National Coalition on Mental Health and Aging
Meeting Minutes
June 30, 2010

Alixe McNeill, Chair of the National Coalition on Mental Health and Aging (NCMHA) and Vice President of the National Council on Aging (NCOA) called the meeting to order and reviewed the proposed agenda. There were 27 members present onsite and 10 via conference call. The meeting began with member introductions.

NCMHA Business

The minutes of the February meeting were adopted with two minor revisions. In addition, Kim Williams, the Director of the Geriatric Mental Health Alliance of New York, was named as the new State/Local Coalition Representative to the NCMHA Executive Committee by a unanimous vote.

Pre-Admission Screening and Resident Review (PASRR) and Olmstead Decision Connection

Bob Bernstein, Executive Director of the Bazelon Center for Mental Health Law updated the Coalition on PASRR when enacted in 1987. It required that anyone entering a nursing home be screened for mental illness/mental retardation. Individuals who met the criteria for these conditions proceed to an independent screening to determine if they need further assessment, treatment or support. Reviews conducted by the Office of Inspector General and studies conducted for the Substance Abuse and Mental Health Services Administration (SAMHSA) have uncovered serious issues with the implementation of PASRR. The Bazelon Center has voiced their concern that PASRR is often not properly implemented at the state-level and has been open to state interpretation. PASRR and the Americans with Disabilities Act (ADA) should be used as complementary tools to address the inappropriate placement of those with mental illness, particularly older adults in long-term care settings.

The Bazelon Center for Mental Health Law has outlined steps to address the problems with PASRR in a paper called "Avoiding Inappropriate Placement of Persons with Mental Illness in Nursing Homes." The paper proposes that PASRR legislation be examined and strengthened, so as to meet its original objective with respect to people who suffer from serious mental illness. Furthermore, the ADA and the Supreme Court's decision in the ***Olmstead vs. L.C.*** underscore the right for people with psychiatric disabilities to receive services in the community and not be institutionalized unnecessarily.

The paper proposes these amendments to Title XIX (Medicaid) to address these issues:

- Strengthen the legislative language regarding when someone with a mental illness can be admitted to a nursing home so as to limit admissions to those with a physical health need for nursing home services (i.e. demonstrate the need for round the clock nursing services) separate from their need for services for a serious mental illness.

- Ensure that Level II screens include a determination of whether the individual can be served in a community setting.
- Shift the responsibility for the pre-admission screen from the state mental health authority (which can have a vested interest in placing people in nursing homes) to the Medicaid agency (which does not).
- For individuals found by Medicaid agencies to need nursing home services, the state mental health authority would remain responsible for determining the person's need for specific specialized mental health services.
- Expand the definition of a person with mental illness (generally following language that currently appears in regulations) in order to clarify that the population of concern is individuals with serious mental illnesses.
- Define the term "specialized services" to mean those services that are relevant for individuals with serious mental illness who are residing in a nursing home and that are designed to address behavioral and functional problems related to the person's serious mental illness (over and above the mental health services a nursing home is required to provide to all residents). This definition does not include as a specialized service inpatient psychiatric hospital services. It is an attempt to correct the inconsistencies in the package of services for those with mental illness compared to older adults.
- Restore the requirement for an annual resident review that was originally part of legislation.
- Require the Centers for Medicare and Medicaid Services (CMS) to issue guidance to states on PASRR and to more aggressively monitor state's compliance with these requirements.
- Require CMS to report to Congress data collected on PASRR and results on monitoring by the agency.

Bob Bernstein asked the Coalition member organizations to review the proposed amendments and provide comments on this draft. Overall, they would like to "chip" away at the current default setting that nursing homes are the only way to deal with older adults with mental illness. A question was raised as to whether the new nursing home assessments will affect this initiative? Bob responded that this initiative is still in its infancy and that the nursing home assessment is further ahead. Bob noted that CMS is very interested in PASRR and is looking at Illinois in particular. Member Margaret Hastings from Illinois expressed interest in helping push for amending PASRR in Illinois. She commented that in Illinois, nursing homes are willing to take people who are difficult to manage, but might not have the services to do so. Bob informed the Coalition that along with the amendments the Bazelon Center has drafted, he has also spoken with Senator Tom Harkin about this issue and the possibility at having a Congressional hearing.

Willard Mays raised the point that States were required to implement PASRR in 1989. However, rules were not issued until 1992. Therefore States had to individually determine how to implement the law. This gap of time resulted in the inconsistency there is today. CMS is trying to help states with this issue. Dan Timmel of CMS is working with the CMS PASRR Technical Assistance Center to help address the problem.

In California, there is a 26 page, level-two assessment. Questions include such questions as: "Where do you want to live?" and "What are your community skills and what do you need help with?" Basically, if you need nursing home care, you have to prove it. Things are very different among the States (e.g. Illinois and California).

A question was raised as to who would do the required review proposed in the Bazelon paper. An independent body would do it when it changes from the purview of the State Mental Health Department to Medicaid. Bob asked Coalition members to contact him if they have any comments or questions (robertb@bazelon.org).

Patient Protection and Affordable Care Act (PPACA) Update

James Finley, National Association of Social Workers representative, updated the Coalition on PPACA. PPACA commits $940 billion over 10 years to expand health insurance coverage to nearly 32 million of the 54 million uninsured Americans. This would be offset by $438 billion in new taxes and more than $500 billion in spending reductions, largely in the Medicare program. Jim presented a Power Point presentation titled "PPACA and Medicare: Outlook for Behavioral Health Care."

Along with health care provisions, other key components of PPACA have made changes to Medicare provisions. Key components include:

- Improvements by gradually closing the Medicare prescription drug coverage gap ("doughnut hole"). Providing new annual wellness visits with personalized prevention plan, eliminating the cost sharing for prevention services, and boosting payments for primary care.
- PPACA Medicare provisions will also save money by reducing payments to Medicare Advantage plans, reducing payments for hospitals and other medical providers.
- There would also be delivery system reforms, new Medicare and Medicaid centers, a new CMS health care coordinating office dual eligibles, and numerous programs, pilots, and demonstrations to improve quality and efficiency.
- PPACA will also create an Independent Payment Advisory Board (IPAB) with 15 full-time members appointed by the President. IPAB will be responsible for generating a formula to produce required Medicare savings if spending exceeds targets. IPAB would submit the proposed formula Congress and HHS. The Secretary would implement the IPAB proposals unless Congress enacts an alternative with equivalent savings. IPAB proposals cannot ration care, reduce benefits, increase cost-sharing, modify benefits, eligibility, or premiums, raise taxes, or before 2020, reduce payments for certain providers.
- With the IPAB in place Medicare will construct experimental models of care as well as bundled payments.
- PPACA also incorporates Accountable Care Organizations (ACOs) which connect groups of providers responsible for improving health status, efficiency and experience of care for a defined patient population. Ideally, it would include patient-centered "medical health homes" that deliver primary care and would coordinate with other providers.
    - Emphasis is on effective clinical care integration and coordination mechanisms focused on enhanced outcomes.
    - Creates "Pay or – provider" contracted relationships, and payment models that facilitate and reward cost – effective high value care
    - Provides health information infrastructure necessary to enable integrated community-wide care coordination.
    - Requires vertically and horizontally integrated providers who serve the population from primary care through acute care through long-term and palliative care.
    - Provides comprehensive primary care by a team of interdisciplinary professionals to address chronically ill patient needs in Medical/health homes by focusing on high-risk or broader populations.

James Finley and Stephanie Reed, NCMHA Vice-Chair and American Association of Geriatric Psychiatry representative, then outlined the system challenges as well as the professional challenges that this new law may create. Questions from members followed.

- Would a practitioner contract with ACOs? Yes.
- How is this different from managed care? A major difference is how ACOs are paid.
- Who organizes ACOs? There will be demonstration projects to learn what is workable.

- Who will be selected for the IPAB? Provider groups are concerned about having adequate representation.

A huge issue for this group is what will be the role of specialty care and behavioral health professionals in medical/health homes and integrated health care teams. The relative lack of comparative effectiveness research for behavioral health services is an issue. The model is also very primary care focused, vs. specialty care focused.

Basically, ACOs can be our future employers. Hospitals *are* in the driver's seat in terms of ACOs. Stephanie noted there are few geriatric workforce provisions other than expanding eligibility of disciplines for Title VII in PPACA. The provisions that there are, lack funding. It was mentioned that the regulations have come out for Medicare wellness visits. The public comment period is open until late August.

System challenges related to PPACA include: improving care access and quality in a fiscally constrained environment; assuring care is affordable; the potential for inequitable care among Medicare, Medicaid, exchanges and employer plans; privacy issues with electronic health records; and, the potential for Medicare fee cuts directed by IPAB.

In closing Jim and Stephanie noted that the launch of these new initiatives is 6 months away. Providers are showing a great deal of interest in the ACO model.

Campaign for Better Care

Lynn Feinberg, Director of the Campaign for Better Care at the National Partnership for Women and Families gave a presentation on the Campaign. It is a broad – based coalition of consumer organizations representing the diverse constituencies with a direct stake in improving the health, economic security and quality of life for older adults with multiple health conditions and their families.

The goals of the Campaign for Better Care Consumer Coalition are two-fold:

- To fundamentally change the health care delivery system to improve care for older individuals with multiple health conditions who are at the highest risk of poor care and high costs – especially those whose medical conditions are complicated by physical or cognitive impairment or whose access to health care is already limited by their income, race, or ethnicity; and
- To build and mobilize a powerful nationwide grassroots movement to advocate for better care for vulnerable older adults with multiple health conditions, and to sustain that movement as a lasting consumer voice for social change.

The Campaign's policy agenda to improve the health care delivery system will be guided by a core set of principles. These principles are based on what older adults with multiple health conditions and their family caregivers most want and need from a patient- and family- centered delivery system. They are:

1. Care should be comprehensive, well coordinated, and anchored in primary care.
2. Care should be accessible and available to patients when they need it.
3. Care should encompass early intervention and active management of chronic illness.
4. Care should be individualized and based on an assessment of the needs, values, and preferences of the patient and, where appropriate, his/her family caregiver. It is delivered in a culturally and linguistically appropriate manner.

5. Older adults and their caregivers should be full partners in their care, and provided with the information and support to manage their conditions, and make informed health care decisions.
6. Effective communication, coordination, and trust should be fostered among providers, patients, and their family caregivers, including through the effective use of health information technology. Patient medical information is readily available at the point of care.
7. Continuity of care should be promoted and patient transitions – across settings – are smooth, safe, effective, and efficient.
8. Health care should be connected to and integrated with the community resources that older adults and their family caregivers need to maintain health and wellness, independence, functional status, quality of life, and well-being.
9. Patients' and family caregivers' experience of care should be routinely assessed and improved.
10. Care should be delivered in accordance with best practices and evidence. Providers continuously assess and improve the quality of their care, and seek to eliminate health care disparities.
11. Patients and their families should have access to quality and cost information that enables them to make informed decisions about providers and services.
12. Care should be team-based and delivered by a multidisciplinary health care workforce that is well trained and competent in geriatrics and chronic care.

Lynn Feinberg closed her presentation by voicing the urgent need for better health care in the United States, specifically in regards to older adults with multiple chronic conditions, their families, and those who care for them. Members of the coalition can join the Campaign for Better Care by signing up via e-mail at www.CampaignforBetterCare.org.

Medicaid 1915(i) State Plan Home and Community Based Services Benefit

This agenda item will be rescheduled.

Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Initiatives Update

Marian Scheinholtz, Public Health Advisor at SAMHSA, updated the Coalition on SAMHSA's Ten Strategic Initiatives. The major issue discussed was that behavioral health is, and should be recognized as an essential part of a person's general health. There are no specific age groups mentioned in the strategic initiatives as they are across the "entire" lifespan. It is important for advocates of all age groups to bring their message forward. The #8 Initiative addresses one of NCMHA's issues: "provide a coordinated approach to address workforce development issues affecting the behavioral health and general health service delivery community to promote the integration of services and the training and use of behavioral health screening, brief intervention and referral for treatment in primary care settings." Updates on the initiatives can be found on www.samhsa.gov.

CMHS Older Adult Mental Health Services Model Project and Sustainability Project

Marion Scheinholtz introduced two small new older adult mental health projects that CMHS/ SAMHSA is supporting. National Association of State Mental Health Program Directors (NASMHPD) is leading the first project which is preparing materials to help states plan and develop mental health services for older adults. The second project, led by the National Council on Aging (NCOA), is studying the sustainability and financing of older adult mental health services after initial grant funding ends. Both of the projects are on the fast track and will be completed in the next few months.

ASA 2011 Aging in America Conference

Willard Mays, National Association of State Mental Health Program Directors and American Society on Aging representative, informed the Coalition that the *Aging in America Conference* will be April 26-30, 2011 in San Francisco. NCMHA is proposing a full day three-session program. Lessons learned from the SAMHSA/CMHS Targeted Capacity Expansion grants will be explored by experts and grantees. The Model Plan and Sustainability projects noted above will be presented. In addition, a Coalition update and policy-oriented session is being planned. Anita Rosen noted that the policy session will cover a number of topics. She asked national and state Coalitions to contribute ideas based organizational experience with legislative initiatives and health care reform. The session will also attend to the NCMHA 2010 priorities.

Member Updates

Organizations present offered the following information. State Coalitions did not have the opportunity to report as the call ended prematurely.

The Spring issue of "Generations" focuses on "Healthy Aging". One article focuses on older adults and mental health including new work in Missouri.

AARP – Leigh Purvis reported there the organization recently released material on substance abuse in older adults.

Administration on Aging – Shannon Skowronski reported that AoA is accepting recommendations for updates to the Older Americans Act which will be reauthorized in 2011. AoA is supporting the implementation of a number of evidence-based prevention programs including Healthy IDEAS and PEARLS, two community depression care programs.

Human Resources and Services Administration (HRSA) – Dan Mereck reported that there will be 28 new geriatric education centers grant awards staring July, 2010. HRSA expects to make additional grant awards by August 1, 2010.

National Association of Social Workers (NASW) – Chris Herman reported that they are developing *Standards for Social Work Practice with Family Caregivers of Older Adults*. The public comment period on the draft closes on August 8th.

National Association of State Mental Health Program Directors (NASMHPD) – The Indiana Mental Health and Aging Coalition and other partners are hosting a one-day conference on Mental Health and Aging: Overcoming Barriers and Seizing Opportunities on Friday, September 17, 2010 in Indiana. Topics include: healthcare reform (mental health and aging), adult suicide, the system intersection of mental health and aging, transition to retirement, and coalition building. CEU credit will be available for social workers, marriage and family therapists, and mental health counselors.

Center on Global Aging (COGA) at The National Catholic School of Social Service (NCSS)– Richard Millstein reported on their second Global Health Memorial lecture on Research. Three faculty members have received grants for research on Spirituality in Older Caregivers.

National Institute of Mental Health (NIMH) – George Niederehe reported that contrary to the New York Times indication of very limited NIH funding at this time, NIMH is funding grants, however, there are fiscal constraints.

Psychologists in Long Term Care – Paula Hartman –Stein reported that the Ohio Department on Aging received AoA funding for Chronic Disease Self-Management Program and for Healthy IDEAS. The state is working with the programs to make training available around the state.

Next Meeting Date

The meeting was adjourned at 12:30 p.m. The next meeting will be held on October 25, 2010 from 10am – 12:30pm at the American Psychological Association in its 6th Floor Board Room.