Name of Event: Working Together for Better Senior Care: Integrating Health, Mental Health & Aging Services

Date of Event: Wednesday, May 25th, 2005

Location of Event: New York City Academy of Medicine

Number of Persons Attending: 125

Sponsoring Organization(s): New York City Department for the Aging, New York City Department of Health and Mental Hygiene, the New York City Health and Hospitals Corporation, the New York City Human Resources Administration, the New York Academy of Medicine and the Geriatric Mental Health Alliance of New York

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Priority Issues:

The 2005 White House Conference on Aging mini-conference convened by the New York City Department for the Aging in partnership with the New York City Department of Health and Mental Hygiene, the New York City Health and Hospitals Corporation, the New York City Human Resources Administration, the New York Academy of Medicine and the Geriatric Mental Health Alliance of New York recommends that:

1) Mental health care for older Americans be given high national priority for funding, education, and workforce development.

2) Integration of mental health, health, and aging services be given high national priority for funding, program development, training, and research.

I) Priority Issue # 1

Too many older adults struggle with mental disorders that compromise their ability to participate fully in life and too few seek treatment for mental health problems. Although approximately 20% of Americans aged 55 and over experience specific mental health disorders not part of the aging process, only 6% of seniors utilize community-based mental health services.

Barriers.

A number of individual and systemic barriers impede the provision of adequate mental health care to older persons:

1) Stigma. Stigma surrounding mental illness and mental health treatment limits access to quality care, services, and treatment. Several inaccurate beliefs regarding mental health and aging are widely held. These include: i) mental health problems naturally occur with aging; ii) people with mental health problems or disorders are weak or inferior; and iii) mental health problems in older individuals do not require treatment (since these problems are a "natural" part of aging).

2) **Under-recognition by professionals**. Many professionals, including primary care physicians, fail to identify the signs and symptoms of mental health problems in older adults. They may hold the same inaccurate beliefs and misunderstandings as the general population about mental health care and aging.

3) **Help Seeking Behavior.** Older adults may not recognize the symptoms of poor mental health or may deny that the symptoms are problematic. They also may believe that nothing can be done to alleviate the symptoms associated with poor mental health. Some may be fearful of acknowledging that they have a mental illness or seeking treatment because of a number of concerns. They worry that if they identify themselves as in need of mental health services, they may jeopardize their health care and their insurance. Other fears include loss of financial security and independence, embarrassment, further isolation, or of being declared incompetent.

4) **Limited Insurance Benefits.** Insurance benefits almost always cover physical health care more adequately than mental health care. When mental health care is covered, it is often fragmented and inadequate. Medicare pays for only 50% (compared to 20% for physical health) of the cost of outpatient mental health services, leaving the remainder of the cost to the patient, regardless of her/his ability to pay. Managed care organizations typically restrict use of mental health services.

5) **Shortage of mental health professionals.** There is a shortage of professionals trained in both geriatrics and mental health. The problem is greatest for minority population who are unable to find a geriatric mental health professional that is culturally competent. In any case, the vast majority of mental health professionals are inadequately trained to address the particular issues presented by older adults who typically are dealing with numerous comorbidities that complicate their treatment. The lack of cultural competence that is pervasive in the health care system is an even greater problem in mental health.

Proposed Solution:

1) **Public Education**. Provide federal funding for national and local mental health education and outreach initiatives.

2) **Professional Training.** Advocate for additional provisions to the Federal Positive Aging Act that include geriatric mental health training of primary care providers. Older adults with mental health problems frequently seek services in primary care settings, indicating a need to optimize the detection and management of mental health disorders in these settings.

3) **Outreach to Seniors.** Promote and fund outreach activities to seniors that engage them socially, physically, and cognitively.

4) **Insurance Reimbursement**. Remove the restrictions on insurance reimbursement for mental health services, so that mental health care has parity with physical health care. New policies should require Medicare to cover mental health care to the same degree that it covers other medical care conditions. Improve prescription drug coverage for those on a fixed income.

5) **Work Force Development**. Develop a federal initiative to look at work force and develop a plan for:

- Enticing a new generation of workers to the field, especially cultural minorities.
- Ensuring that mental health professionals acquire adequate knowledge of the cultural background and values of the ethnic minorities they serve, which will enable them to determine the service approaches that best meet their mental health needs.
- Developing paraprofessional and volunteer roles in mental health services.

II) Priority Issue 2

Services for older adults are delivered by a variety of distinct and discrete care systems at both the institutional and community levels: medical care, long-term care, mental health services, and aging network services. These systems are highly fragmented and a source of confusion for older adults who tend to have multiple needs. Connections between primary care and social services are limited, as are links between primary care and mental health services. Although there is unanimous agreement about the value of communication and of streamlined intake procedures, most agencies continue to function in isolation from one another. Seniors frequently receive uncoordinated care from these different service systems and experience gaps in services that often lead to poor health outcomes and even institutionalization.

Barriers

Service delivery systems for older adults operate under different principles and cultures. Statutory and regulatory requirements governing government funding for service systems do not currently promote – and sometimes actually discourage – collaboration across systems. Conflicting priorities lead each system to focus on what they regard as their primary functions rather than the development of collaborative programs and strategies. Limited funding and dedicated funding streams also do not encourage the sharing of resources. Structures to facilitate cross-systems information sharing and cross-systems training are also lacking.

Solution

1) **Needs Assessment.**

- Conduct a national needs assessment to learn who gets care, what needs are being currently met, by whom they are being met, and where they are being met.
- Provide funding for local needs assessment projects.

2) **Information Exchange.**

- Encourage and support development of comprehensive community resource guides and databases on all providers within the community, their services, locations, languages spoken by staff, etc.
- Use technology for information exchange and train providers and seniors to use this resource.
- Organize open forums for providers from health, mental health, aging services, sensitizing them to the roles, responsibilities, and barriers of others.
- Create a national registry of evidence-based practices and programs for better integration of services.

3) **Professional Training.** Establish federal initiatives aimed at creating a corps of health and social service professionals trained to work on geriatric teams.

- Train and cross-train provider staff in community settings, including hospital discharge staff, aging providers, mental health providers, and clinic staff and doctors.

- Develop core curriculum across professional disciplines, to include geriatric care, team building, and working within multi-disciplinary teams.

4) **Models of Cross-systems Collaboration.**

- Establish a federal grant-funded program to support development of model community-based, collaborative service planning and delivery structures including:
    - One-stop models
    - Collocation of services. For example, co-location of a social worker at physician's offices,
    - Interdisciplinary consultation, e.g. geriatric psychiatry on call to community-based agencies, ERs, etc.
    - Health promotion, prevention and early intervention programs.
- Support the Federal Positive Aging Act of 2005 which is designed to increase the availability of mental health services for older adults by integrating them into primary care services and extending them to other settings.

5**) Funding Mechanisms**. Identify and overcome funding barriers to providing integrated services.

- Reform Medicare to allow same day visits to both medical and mental health providers.
- Provide incentives for collaboration e.g. provide reimbursement for collaboration and phone time for follow-up.
- Specify collaboration requirements for federal grants.
- Organize open forums among funding sources

6) **Research.** Provide funding for research to identify and evaluate models of coordinated or integrated care.