



National Coalition on Mental Health and Aging

Draft Meeting Minutes

June 26, 2017

Welcome and Update

Kimberly Williams, NCMHA Chair and the Geriatric Mental Health Alliance of New York representative, called the meeting to order and welcomed the 17 members present onsite and the 15 members who joined via conference call. The minutes from the March 10, 2017 meeting were reviewed and approved.

Kim raised an issue that had been discussed at the March meeting. At that meeting, NCMHA was asked to write a letter to the Centers for Medicare and Medicaid Services in support of reimbursement for Certified Older Adult Peer Specialists. A recommendation was made for NCMHA to submit such a letter. However, a number of concerns were subsequently raised. After Executive Board discussion, it was decided that NCMHA will not submit the letter as it is inconsistent with its mission and past procedures. Our mission, as noted in the bylaws, is to work together towards improving the availability and quality of mental health preventive and treatment strategies to older Americans and their families *through education, research and increased public awareness*. Kim clarified for the group that NCMHA does promote broad policy issues (including the need for a larger and prepared geriatric mental and behavioral health workforce) and educates its member organizations on legislative and regulatory issues. However, it does not take positions on specific legislation, nor does it advocate on behalf of specific provider groups. It was noted that historically this policy was established to allow participation of our federal agency partners who would be unable to be NCMHA members if it were an advocacy vs. education focused coalition.

Findings from a National Study of State Units on Aging (SUAs) on Evidence-Based Program Delivery, Funding and Technical Assistance Needs

Kathleen Cameron, MPH, Senior Director of NCOA's Center for Healthy Aging described the center's two National Resource Centers funded by ACL/AoA. They are the Chronic Disease Self-Management Education (CDSME) and Falls Prevention Centers. They work through states/regions/tribal agencies and provide technical assistance in implementing evidence-based programs and offer one-on-one support, networking through work groups, webinars, online tools and resources, data management, sharing best practices and learning collaboratives (on network development, service reimbursement, etc.). Other areas of focus for the Center are behavioral health, oral health, physical activity, and flu prevention.

Kathleen then described the 2017 National Survey of State Units on Aging on Evidence-Based Programs. It was an on-line survey conducted from March 18 – April 26 that consisted of 19 questions regarding current evidence-based program offerings and reach, funding, health

concerns, program gaps, and technical assistance needs. Thirty-one State Older Americans Act Title III-D Coordinators responded.

A total of 58 unique program offerings were identified by Coordinators, 27 of which derived from the pre-populated list provided in the survey, and 33 others were mentioned in the open/other field. The most popular programs were Chronic Disease Self-Management (29), Tai Chi (26), A Matter of Balance (24), and Diabetes Self-Management (23), all of which were offered in upwards of 70% of states. HealthyIDEAS, a behavioral health program from Baylor University that focuses on depression prevention was identified by 11 states. Thirty percent of states doing HealthyIDEAS reported using Title III-D funding for this program. Ten states offer the Program to Encourage Active Rewarding Lives for Seniors (PEARLS), an intervention for minor depression or dysthymia. PEARLS provides six to eight home-based sessions with a trained social service worker utilizing problem-solving therapy, social and physical activity planning, and participation in pleasant events. The Screening, Brief Intervention, and Referral to Treatment (SBIRT) program, an early intervention and treatment for people with substance use disorders, was offered in two states.

The most common health concerns identified by Coordinators were diabetes, falls prevention, arthritis, hypertension, heart disease, chronic disease, and nutrition. Surprisingly, mental health fell towards the bottom of the list along with cancer and obesity. 42% of states reported programming gaps, including diabetes, limited English proficiency, culturally specific programs (including Native Americans), and caregiver programs. Not surprisingly, sustainability strategies was the highest reported need for technical assistance, as funding from OAA Title III-D is not enough to match the growing older adult population. The next highest needs were establishing partnerships with health care providers, creating network hubs for referrals and contracting, understanding payment models (particularly emerging models), quality assurance and fidelity, a review to determine Title III-D alignment of programs, and centralized data management and reporting systems.

The most popular offering, the Stanford [Chronic Disease Self-Management Program](#) (CDSME) is a two and a half hour workshop offered, once a week, for six weeks, in community settings. Workshops are facilitated by two trained leaders, one of whom has a chronic condition. The core content includes symptom management/social role function, exercises to build self-efficacy, goal setting and action plans, and problem solving to overcome challenges. The CDSME program benefits attaining the triple aim of better health, better care, and lower costs. In terms of health, participants have better self-assessed health and quality of life, fewer sick days, increased activity, lowered depression, and improved symptom management. Better care outcomes include improved communication with physicians, improved medication compliance, and increased health literacy. Finally, CDSME lowers costs by decreasing ER visits and hospitalizations (\$364 net savings per person). The average age of CDSME program participants is 65.3 years – so the “younger old.” 68.5% of study participants identified as white, 16.3% Hispanic, 22.9% African-American, and 3.9% Asian-American. Over half of CDSME participants have more than one chronic condition, 19.3% have a depression or anxiety disorder, and 27.5% are caregivers.

Kathleen then described the Evidence-based Program Review Council also funded through ACL. The Council identifies new health promotion and disease prevention programs that meet the Older American Act Title III-D criteria. The programs must 1) demonstrate effectiveness in

improving the health and wellbeing or reducing disease, disability and/or injury among older adults, 2) use experimental or quasi-experimental design, 3) publish research results in a peer-review journal, 4) be fully translated in one or more community sites and 5) include dissemination products that are available to the public. The first round of program reviews will be done in Fall 2017. They are working with Leadership Council of Aging Organizations to disseminate the call for programs.

Kathleen's PowerPoint presentation was distributed to members. If you would like a copy, contact Alex Watt at awatt@apa.org.

Aging Veterans and the Veterans Health Administration (VHA): Resources and Community Partnerships

NCMHA welcomed the following individuals from the VHA: Michele J. Karel, PhD, ABPP, Psychogeriatrics Coordinator, Mental Health Services, VA Central Office; Jamie D. Davis, PhD, Health Systems Specialist, Office of Community Engagement, VA Central Office; Kenneth Shay, DDS, MS, Director of Geriatric Programs, Geriatrics and Extended Care Services, VA Central Office; Gwenn Sullivan, MSN, Veteran Community Partnerships, Contractor, National Hospice and Palliative Care Organizations; and Wendy Tenhula, PhD, Deputy Chief Consultant for Specialty Mental Health, Mental Health Services, VA Central Office.

Michele began by noting that there are over 22 million Veterans in the U.S. with only 9 million enrolled with the VA, 47% of these Veterans are over age 65. Older Veterans are "10 years older" than age-matched non-Veteran counterparts in a variety of health indicators which leads to more interacting diagnoses and medications, more functional dependence, and more caregiver needs and challenges. Of VA patients over age 65, 70% use one or more other non-VA healthcare services, yet there is no systematic linkage among these providers or services. This results in discontinuities in care and documentation, and redundant and missed services. About 37 % of male veterans between 65 and 74 years old, 28% of those 75 to 84, and 35% of those 85 and older use VHA services. A minority of Veterans use the VHA as their primary source of care. Many veterans use both the VA and civilian health services. Ten percent of all living veterans are women.

For a little over a year, the VHA Community Engagement Mission has been elevated within the VA system. The #2 goal in the VA Strategic plan is now to: Enhance and Develop Trusted Partnerships with Federal, State, Private Sector, Academic Affiliates, Veteran Service Organizations and Non-Profit Organizations. They serve as a facilitator and access point to organizations interested in partnering with VHA in the service of Veterans and as a resource and catalyst for the growth of responsible and productive partnerships. They view partnerships as very important as they build capacity, leverage resources, address new and emerging needs, and build on the experiences and knowledge of each other. Partnerships are valuable in areas including elder abuse, suicide, promoting good health, and aging in place.

Why should state and local organizations partner with the VHA? There are many reasons including advancing shared objectives, enhancing impact through sharing resources, and working together to demonstrate measurable outcomes. They hope to turn the informal relationships the VHA has cultivated with other organizations into formal relationships (MOUs) to address issues such as mental health, caregiver support, homelessness, and transportation. The vision of Veteran Community Partnerships (VCP) is that all Veterans and their caregivers will

have access to and choices among services that allow our Veterans to stay in the place they call home. Its mission is to foster Veterans' seamless access to, and transitions among, the full continuum of non-institutional, extended care and support services in VA and the community.

VCPs are formalized partnerships through which local VA facilities connect with state and local community service agencies to enhance and improve access to and quality of care, promote seamless transitions, educate community agencies and VA providers, support caregivers, and develop and foster strong relationships between VA and community agencies and providers. There are over 40 VCPs currently in operation. Each local VCP is unique depending on the focus of the community's effort. VA Medical Center Partners can include hospice and palliative care, VA Voluntary Service, OIF/OEF program, Social Work Service, Nursing Service/Community Health, Mental Health Service, Geriatrics and Extended Care, Office of Public Affairs, Homelessness, and Veteran Experience Office. Community partners can include Veterans, Veteran's services organizations, hospice-Veteran partnerships, community, county, and state human services agencies, aging networks, caregivers and caregiver coalitions, academic institutions, service organizations, faith-based organizations, non-profit and charitable organizations, philanthropic organizations, hospice organizations, home care agencies, respite organizations, and disability groups.

In terms of VCP activities, they: (1) conduct assessments to determine the unique needs of Veterans within communities; (2) exchange information between VA and community agencies in an effort to keep both informed of local and VA resources, strengths, and potential growth areas; (3) educate community agencies about specific veteran-related issues and benefits; (4) conduct community outreach educational programs for veteran's groups and community agencies to provide information on the VA continuum of care, available resources, and options; (5) hold local, regional, and statewide educational events for both community and VA stakeholders to provide information on the continuum of care options and VA healthcare system; and (6) create and disseminate educational tools that partners can access for the most current and complete information on resources for veterans, in the VA and in the community. Many of these activities are bidirectional. Community partners also educate and serve as a resource for VCP staff.

The VCP National Advisory Council has been indispensable in setting up the program and in its implementation. The Advisory Council has been very engaged in guiding VCP's activities. They meet quarterly. Members include: Administration for Community Living, Disabled American Veterans, LeadingAge, National Alliance for Caregiving, National Association of Area Agencies on Aging, National Hospice and Palliative Care Organization, VHA Hospice-Veteran Partnership Workgroup, VHA Office of Care Management and Social Work, VHA Office of Community Engagement, VHA Offices of Geriatrics and Extended Care, VHA Office of Nursing Service VHA Offices of Primary Care Services, and VHA Office of Rural Health.

The VA does have many mental health resources for community healthcare providers. The [VA Community Provider Toolkit](#) provides key information and tools for community providers serving veterans including military service screening, military culture, and behavioral health treatment services and resources. The [Military Culture: Core Competencies for Healthcare Professionals](#) is a free, four-module course that aims to help health care professionals be more culturally competent when they serve Servicemembers, Veterans and their families. The [Post-Traumatic Stress Disorder \(PTSD\) Consultation Program](#) provides free email or telephone

consultation with expert PTSD clinicians to community providers who are treating Veterans with PTSD. Their expertise includes Evidence-based treatment medications for PTSD, assessment and diagnosis, referring to higher level of care (like residential treatment), and resources. The National Center for PTSD has over 50 hours of online continuing education courses, many of which are a part of the [PTSD 101 Course](#) series. These courses are each one hour in length and provide training about a variety of issues. [Make the Connection](#), www.maketheconnection.net, is a national outreach campaign relevant to all Veterans and their families, regardless of eligibility for VA care or range of mental health issues. It is designed to reach Veterans where they are—online and through trusted media and influencers—when they need support. Users can filter information based on their experiences (when they served, which branch they served in etc.) and then receive information about resources. Lastly, the [Veterans Crisis Line](#), staffed 24/7/365, provides free, confidential counseling and referrals to Veterans, their families and friends, and current service members. The VA is also partnering with the Department of Defense to transition active service members to veteran services getting veteran benefit information to them before they leave the service.

The speakers noted that often just asking a client if they are a Veteran can, in itself, open the door for increased dialog and a broader system of care.

A question and answer period followed. The first question related to VHA's use of peers. The response was that peer support services are being used more and more and they are working to expand them beyond mental health (which is how the legislation was written for the current programs). There are currently 1100 individuals working as peers in mental health services and that number is increasing. The fact of the matter is that many relatively young and impressionable individuals are released from service and suddenly find themselves in adulthood and find the pressures of reintegration to be so great. Peers are particularly helpful in assisting with these issues.

A question was asked about reimbursement for service provision. The response was that in the VA choice program, the VA allows patients to see providers in their communities and then pays community providers. For veterans interested in signing up the information is here: (<https://www.va.gov/opa/choiceact/index.asp>). The information for providers is available at: https://www.va.gov/opa/choiceact/for_providers.asp. To discuss possible establishment of a local Veteran-Community Partnership, please contact Dr. Jamie Davis and/or Gwenn Sullivan: Jamie.Davis5@va.gov and gsullivan@nhpco.org

A question was asked about Veterans with mental health issues using Veterans Choice. The response was that use of Veterans Choice has had a lower uptake in the mental health arena. Two to five percent of patients use Choice for mental health services, compared to 30% for other services. Patients often choose to wait to see a VA provider instead of going to a community provider for mental health issues.

The presenters concluded their presentation by noting that they look forward to discussing and partnering with interested NCMHA members. For more information see:
Geriatric and Extended Care programs: <http://www.va.gov/geriatrics/>
Mental Health Services: <http://www.mentalhealth.va.gov/>
Caregiver Support Program: <http://www.caregiver.va.gov/>
Social Work Services: <http://www.socialwork.va.gov/>

The presenters' PowerPoint presentations and other resources were distributed to members. If you would like a copy, contact Alex Watt at awatt@apa.org.

NCMHA's Working Committee Reports

Website Development: Marcia Marshall reported on the development of the new [NCMHA website](#) by Mental Health America and NCMHA. The process has been stop and go lately as their MHA contact has been very busy, so the site has not yet gone live. The web team is looking for public domain pictures. If anyone has a source for this, please contact Marcia. Kim Williams thanked MHA for their work on the website. Once the website is up and running, the Coalition will need to determine the policy related to what will and will not be posted. Presentations such as those from the VA will be a good resource to post. Upcoming events can also be submitted to the calendar when it's live. Marcia will send a message to the full coalition about the types of information that can be included on the website, once these policies are determined.

Public Awareness: Debbie DiGilio reported that there were no updates but the committee needs members and a chair. She announced that throughout the month of May, which was both Older Americans Month and Mental Health Awareness Month, NCMHA promoted member events and resources.

Coalition Development: Mike O'Donnell shared the most recent State Coalitions, Alliances and Partnerships roster and the handout, Advocacy - the Power of Coalitions, from the Advocacy Toolkit for State Mental Health and Aging Coalitions.

Kim thanked the Working Committees and asked members who are interested in participating in any of the committees to contact Alex Watt at awatt@apa.org.

Mental Health and Aging Policy Update

[Please note: As efforts related to repeal and replace are a moving target, we have not included segments of Joel's presentation. However, his entire Power Point presentation is available from Alex Watt at awatt@apa.org.]

Joel Miller, Executive Director, American Mental Health Counselors Association, began his update by noting that the passage of the Affordable Care Act (ACA) was a major milestone in long-standing efforts to ensure access for all Americans to appropriate, high-quality and affordable behavioral health care and prevention and treatment services. Many of the most prominent features of the ACA were instrumental in establishing the CENTRALITY of behavioral health services within the overall health care delivery system – such as the designation of mental health and addiction services as one of the ten categories of essential health benefits. It also created a way for lower-income and other uninsured individuals to obtain health insurance and also made a number of changes to how the mental health and health care systems can better operate through delivery reforms.

On May 4, 2017, the House of Representatives passed the American Health Care Act (AHCA) by a near party-line vote of 217 to 213. Provisions include eliminating the taxes and tax increases imposed by the ACA, phasing out enhanced funding for the Medicaid expansion, and imposing block grants or per capita caps on Medicaid. It would also remove the individual and employer

health insurance mandate penalties, increase age rating ratios from 1 to 3 to 1 to 5 in the individual and small group market, and permit individual states to waive the ACA's essential health benefit requirements. Older consumers would pay more for coverage under this plan. The oldest Americans on the individual health insurance market are 64 and under the ACA they can be charged no more than 3 times what a 21-year-old person would pay. The new GOP plan would broaden the age bands, as these rate limits are called, to 5 to 1, allowing health plans and insurers to charge the oldest consumers at a rate five times more than younger ones. Moreover, the proposal would give the states the latitude to broaden those limits even further. The plan also includes a phase out of the Medicaid Expansion program. Medicaid is the biggest payer for mental health services in the US, covering 27% of mental health care for Americans and is vital to the mental health of lower-income and older Americans across the country.

The Senate ACA Repeal and Replace bill, known as "The Better Care Reconciliation Act of 2017," essentially blocks out most of the key provisions of the ACA over the next several years. It is an attempt to balance the demands of conservative Republicans trying to unwind the "Democratic welfare state" and a handful of more pragmatic moderate Republicans opposed to simply throwing millions of people off their current health insurance coverage they have secured through Medicaid and the health insurance exchanges. For the conservatives, the bill includes repealing just about all of its taxes (that help pay for health insurance coverage such as health insurance and medical device taxes), rolling back the Medicaid expansion while ending Medicaid's open-ended federal entitlement to the states, and ditching the individual mandate to buy coverage and the employer mandate to offer it to employees. But for the moderates, the draft would keep much of the ACA's individual insurance subsidy structure, creates a "softer landing" for those on the Medicaid expansion, and wouldn't allow states to opt out of key protections for patients with pre-existing conditions as the House bill did, that resulted in substantial Democratic criticism.

The Senate bill does protect those with pre-existing conditions, including mental illness, more than the House version. It does this by keeping a provision, known as the community rating, that prevents health insurance companies from charging higher premiums for those with pre-existing conditions more. However, the Senate's plan may still propose giving states the power to waive essential health benefits. This would allow health insurance companies in those areas to exclude certain benefits from their coverage, like mental health and substance use disorder services. An analysis published before the Senate draft was released, by the Center for American Progress said health insurance premiums could significantly increase for MH/SU disorder treatments because of these waivers.

Any changes to MH/SU coverage and care won't occur in a vacuum. The ongoing opioid crisis is the most pervasive, expensive, and deadly drug epidemic in recent times, and the Senate Repeal bill would unquestionably curtail federal tools for combatting the problem. Medicaid is paying 50% of all medication-assisted opioid treatment. The decreased funding for Medicaid in the Senate bill would not only risk cutting in half federal funds for medication-assisted treatment, it would also decrease cost-effective preventative care that could identify and assist people before they start spiraling through addiction. Research indicates that at least some of the opioid crisis is created—and then exacerbated – by widespread mental-health issues like depression. So, the Senate bill would be something of a double whammy: diminishing both the prevention and the crisis-response functions of public health. That would hit hardest in the states with the worst fortunes already, states like West Virginia and Kentucky. The bill does create a \$2 billion fund to

provide grants to states for MH/SU treatments, but those funds fall far short of what is needed to attack the problem.

All of ACA's taxes would be repealed by the Senate bill. Like the House version, the "Cadillac Tax" would come back in 2026 because there wouldn't be enough money to permanently repeal it. While employers will never likely pay a "Cadillac Tax", this would likely become a year-to-year challenge for eliminating it, a la the Medicare physician fee cuts saga. The health insurance tax would also be repealed. The CBO has had the details for a while and is scheduled to have their score on Monday, June 26th. Undoubtedly, they will find that millions fewer will be covered once the Medicaid rollback is fully operational.

The Republicans have to get something done. If they don't they will jeopardize the rest of their agenda and that may lose them their base come the 2018—and 2020—elections. The GOP mission statement is to enact entitlement reform (in the form of per capita block grants), tax cuts to wealthier Americans and corporations, dismantle the "Welfare State," shift costs to the States, and block Federal funding of Planned Parenthood.

The Department of Health and Human Services (HHS) estimates 60 million people with mental illness and substance abuse disorders received coverage under plans covered by the ACA. Mental health is now an "essential benefit" covered at the same level as other medical care for 22 million people in exchanges and Medicaid expansion. Care for people with pre-existing conditions, includes mental illnesses. Uninsured rate for adults with "serious psychological distress" dropped from 28.1 percent in 2012 to 19.5 percent in the beginning of 2015, (CDC). The Senate and House bills would cut millions from mental health and substance abuse treatment.

The reductions in subsidies to buy health insurance and the Medicaid coverage cuts could have profound, far-reaching consequences for Americans coping with mental illness. While it's difficult to ascribe financial estimates to the AHCA plan, we do know that with less funding for Medicaid this will mean less help from mental health professionals and fewer appointments. One of the main features of the ACA was the ban on denying or charging those with preexisting conditions more for coverage. Mental health conditions that could potentially lead to denial of coverage or an increase in premiums, depending on the insurer's definition include: alcohol or drug abuse, Alzheimer's/dementia, anorexia, anxiety, bipolar disorder, depression, and obsessive-compulsive disorder. It is a frightening possibility that people with these conditions will lose coverage under either of these new bills.

A question raised was: isn't the evidence strong enough that mental health funding will bring down costs? Joel responded that we have seen the effectiveness and cost effectiveness of patient centered medical homes and insurance companies are starting to understand this. Health Plans are starting to look at peer review literature and information that comes out of conferences, so it is starting to have an impact in some quarters.

Election of 2017-2019 NCMHA Officers and Executive Committee Members

The four-person Nominating Committee composed of Viviana Criado, Chris Herman, Alixe McNeill, and Kim Williams had a number of conference calls to develop the proposed slate. The following candidates for NCMHA Officer and Executive Committee positions for the 2017-2019

are being nominated. All of the candidates have confirmed their willingness to serve in these positions, which begin after this meeting and end after the May/June meeting in 2019.

- Chair: Joel Miller, American Mental Health Counselors Association (AMHCA) (1st term)
- Vice Chair: Deborah DiGilio, American Psychological Association (APA) (1st term)
- At-large: Christy Malik, National Association of State Mental Health Program Directors (NASMHPD) (1st term).
- At-large: Kathleen Cameron, National Council on Aging, Senior Director of Center for Healthy Aging (NCOA) (1st term)
- At-large: Karen Orsi, Director, Oklahoma Mental Health and Aging Coalition (1st term)
- Consumer/Family Representative: Michael O'Donnell, Illinois Coalition on Mental Health and Aging (2nd term)
- State/local Coalition Representation: Kim Burton, Maryland Coalition on Mental Health and Aging (1st term)
- Immediate Past Chair: Kimberly Williams, Geriatric Mental Health Alliance of New York

Member Updates

[American Mental Health Counselors Association](#) – Joel Miller reported they are preparing for their annual conference, [Innovate and Advocate: Pathways to Clinical Excellence](#) on July 27-29 in DC. The conference will include a leadership training institute and advocacy training.

[American Psychological Association](#) – Deborah DiGilio reported that the APA Briefcase for Family Caregivers for Professionals has a new supplement, [Connecting with Caregivers](#), an online resource for family caregivers of individuals across the lifespan. It explores common health, financial, legal and ethical problems that caregivers often face and self-care tips and tools, and resources. The articles of the *American Psychologist* will be highlighted at the July International Association of Gerontology and Geriatrics (IAGG) symposium - *Addressing Issues Facing a Diverse Aging Population: Scientific Perspectives for Practice and Policy*. This [press release](#) contains links for free access to some of the *American Psychologist* articles.

[American Society on Aging](#) – Willard Mays reported that NCHMA will once again hold a policy day at the [Aging In America Conference](#) in March 2018 in San Francisco. Two sessions will be held, first is “What the New Administration Needs to Know, One Year Later” led by Robin Goldyn and Lynn Feinberg, MSW. The second session will highlight ACL, AoA, and SAMHSA programs on mental health and behavioral issues. NCMHA will also host peer group meeting for coalitions. Mike O'Donnell, Viviana Criado, and Willard have submitted a proposal for a round table on mental health and aging coalition building.

[Geriatric Mental Health Alliance of New York](#) – Kimberly Williams reported that New York is continuing their geriatric mental health demonstration grants program. The program, now in its fourth round, is focused on creating local triple partnerships of mental health, substance use, and aging services to address unmet needs of older adults in these areas.. Upon convening representatives from the 8 new grant projects, the divisions among providers is worse than they expected but they are aiming to support how the organizations can better work together.

[Health Resources and Service Administration](#) – Joan Weiss announced that HRSA is releasing [Training Curriculum: Alzheimer's Disease and Related Dementias](#). This new curriculum consists

of sixteen core modules and four supplemental modules for health educators to train the primary care workforce about dementia care, and to help providers address caregiver needs. HRSA has also recently hired new staff members.

[Illinois Community Coalition on Mental Health and Aging](#) – Mike O’Donnell reported that Illinois still has no state budget. It is currently 700+ days without one.

[Maryland Coalition on Mental Health and Aging](#) – Kim Burton reported they have hired five regional geriatric behavioral health specialists to work in five Maryland regions. They are funded with Medicaid Rebalancing and Money Follows the Person funds. They will focus on effective discharge programming and ramp up PASRR efforts. They are also going to provide intensive training and put data mechanisms in place to track outcomes achieved.

[National Association of State Mental Health Program Directors](#) – Christy Malik reported that NASMHPD hosted a webinar, *Building Relationships Between Mental Health and Aging Services*, on May 10. The archived webinar and PowerPoint slides are available [here](#). NASMHPD is convening their annual meeting July 30 to August 1. This year's meeting theme is "It Isn't Always About Beds..." that will focus on the continuum of care services across the age spectrum.

[National Council on Aging](#) –Kathy Cameron reported on NCOA’s [Reaching the Hard-to-Reach Through Out-stationing](#) project. As public benefits programs often remain undersubscribed by the populations that need them most, this project outstations a full-time eligibility worker in community sites, to provide benefits outreach, and help with applications and renewals.

[National Board for Certified Counselors](#) - Jake Jackson introduced himself as the new representative from National Board for Certified Counselors. He has been in this position for a week. Their current priorities include the Mental Health Access Improvement Act of 2017 which Joel reported on earlier.

[Oklahoma Mental Health and Aging Coalition](#) - Karen Orsi reported that they continue to work on a number of projects including the development of a mental and behavioral health strategic plan and an older adult peer support specialty. They are conducting a statewide depression initiative for older adults and are planning to start an Older Adult Mental Health First Aid program.

Rhode Island Elder Mental Health and Addiction Coalition – Janet Spinelli reported they are looking for examples of state mental health and aging coalition bylaws. Please share your coalition’s bylaws with her.

[Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#) – Eric Weakly reported that the SAMHSA-HRSA Center for Integrated Health Solutions sponsored their 2017 Primary and Behavioral Health Care Integration Grantee meeting earlier in June. It had excellent information, which is available [here](#). Alixe McNeill reported that NCMHA nominated Kimberly Williams for the SAMHSA Interdepartmental Serious Mental Illness Coordinating Committee.

Virginia Geriatric Mental Health Partnership – Andrew Heck reported on a study they have just completed regarding antipsychotic medication usage in assisted living facilities (ALFs). He will

send the report when it is final but noted that there is a lot of antipsychotic use in these facilities. As CMS doesn't regulate ALFs, the extent of the problem is unknown. The Virginia Geriatric Mental Health Partnership also has conducted [webinars](#) with funding provided to the Partnership by the Virginia Center on Aging.