitate structured hoarding groups, which is an underserved population. Another project is the certified older adult peer specialists, started by Dr. Cynthia Zubritsky, and a TTI grant, conducted through the state's home and community-based frail elder waiver.

Regarding options counseling, there are approximately 130 to 140 Options Counselors statewide. These counselors report that getting in the door is a significant challenge with people who have SMI or substance use disorder and who may be homeless. If they are able to meet with the individual, the counseling cycle looks a little bit different and may take longer than non-SMI consumers. Other challenges arise when individuals change their focus or their goals or have a great deal of ambivalence, which makes decision-making a challenge in this shared model where both parties play a role.

When informal supports are few, issues in securing housing, accessing resources, and coordinating with other service providers can be a challenge. Further, determining the cause of the person's behavior is difficult, since the Options Counselor may not have much information about the individual. For example, with a person who has a dual diagnosis or substance use disorder and depression, or bipolor disorder, in addition to medical conditions, it may be difficult to know if the person's lack of responsiveness/lethargy, is due to depression, substance use, or to another illness.

A two-day motivational interviewing course for Options Counselors helps them understand their role and effective techniques to encourage people to move forward. Options counselors can also draw on past successes and share their wisdom to show how the process has helped people in similar situations. It is also imperative that connections with provider agencies improve since a very comprehensive approach is required to support people.

Adjusting the expectations and definition of success would also be helpful to avoid some of the frustration and burnout option counselors may experience. Counselors are encouraged to embrace the person-centered approach by employing the three promises of the person centered model: listening; taking action on what is heard by following up with some quick, immediate step; and , practicing honesty. This includes honesty about about the limits of the options counseling role. Through the ACL grant, a person-centered training model was offered online and in-person.

Regional options counseling meetings also provide support to those in the field and mental health is often a focus. One popular training called *Safety, Hope and Healing* by Charity Bell from the Department of Mental Health, teaches self-care and self-awareness. Also, each region has mandated ADRC meetings with the counselors and the behavioral health partners to help build those relationships. Massachusetts supports discounted training through a portal available through Boston University CADER that offers a person-centered counseling certificate program as well.

Dr. Robert Cosby, Associate Professor, Howard University; Director, Howard University Multidisciplinary Gerontology Center; Dr. Janice Berry, Associate Professor, Howard University School of Social Work.

Older adults experience social isolation, depression, cognitive impairment, and “chronic mental illness," which includes poor functional outcomes and lower quality of life. For instance, impoverished people are forced to look for alternate housing while veterans are pushed out of their jobs, in some cases because of comorbidities related to self-medication. Issues associated with palliative care and the legal use of prescription opioids for pain management has led to people resorting to buying street drugs, such as heroin. Therefore, psychosocial interventions that are person-centered are critical to address these problems.

Interventions should optimize social integration, challenge the high cost of service utilization, and integrate both behavioral and physical health. However, finding community-based supports through wraparound services and psychosocial interventions continue to be problematic. Further, providing interventions that are cost-effective and that meet the need of communities and individuals is quite tricky, regardless of the ethnicity of the community.

Without the perspective of cultural awareness and cultural sensitivities, older adults with SMI will continue to struggle and have significant problems with quality of life and functioning. Notably, impaired psychosocial functioning is associated with higher cost due to premature institutionalization, high recidivism, increases in hospitalizations, and poor health outcomes. However, integration of primary care and behavioral health is imperative, especially for seniors with SMI.

The traditional color-blind approach to treatment is a severe disservice to a multicultural population. Cultural sensitivity and knowledge are needed for effective psychopharmacological interventions. Ethnic differences affect absorption, metabolism, and excretion. Practitioners need to understand pharmacodynamics from a cultural perspective because of the physiological, behavioral, and psychological perspective, as well as the social effects of the psychotropic medication.

Treatment issues also abound. A lack of cultural awareness and sensitivity can cause neuro-cognitive deficits and exacerbate age-related changes in the individual that presents with SMI. Prescribing practitioners need a clear understanding of the pharmacokinetics and the psycho-pharmaco-dynamics of the medication to avoid exacerbating their mental illness. Further, if the clinicians are not collaborating with the pharmacologist or the primary care doctor, issues can manifest as a result of the lack of communication.

The framework of cultural intelligence focuses not on what clinicians see, but rather what the client reports. For example, one Eritrean woman who presented inpatient was to be injected with a psychotropic medication to calm her down, when the real problem was she could not return to her country to be with her dying father during his transition process because of political concerns. She did not need a prescription; she needed permission to wail and grieve, which was part of her cultural practice.

Rather than chasing elusive cultural competency, cultural intelligence implies the understanding of complex cross-cultural relationships. Without the lens of cultural intelligence, cultural awareness, and cultural sensitivity, significant problems in rendering services to diverse population will continue.

Recommendations focus on policy changes:

- Link payment to service delivery
- Design treatment programs that work with culturally diverse clients
- Consider cultural systems of care and quality of life for those that are struggling with mental illness
- Educate individuals, families, and communities about mental illness
- Enhance best practices of psychosocial interventions, to expand capacity for home and community-based living.
- Cultural intelligence is necessary for the improvement of health outcomes in a diverse population.
- Advocate and demonstrate why a cultural intelligence lens is vital to address the need for appropriate culturally informed care in all aspects of long-term care.

Dr. Timothy Smith, National Director of Inpatient and Outpatient Recovery Services at the Veterans Administration (VA)

The President's New Freedom Commission found, among other issues, that mental health care across the nation is lacking and very fragmented. The VA incorporated a strategic plan into the

Uniform Mental Health Services Handbook published in 2008. The Handbook acts as a primary guide for the VA and requires all VA medical centers to provide a certain level of mental health care, all of which is to be recovery oriented. Part of the transformation involved turning day treatment centers into recovery centers that help veterans with SMI who are unable to work or go to school, to design their lives through an individualized and person-centered approach.

The concept of community institutionalization, a phrase coined by Joyce Bell in 2015, refers to meeting legitimate social needs in an institution with the goal of helping people become integrated into the community and to participate in the community, (i.e., someone going to a VA day treatment center and getting their needs met through socialization). This paradigm is supported by Thomas Joiner, a professor with honors at Florida State University and an expert in suicide prevention. In his 2017 article, Interpersonal Theory of Suicide, he states that people spiral away from suicide when they have meaning and purpose combined with community integration and community inclusion. The panel was encouraged to refer veterans with SMI and a GAF of 50 or less to one of the 108 Psychosocial Rehabilitation and Recovery Centers (PR RCs) across the nation. They were also urged to transform any maintenance-style day treatment centers, (i.e., community institutionalization), into programs that bring about true community integration.

Kathy Cameron, Senior Director, National Council on Aging (NCOA), the Center for Healthy Aging

The National Council on Aging (NCOA) is committed to creating a just and caring society in which each person lives with dignity, purpose, and security, which is the key to healthy and successful aging. To that end, NCOA houses the National Institute for Senior Centers and the Center for Benefits Access, which helps older adults get access to a broad range of services and benefits. The Center for Healthy Aging, funded by the ACL, directs two resource centers; one focusing on chronic disease self-management and education programs and one focusing on preventing falls among older adults, which is often due to medications that they are taking and is the leading cause of injury and injury-related deaths for this population.

Over ten years ago, NCOA was involved in developing the Get Connected toolkit, an excellent resource for community-based organizations to educate older adults about mental health and substance use. This free online kit can be used in any community-based organization such as a senior center.

The most common mental health conditions in a specialty geriatric outpatient clinic are depression, and dementia, benzodiazepine dependence (11 percent), and alcohol dependence (9 percent). Notably, benzodiazephine is used to treat anxiety and sleep disorders, which are also common mental health conditions among the senior population.

In the VA population, 7.5 percent of those with a psychiatric condition also have a substance abuse disorder; however, this declines with age in that particular population. In the inpatient psychiatric setting, there are much higher rates of dual diagnosis: 40 percent have co-occurring disorders with alcohol being the most common substance used, but 30 percent use alcohol with

other substances, rates that will continue to increase because of the opioid epidemic, and 71 percent of those have depression.

The impact of mental health issues on older adults is more severe for those with a dual diagnosis and include poor health outcomes, complications of their mental health, and complications related to the chronic conditions that they are suffering from, higher health care utilization, and costs. There are higher rates of suicide ideation, higher rates of poverty, marginalization, stigma, fractured relationships, particularly for those with dual diagnosis and long-term mental health issues and substance use issues. Notably, the risk of suicide can be six times higher for those with dual diagnosis.

There are higher rates of prescription misuse among the older adult population as well, particularly among women and those with depression. Data from 2017 on opioid use among the senior population with Medicare part D, show increasingly higher rates of opioid use. Thirty percent of older adults experience chronic pain and may self-treat other issues like depression. Further, opioid-related harm among the senior population includes deaths, emergency department visits, and suicides.

An integrated approach to health is needed. Mental health and substance use issues often get overlooked by practitioners. They are not screening and assessing for depression, anxiety or substance use, and may attribute symptoms to something else that is going on in the life of the older adult.

One focus area for the National Council on Aging is the implementation and sustainability of evidence-based programs such as SBIRT, chronic disease self-management, education programs for community-based organizations and others about non-pharmacologic approaches to pain. Healthy IDEAS and PEARLS - Program to Encourage Active, Rewarding Lives - are also two excellent depression management approaches for older adults living in the community. However, with only $25 million in funding from the Older Americans Act to serve the entire nation, resources are limited. Lastly, Senior Reach is a gatekeeper approach to find socially isolated people that trains people in the community to identify red flags for people at high risk for mental health issues and substance abuse.

DISCUSSION: CULTURAL DIVERSITY IN MENTAL HEALTH CARE FOR OLDER ADULTS

Before looking externally, the MADMH had to look inward and address the lack of race equity and inclusion by focusing on school outreach to train people of color to create a pipeline of candidates beginning with internships and strive to employ and promote a diverse workforce. Howard University is doing likewise while also addressing the lack of integrated care systems.

SAMHSA funds the Behavioral Health Workforce Development Training allowing students in medically underserved areas to be trained in integrated primary and behavioral healthcare, cultural intelligence, and cultural sensitivity. The Health Occupation Students of America for high schoolers interested in the mental health professions, focused on behavioral health in

2017. Though not all pursue higher education, students are more likely to go on to college if they are engaged at the high school level.

Oregon has an Office of Equity and Inclusion that uses cultural brokers and community health workers in their person-centered primary care homes spanning 36 counties. Further, Oregon Health Authority has used data analytics to isolate and analyze race and ethnic outcomes statewide to improve outcomes by developing metrics to incentivize screening.

Trauma-informed care is also an essential element of cultural diversity or cultural intelligence. North Carolina has included trauma-informed staff training as a requirement in many of their contracts, which includes working with and knowing how to address the needs of the LGBTQ community.

The ownership for providing services to people with SMI as they age is also an issue. One strategy is embedding Mental Health Specialists in various settings. This allows for services while educating everyone else at the agency, which could help overcome feelings of inadequacy in serving people with complex needs. For example, Indiana requires a designated Older Adult Specialist in each mental health clinic. Oregon has an initiative that requires specialists to be on-site for at least two days in offices that provide aging services. Massachusetts has a similar model. Agencies report that without the benefit of consultation, staff would not know how to refer, and many individuals would not qualify for DMH services. Some of the positions are possible through private funding as well as gap funding available to the agency while Oregon is state funded. Panelists recommend government funding streams to embed specialists as consultants since doing so is cost-effective.

Panelists were also asked to elaborate on self-management and self-care. The Chronic Disease Self-Management Education Programs, a suite of programs developed at Stanford University, has been shown to improve some mental health symptoms and are supported by the NCOA and others. Sustainable funding streams are also being explored for Healthy IDEAS, PEARLS, and SBIRT.

Massachusetts has promising pilot programs such as PeerTECH, which is an iPhone-based project that couples an iPhone with an older adult in their home with a peer specialist who also has an iPhone or iPad, essentially doubling the contact time. They are also looking to expand tele-behavioral health in the next fiscal year, which is critical in light of the overall shortage of geriatric psychiatrists, and the urban location of providers when most of Massachusetts is rural.

Oregon is using the Project ECHO methodology with 20 nursing homes in their first cohort. Project ECHO - Extended Community Health Outcomes -comes out of the University of New Mexico and is designed to build capacity through telementoring and case-based learning. A complex case is presented to the entire cohort and then discussed by the expert panel through a 15-minute educational presentation complete with written recommendations at the end of the session.

What is the training and education needs of ADRC staff and community mental health center staff to best meet the needs of older adults?

The challenges of working with specialized populations demand additional training. To meet the challenge, the ADRC in Brown County, Wisconsin, began building subject matter expert teams into the staffing to allow for concentrated training. These experts then train the rest of the staff and act a resource to them. However, lack of reinforcement on the skills learned is a barrier to transformation. Regular follow-up after training could include case studies or check-ins with trainees.

Another recommendation would be to develop core geriatric behavioral health competencies for behavioral health or human service professionals. Though the National Coalition on Mental Health and Aging has basic foundational competencies, they are not used nor integrated across professions. However, North Carolina's Geriatric Adult Mental Health Specialty Teams have reached out to the ADRCs and provided training, becoming a valuable resource to other agencies. Conversely, New York has taken a generalist approach with cross-training for other systems to learn about what is available in New York state. They are also embedding the person-centered thinking for their "No Wrong Door" certification.

Panelists agreed it is impossible to train every person in every aspect of behavioral health and the biological changes in aging so knowing how to access needed information is critical. On a local level, New York Connects addresses that issue by operating a 24/7 crisis suicide prevention line and providing training on handling callers who might have mental health issues. Further, helping Options Counselors to identify those in need even when the individual does not identify as having a mental health or substance abuse issue is an important training component. However, it takes a team of supervisors to create an organizational cultural that values communication.

The District of Columbia requires all direct care providers and frontline staff at the ADRC to participate in person-centered training and have incorporated the skills as part of their performance plans and evaluations.

PANEL #3 PRESENTATION: GOVERNANCE AND FUNDING: (1) GOVERNANCE AND BOARDS; (2) FINANCIAL CHALLENGES AND BARRIERS FOR BEHAVIORAL HEALTH SERVICES, AND (3) FINANCING ADRCS

FACILITATOR: MAURINE STRICKLAND, OFFICE FOR RESOURCE CENTER DEVELOPMENT, WISCONSIN DEPARTMENT OF HEALTH

RON MANDERSCHEID, MD, EXECUTIVE DIRECTOR, THE NATIONAL ASSOCIATION OF COUNTY BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITY DIRECTORS AND THE NATIONAL ASSOCIATION FOR RURAL MENTAL HEALTH

For the last 60 years, the field has focused solely on the deficits of people with SMI but is now beginning to focus on strengths, which is a critical transition for moving toward self-

management and self-direction, even among people who are seniors. Statistics show that 100 million people will be 65 and over by 2060. Further, common epidemiology points to 20 million older adults having behavioral health conditions, and 5 million meeting the criteria for SMI. According to data from 2000, however, many of these people will have a shortened life span of 25 years. Replicated studies since then have not found an improvement; in fact, Texas found the lifespan was shortened by 29 years.

Another issue is the burnout of psychosis. Multiple studies found that when people with schizophrenia or a major bipolar disorder reach the age of 55 or 60, the disease burns out but numerous social deficits accumulated while they had the disease remain and must addressed.

Recommendations include 1) improve the epidemiology on this population, which has not had a national survey since 2004 and 2) create an office for seniors that is then housed within a department of HHS, such as the Office of the Assistant Secretary for Planning and Evaluation, where these activities become coordinated.

Panelists were urged to look into the 1915(i) waivers in their respective states. About 75 percent of the money spent through Medicaid on home and community-based services goes to the intellectual developmental disabilities (IDD) population while only about 20 percent goes to the older adult population. Further, the 1115 demonstration waiver can help build systems of care for the senior population similar to systems built for the substance use disorder population.

Because SAMHSA does not have a center focused on seniors, a grant or contract that allows for information sharing is needed and advocating for such funds could make it a reality. A set-aside of 5 percent in all SAMHSA resources that focuses on seniors in each program would be a great start.

Information technology is going to be very important for this population since approximately 42 million Americans live by themselves, which puts them at very high risk of becoming socially isolated, especially for adults with SMI. For example, social media is adaptable for building virtual systems of care, as demonstrated through a project created by University of Southern California students that linked social media to primary care programs.

There is currently a national initiative to create a toolbox on self-determination for the IDD population, which could be adapted for the older adult population to share information on pertinent topics such as policy and waivers. For example, SAMHSA could survey the states on the 1915(i) and 1115 waivers to see whether they apply to this population, and then include that information in the toolbox for others to adapt.

Today's programs are not sustainable for an ever-increasing aging population. In the future, the concept of health insurance must change entirely and focus on keeping people well rather than the current system that spends 96 cents out of every dollar treating them when they become level 4.

Lastly, people need both mental health care and substance use care. At a minimum, programs should be screening for mental health, opioid, and substance use issues, which is not a stretch when screening for depression is part of the Affordable Care Act and CMS has added SBIRT for substance use.

Laurie Pferr, MPA, Deputy Director Policy, Planning, Program and Outcomes, NYS Office for the Aging

When New York State embarked on their ADRC project, they closely followed Wisconsin's work as a model and incorporated two basic tenets of the "No Wrong Door" program that helps the ADRC staff to make connections and cut across various systems: 1) Give people choice to the greatest degree possible, and 2) Have a program that is person-centered.

The New York State Office for Aging along with the New York State Department of Health Medicaid Director and the Governor's Office, discussed the need for governance and involvement leading to the establishment of New York Connects, located in 54 of 62 counties. After the recession, funding was reduced to $3.3 million, which covered basic information assistance, options counseling, and long-term care councils.

Long-term care councils are involved with local government and comprised of providers, advocacy groups, health systems, aging services, Independent Living Centers, and consumers. Their purpose is to identify and bridge service gaps within their community and county, (e.g., transportation or mental health services). With the implementation of the Balancing Incentive Program (BIP), New York Connects became a full system through a collaborative effort with multiple departments and agencies.

Governance emanated from the top with the charge to expand New York Connects into a statewide program with added functionality to include individuals of all ages and varying needs. In 2015, New York Connects was in 58 Area Agencies on Aging and in 2017 all contracts, which included a set of standards, were amended based on the populations. They were also required to develop a Level 1 screen as part of BIP, called the "No Wrong Door" screen, which now includes the age, the GAF-7, and the PHQ-9 as part of the conversation with the individual instead of using it as merely an assessment tool. They also added a 1-800 number at the state level that routes to all the local New York Connects offices. If the person cannot understand the voice prompts, the call goes to the New York State Office for Aging to help connect the person to services or provide translation services if needed.

The Independent Living Centers were brought into the NWD/ADRC work through a contract in 2017. Fulfilling a local level requirement, Area Agencies on Aging, local social service districts, and the Independent Living Centers work together while New York Connects is the hub for New York State's "No Wrong Door" program. If a person cannot use the telephone and is homebound or it becomes apparent that their needs are significant, a staffer goes to their home and works with them. A collaborative mental health team, including local mental health commissioners, engaged through local implementation teams, work to figure out cross-referrals, cross-training at the local level, and availability and access to local resources and

systems. Information technology, also a collaborative effort, required an RFP to create one statewide system for the 58 Area Agencies on Aging that each had separate IT systems.

Ann Marie T. Sullivan, M.D., Commissioner, New York State Office of Mental Health

The design of financial systems is not easy to navigate and result in fragmented outcomes. Further, waivers offer some degree of coordinating services and panelists were urged to pay attention to them and seek them out. However, waivers are very intricate and challenging to manage from the state perspective, and care coordination sometimes is difficult to implement. Remembering to keep the design simple and flexible is important for implementation.

Financing affects every service. For instance, when New York began moving people out of adult homes, 700 to date, due to Olmstead problems, there were significant challenges because of how health homes are financed and the way managed long-term care plans provide services. Similarly, 500 older adults who had been institutionalized for five years or more were moved with step-down services and flexible wraparound services. Staff stayed with them until it was no longer necessary and continued to check on them once they were successfully moved into the community. The population only had a 5 percent return, and 2 percent of those moved back into the community.

Recommendations for braided funding include SAMHSA identifying key evidence-based services for this population and incentivizing people to include and pay for them in the delivery system similar to the block grant set-asides in the first episode psychosis initiative. Additionally, there must be parity in payment since behavioral health is an underpaid system by every insurer. Not only should cognitive services be paid for, but the time it takes to address and support an individual's needs should be considered as well. The dramatic gap in payment is a significant element in workforce shortages. Technology is another area that is lagging, which is unfortunate since every other field is racing ahead with the latest innovations.

There must be advocacy to change the tide on coverage for the SMI population, which accounts for a large percentage of the aging population. Though they need them, specialized services may be denied since benefit plans vary. Further, as people age out of Medicaid and transition into Medicare, it becomes increasingly difficult to get approval for services. For example, if a walker is needed to help someone leave the house, it is covered. If it is a cognitive issue that prevents someone from leaving their home, it is difficult to get reimbursed for services that address the issue.

Stigma and discrimination are also barriers to services. For instance, even though cognitive therapy for depression is effective for people 80 years old and above, older adults are generally given pharmaceuticals instead. Notably, when New York subsidized cognitive therapies, the results were impressive. Fortunately, the collaborative care model is gaining traction in New York and is paid for by Medicare. Elmhurst Hospital's geriatric clinic found 5 percent of the patients had a positive screen for depression whereas the primary clinic had not identified one

person with depression. By implementing the PHQ-9 screening, the percentage of individuals identified with moderate to severe depression rose to 16 percent.

ACT, perhaps the most evidence-based treatment for SMI, is tremendously effective for individuals who cannot navigate the system and is mostly Medicaid funded. Unfortunately, an individual does not lose the need for ACT when they turn 65 and yet it is not paid for by Medicare.

New York has implemented many initiatives to educate people on SMI, such as Project ECHO, which is an incredibly effective geriatric collaborative. Though Project TEACH is currently used for kids and for women with maternal depression, they are considering it for geriatrics as well with hubs across the state.

A demonstration grant that the legislature funded in New York over 10 years ago was initially used to implement the collaborative care initiatives and had excellent results. Those grants are now being used to start partnerships enabling communities to work together to provide geriatric services. Technical assistance is also provided across the state to help people to learn how to handle geriatric billing for maximum reimbursement.

Devon T. Christianson, CSW, MS, CIRS-A, Director, Aging and Disability Resource Center of Brown County

Wisconsin has a population of over 5 million people across 72 counties as of 2017 and 46 ADRCs throughout the state; some are standalone, and some are regional, but even so, there is a brick and mortar physical location in almost every county. ADRCs are often integrated and have reasonably robust service reach throughout the state. There are approximately 1.3 million people age 60 and older. With the rural northern counties aging the fastest, by 2035, the areas with the least amount of services will have close to 30 percent of the older population. Because it is based on the percentage of people and not volume, attracting providers is tough.

Though severe issues of isolation abound due to geography and workforce shortages, Wisconsin ADRCs handle 500,000 contacts each year with information assistance and options counseling professionals at the helm. Of the 66 percent of older persons served, about 57 percent have co-occurring conditions.

Wisconsin's GPR is around $38 million, but its expansive reach has been achieved by the tremendous state commitment to ADRCs, and the focus of drawing on $30 million in federal funding. Allocations are based on the population, but there is an assumption that at least 38 percent of funding dollars must come from federal administrative claiming, which includes time reporting requirements of 15-minute increments.

Additional dollars are also invested in relocation programming. Wisconsin prioritized an entitlement program with specialized staff and funding to ensure that every person in a nursing home can return to the community. Dementia Care Specialists will be in 24 counties to

implement evidence-based programs around behavior interventions including an ECHO-type team.

Wisconsin's ADRC program is heavily county-based system, and therefore, counties contribute tremendously to the success of local programs. For instance, Brown County has the only nonprofit ADRC in the state and depends on 37 percent of its funding to come from the federal government, 38 percent to come from the state, and 11 percent from the county. They also receive cash donations and other innovative strategies. With these dollars, they prioritize the core services of options counseling and enrollment counseling. They also provide functional eligibility assessments for long-term care. The Older Americans Act programs, such as volunteer services, nutrition programs, volunteer programs, are next in line for funding.

Prevention is a critical component as well and should include socialization opportunities, exercise, and wellness programs, among others. However, the state funding contract includes it only if there are funds left over. ADRCs in Wisconsin are designed to provide the full range of services specifically to adults with mental illness and/or substance disorders when the individual is older, has an intellectual disability, or a physical disability; however, there is a disconnect at the state level and systems are siloed regarding care and treatment, the ADRC network, public health, and funding.

Despite myriad challenges, Brown County's ADRC has a culture of hospitality regarding mental health even though the community, which is myopic around crisis services, does not. Being outside the service delivery arena, these advocates are seen as trustworthy, conflict-free, and neutral advocates even for caregivers, something lacking in the mental health field. Focusing on mental wellness, they offer mindfulness classes, an evidence-based program helping older people have positive thinking.

A grant project enables them to link to a satellite counselor in the organization. Further, a partnership with the Medical College of Wisconsin and other foundation programs enable them to have residents-in-training offer free mental health counseling for older adults. The ADRC has the opportunity to make an extensive clinical discovery through a comprehensive psychosocial assessment and connect people to service. They also offer various groups and classes, including a class in harmonica that not only combats social isolation, but is an excellent therapy for COPD.

For sustainability, they opened a coffeehouse inside the ADRC, perfect for the "senior center" environment they have created. Employing people with disabilities, the coffeehouse caters to the public and employees are in the front of the house serving customers rather than being relegated to washing dishes. This real-world training has enabled 50 percent of them to progress to real jobs. The profit is reinvested into their nutrition programs.

Discussion

Regarding the initial financial investments, system infrastructure, and program capacity building, what do you anticipate are needed to support the implementation of a continuum of care for older adults with SMI, beginning with the front door?

The design of the financial system is important. Set-asides in the mental health block grant and substance abuse block grant of 5 percent would provide seed money to get started and address the subtle issues around payment. (Manderscheid)

The "No Wrong Door" program acts as "the front door," because anyone should be able to get assistance. However, that takes adequate funding, which has fluctuated over time. Currently, New York has committed about $27 million, and they are looking into Medicaid claiming. (Pferr)

Embedding payment on an ongoing basis for all services is critical. Another way, which is not as strong, is that hospital systems have some degree of community responsibilities, with community dollars going back out. Value-based initiatives and discussion on social determinants of health also provide an opportunity to engage systems. (Sullivan)

Do you find there is acceptance or reluctance for older adults to accept recommendations from ADRCs related to mental health referrals? Is there more acceptance or reluctance from families?

The role of families, friends, and peers is crucial in getting people to services, perhaps more so than the role of the professional. Behavioral healthcare is focused on diverting people with major mental illnesses and substance use illnesses from going to jail, so a similar model could be used in this space. (Manderscheid) The Crisis Intervention Team model is being used successfully in Connecticut with specific training on older adults with dementia. (Leavitt-Smith)

What type of contacts do ADRCs receive from older adults and families related to opioid use?

If a person is depressed, the probability triples that they will take opioids at some level while the probability of developing "secondary depression" doubles within 30 days for a person who takes opioids and does *not* have depression. That means to address opioids, depression, which is a significant problem amongst the elderly, must first be addressed. However, not one of the 306 opioid bills currently being considered creates the linkage between opioids and mental health care. (Manderscheid)

Further, opioid misuse leads to other types of street drugs involving older people. Also, their living situation may include a person with a substance use disorder and can often lead to financial exploitation, elder abuse, verbal abuse, emotional abuse, and physical abuse. (Pferr) Better integrated treatment plans that address psychopharm issues are critical in breaking the cycle. (Sullivan)

Mr. Joshua Hodges, MPA, gave closing remarks for this session. Mr. Hodges is the Acting Deputy Administrator for Center for Integrated Programs at ACL. He related that connecting people to resources is an ongoing ACL priority.

Report Out, Closing Remarks, and Questions and Answers – Following the day's discussions, a closing session was held for final comments, questions for panelists, and summarizing recommendations.

Recommendations Facilitator Recap

1. Understand and manage older adult behavioral health needs and use Connecticut's behavioral health asset mapping study and methodology as a model.
2. Systems are fragmented and historically have not needed to work together. They have different goals in mind. Like working in corrections whose goal is public safety and working in mental health whose goal is individual behavioral health wellness. There is a need to move towards a more integrated treatment system.
3. The workforce is underdeveloped and inadequate, especially since 5 percent of SMI is late onset.
    a. Provide training and methodologies for reimbursement to fund service delivery, because it's underfunded now.
    b. Develop specialists who are available across systems to address specific issues and, number three, use of peers and caregivers, development of peers and caregivers.
4. Build peer and family expertise.
5. Build mental health screening into various systems. Identify a single way to assess across systems, use the same instrument, and let us all understand what that instrument means, all the workers and family members.
6. Build technology and use more technology.
7. Improve epidemiology about population strength.
8. Move from a symptom/deficit system of describing individuals to a strengths-based system.
9. Develop a co-occurring treatment system for older adults.
10. Better expertise for prescribing practices for psychopharmocology.
11. The expansion of federal funding.
12. Review how things are funded under Medicare.
13. Pay attention to the waiver programs; review funding opportunities and understand them better.
14. Train peers in Illness Management and Recovery
15. Advocate and educate for cultural intelligence.
16. Support and fund evidence-based clinical interventions and community-based programs.