

“Visions for Kansas: Older Adults at the Crossroads,” an Independent Aging Agenda Event

On May 3, 2005, the Kansas Mental Health and Aging Coalition sponsored the 2005 Mental Health and Aging SUMMIT, **“Visions for Kansas: Older Adults at the Crossroads.”** This year’s summit was designated as an **Independent Aging Agenda Event** thus the event report and recommendations will be submitted to the Policy Committee of the White House Conference on Aging. The summit was free to all 110 attendants and was paid for by donations, including the facilitation services provided by Melissa Ness from Connections Unlimited, Inc. The event also qualified for continuing education units.

The summit’s agenda centered on the issues of “Our Community” and how we can transform mental health services to improve access and increase mental health services for older adults in Kansas. The summit started with professionals sharing information from their area of expertise, ranging from service delivery systems, education, mental health, aging, and advocacy. The event ended with a report out and wrap-up of each workgroup’s recommendations for possible solutions in making the system work better in Kansas.

Opening remarks were made by Secretary Pamela Johnson-Betts with the Kansas Department on Aging and Acting Secretary Gary Daniels of the Kansas Department of Social and Rehabilitation Services. Both cabinet level leaders emphasized issues that involved increasing awareness of mental health issues, increasing access to mental health services and informing older adults about services and programs available to them. Attendees also heard from experts on specific areas of concern. It began with a discussion by Barbara Huff, Consultant to the Federation of Families for Mental Health, on what family-driven care means. She provided a working definition of “Family-Driven Care” and requested feedback from participants on whether it would also represent the needs of older adult consumers.

Annette Graham, Director of the Central Plains Area Agency on Aging, discussed “Collaboration between Service Provider Systems.” She addressed how there is a need to build relationships that have the potential to increase cross-functional services across systems. She noted that individuals need to increase their common understanding of what mental health is and how it can be accessed. She stated there is a need for providers to use common language and take time to address needs before a crisis occurs, with a focus on the older adult consumer. She concluded there is a need to have a flexible approach in the context of “stigma”, how we should address specific needs, and modify our approach in an effort to identify “non-traditional” approaches to helping older adults.

Ron Denney, Deputy Secretary of Health Care Policy, discussed issues/concerns surrounding “County Line Problems/Rural Issues.” He informed participants that the 29 state licensed mental health centers operate in catchment areas and are required to deliver services in that specific area. He pointed out that in addition to the state providing funds for the development and delivery of services, each area’s county governments provide different amounts of local mill levy funds to ensure services are available in their specific counties and that they are services specific to the needs of their residents. As an example, a person with private pay could access services in any county because there are no licensing issues tied to the reimbursement but with publicly funded services each community mental health center may handle fees differently from possible discounting to a sliding fee scale.

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Another issue brought up was that geographically there are barriers such as the transportation needs of rural consumers. Often access to informal service delivery systems are limited and that infrastructure differences from urban, rural and frontier can add to the barrier of accessing services. As an example, a person living in rural Kansas may not have a formal transportation and the only way that person may be able to get into a center for services is if they have an informal support system that can transport them, or if a more urban county is experiencing waiting lists they may build in criteria that prohibits them from serving surrounding counties because of limited staff to serve the demands outside of their county.

Rosemary Chapin, University of Kansas School of Social Welfare - Office of Aging & Long Term Care, addressed issues with “Shortages of Geriatric Professionals in Public Mental Health Services.” She informed participants there is a low recruitment and retention of individuals going into social work, especially in the areas of psychologists, psychiatrists, and nurses with geriatric expertise and experience. She identified the challenge as having an aging curriculum, internships/placements and increasing competencies. Recruitment at the student level involves looking at how we develop strategies, such as stipends and loan forgiveness, to attract students into the field of aging and mental health. Another issue is once the student gets their Master’s degree, in order for them to become a Licensed Specialist Clinical Social Worker they need 4000 hours of post-graduate supervised clinical work experience in a clinical setting with supervisor’s attestation.

Bryce Miller, with the Older Adult Consumer Mental Health Alliance and the Depression and Bipolar Support Alliance, discussed the need for “Trained/Certified Older Adult Service Coordinators.” He suggested to the group that each Kansas Community Mental Health Center should have an aging specialist or an “Elder Service Coordinator.” These individuals would oversee program development, training, and interagency collaboration, and participate in regional and statewide planning activities with other elder servicing agencies. His handout illustrated that there is some form of an Elder Wrap-Around occurring in all 10 regions due to collaborative efforts between public and private sectors.

Leslie Huss, Kansas Department of Social and Rehabilitation Services, and Valerie Mellow, Kansas Department on Aging, shared information on “Collaboration between State Agencies.” They discussed collaborative efforts already occurring and the value of those efforts. They indicated that through collaboration they were sharing staff time, funding, and other already existing resources. They encouraged the building of local coalitions in communities whereby providers and stakeholders share information with other stakeholders and professionals who work with elderly individuals. They noted the benefits of coalitions included providing a meeting time to discuss what services are available and how individuals could access those services. In conclusion they stated coalitions are good for building cross-agency relationships and create a great forum to discuss needs at the local level and how they may be able to help each other meet those needs.

Mary Carman, Vice President of Older Adult Services at Prairie View, covered “Funding of Mental Health Services for Older Adults.” Mary passed out a tip sheet that covered Medicare, Medicare supplemental insurance and secondary insurance, other insurance, Grants, and County Funding. She indicated there are concerns about how Community Mental Health Centers can

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bill for their staff time and that recruitment was just as much of a challenge as finding the funding to bill for staff time. She stressed the concern is more than funding following the population but most importantly how to ensure access to needed mental health services and the professionals who can provide the services.

Karen Ford Manza, National Alliance for the Mentally Ill, and Rosemary Mohr, Mental Health Association of South Central Kansas, informed participants about “Consumer Advocacy and Stigma Busting.” They shared the importance of story telling as an advocacy strategy and noted telling individuals about an actual person and how they met their needs increases people’s abilities to raise awareness of mental health needs and services. They discussed peer support and education models that could be expanded to increase supports and concluded with the thought providers need to look at models that increase opportunities for how older adults can access services through their primary health care settings.

Mike Hammond, Association of Community Mental Health Centers of Kansas, Inc., discussed the “Role of Association in Expanding Aging Services.” He stated professionals and providers need to look at traditional populations served versus non-traditional populations needing services and how that can be accomplished. Additional strategies he included were; marketing of professionals, initiatives to promote access and service availability and highlighting centers as a community resource.

Wes Cole, Governor’s Mental Health Services Planning Council, told participants of the council that new lines of communications are needed and providers and other local stakeholders should be learning about each other’s systems and developing strategic plans that can grow with the community and the baby boomers that are coming.

The participants then broke into work groups. The participants comprised individuals from several Area Agencies on Aging (AAA), County Councils, Adult Protective Services (APS), several Community Mental Health Centers (CMHC), Kansas Department of Social Rehabilitation Services (SRS), Kansas Department on Aging (KDOA), Senior Centers, County Health Departments, Senior Health Insurance Counseling for Kansas (SHICK), University of Kansas – Office of Aging & Long Term Care, Nursing Facilities (NF), Governor’s Mental Health Services Planning Council (GMHSPC), Housing Authority, Housing Corporation, Administration on Aging/HHS, Long Term Care Ombudsman, United Way, Prevention and Recovery Services, Kansas Area Agency on Aging Association, Meals on Wheels, Friendly Visitors, Breakthrough House, Other Advocacy groups, Kansas Library System, SRS-Economic and Employment Specialist (EES), Harper Hospital (Dist5), Catholic Community Services, National Alliance for the Mentally Ill (NAMI), Life Connections, Trinity Presbyterian Church, Alzheimer’s Association Caregivers, Senior Companions, Foster Grandparents, Silver Haired Legislature, Kansas Mental Health and Aging Coalition and Consumers.

Participants worked in groups of five or larger and chose up to three priorities to work on. The groups looked at barriers, resources, partners and collaboration to make recommendations for possible solutions in improving services and systems. It should be noted that each of the agenda items discussed have a validity of its own, however for the purposes and to meet the

requirements of this report, the following are the top priorities the workgroups identified, prioritized by total number of priorities worked on: 1) Collaboration between Service Providers and State Agencies, 2) Shortage of Geriatric Professionals, 3) Funding of Mental Health Services for Older Adults and 4) Trained/Certified Older Adult Service Coordinators.

Collaboration between Service Providers and State Agencies

The following barriers are not listed in any specific order.

- Multiple service providers and disjointed nature of service coordination
- Confusion about payment sources and paperwork involved in qualifying for services
- Organizational structures of state agencies/providers and their funding structures
- Communication gaps for consumers and providers
- Lack of knowledge/understanding between service providers regarding each other’s services and how they work
- Available services are done by different service planning areas/catchment areas (both within the provider network itself and geographical coverage)
- HIPAA guidelines
- Time constraints, limited staff available and efforts involved in keeping collaboration going

The following solutions are not listed in any specific order.

- Create opportunities to share information on what has been done and what is working
- Combine resources/coordination of dollars, get entire community (mental health providers, area agencies on aging, hospitals, doctors, neighborhood associations, fire and police departments) involved in defining what is needed
- Use technology (televideo/telehealth models) for support groups and possibly providing services
- Combine efforts to seek out grant funding, doing more with less philosophy
- Identify wasteful service practices that may be caused by existing procedures, such as multiple case managers that may overlap
- Identify functions that are critical practices based on current best practices
- Fund pilots based on best practices and research
- Inform politicians; involve local and city officials in developing local coalitions that are committed to have personnel involved in improving communication and supports to the elderly
- Educate physicians and their offices on what services are available in the community
- Increase knowledge of services available within each service provider systems

Shortage of Geriatric Professionals

The following barriers are not listed in any specific order.

- Inadequate pool of mental health professionals, especially in rural areas
- Lack of early promotion/support for individuals to go into the health/mental health profession
- Lack of professionals who can provide oversight for practicums
- Lack of prevention and education promoting healthy living
- Lack of incentives to go after a geriatric/mental health degree

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The following solutions are not listed in any specific order.

- Offer loan forgiveness, scholarships for rural areas
- Offer stipends for work, certified, education, e.g. Perkins forgiven if willing to commit to working with elderly instead of children
- Work with nursing homes/retirement communities, Medicare/Medicaid agencies, mental health providers, hospitals, Board of Regents, Behavioral Sciences Regulatory Board, churches, etc., to increase opportunities for practicums and for opportunities to educate everyone on what is a normal part of healthy aging
- Six prong approach between the State of Kansas, Education, National Professional Groups, Board of Regents, Licensure and families
- Review/evaluate laws that deal with licensing of professionals who can provide services and what those services should look like, especially for community based mental health services for seniors
- Increase outreach/education to high schools, junior colleges and universities to encourage new professionals to enter aging arena
- Encourage requirements of geriatric study in field placements

Funding of Mental Health Services for Older Adults

The following barriers are not listed in any specific order.

- No allowances for incidental type two billing
- Restrictions on ARNP services and limited availability of professionals qualified to provide services
- Lower reimbursement rates for public providers verses private practice
- Transportation needed to get homebound and rural customers into office for services
- Lack of funding available for mental health aging specialists
- Funding restrictions to meet needs of non-target population
- Limited funding sources (service options) for those on limited income, i.e. psychotropic medications, can be last place when a person is not income eligible for Medicaid but does not have insurance to cover medication need
- Legislative concerns and issues not addressing identified population, i.e. cutting budgets, freezing and/or removing funding for services to elderly

The following solutions are not listed in any specific order.

- Kansas should re-instate incident two billing
- Modify ARNP protocol
- Promote more individuals going into psychiatric nursing
- Combine efforts to find grants/match funds to provide aging specialists
- Government negotiate with private vendors to provide formularies for psychotropic medications
- Funding for rural areas that lack resources and services for the elderly population

Trained/Certified Older Adult Service Coordinators

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- Lack of knowledge on language and values that support the views of older adults, such as day services verses day care
- Lack of importance/value placed on working with older adults, viewed as demeaning work
- Definition of geriatric should be more of aging, we’re “all” doing it, lack of societal value of the dignity and respect that should be a person’s in older life
- Lack of trained, licensed personnel to work with older adults
- Reimbursement for non-billable service components that are an unrealized cost savings
- Clinical services provided mainly in the office
- Lack of knowledge regarding family and older adult consumer needs
- Disjointed service provision and funding causing turf issues
- Health verses mental health instead of a holistic approach
- Small rural populations

The following solutions are not listed in any specific order.

- Senior Centers, congregate meal sites, faith-based organizations, senior housing, assisted living facilities, nursing facilities, area agencies on aging, independent living centers, adult protective services, mental health centers/professionals, doctors, nurses, community businesses, associations, transportation, and volunteer organizations can build a sense of community and look at models like the gatekeeper program in Topeka
- Consider developing programs that are based off of research; what do other states have for programs that are supported by research on mental health and aging
- Develop a model similar to the Program for All-inclusive Care for the Elderly (PACE)-a medical program that coordinates all needed services with incentives for keeping services in the home verses nursing home
- All aging service providers, community mental health centers and area agencies on aging coordinating education and outreach efforts ensuring accurate information is shared and available to all older adults and their families
- Entire community involvement/collaboration in providing service options

Participants also shared thoughts on a SUMMIT Survey/Evaluation. Strategies that individuals or their agencies had already implemented were: 1) Utilization of senior volunteers to provide support and assistance to elderly with needs through programs such as: Senior Companions, Foster Grandparents, and the Retired Senior Volunteer Program; 2) Outreach to seniors at risk for abuse; 3) Crisis assessment program for seniors; 4) Inter-agency collaboration on individual cases; 5) Family and consumer driven plans of care; 6) Partner with Caregiver program; 7) Community outreach, linkage with primary care physicians; 8) Gatekeeper program; 9) Formed coalition with faith-based organization within three communities to establish services for family and those who have dementia; and 10) Arts and Inspiration centers.

Participants reported approaches to prevention and intervention that included: 1) Peer support groups; 2) Medication evaluation/counseling/case management; 3) Depression screening, elder abuse prevention, education of seniors on mental health, and covering services which include housing; 4) Help with Medicare issues, particularly medications and insurance; 5) Nutrition based and work on helping older Kansans understand the importance of good nutrition; 6) Educate, intervene, refer to physicians, senior diagnostic center and community mental health

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center; 7) Nursing evaluation with proper referrals and follow-up; 8) Facilitate development of grief and caregiver support groups; and 9) Work one on one with other agencies.

There seemed to be an overall logical understanding that there is an unrealized cost saving potential in treating the whole person, instead of doing triage in a variety of ways that does not necessarily meet the older person’s total service needs. There was general consensus state agencies and service providers should focus on strategies that will engage and include seniors in maintaining community supports. Participants mentioned a need to put “value” on the older person, on their experiences and how they can help develop services that will meet their needs.

The overall recommendations of the group were: 1) Start building partnerships/coalitions across service delivery systems (including nontraditional stakeholders such as faith-based, education and transportation providers); 2) Look at new ways to deliver services that include partnering with other providers; 3) Educate the public at large about healthy living across the life span verses getting old; 4) Use best practice models to build programs on; and 5) Place value on providing services to the elderly, including the provision of incentives for individuals to go into the geriatric and mental health professions.

The SUMMIT Committee extends thanks to: Kansas Mental Health and Aging Coalition, Secretary of Aging, Secretary of Social and Rehabilitation Services and Partners for acknowledging the importance of collaboration and providing the opportunity for the participants to attend the summit. It is the commitment of allowing staff time to listen, learn and exchange ideas on how to meet the needs of older Kansans that give way to new ideas of doing business. It is the opportunity to build upon each other’s strengths. Such occasions provide us with insights in how to grow positively and look at how we can meet increasing service demands while providing education to the public at large, so seniors can grow healthier and have a better quality of life. While funding is such an integrate component of how government does business and there are more demands on professionals to do more with less, the time is here to see what we can start doing to improve knowledge of the needs and to start building “supports” at all levels of life. Each participant was challenged to consider building or getting involved with a local coalition. A local coalition made up of city government, community based service providers, physicians, hospitals, police, fire, pharmacies, education and transportation.

The Kansas Mental Health and Aging Coalition is made up of partners across systems and includes the: Association of Community Mental Health Centers of Kansas, Bert Nash Community Mental Health Center, Central Plains Area Agency on Aging, Depression and Bipolar Support Alliance, Galichia Center on Aging-Kansas State University, Heart of American’s Alzheimer’s Association, High Plains Mental Health Center, Jayhawk Area Agency on Aging, Kansas Department of Social and Rehabilitation Services, Kansas Department on Aging, Kansas Public Health Association, Mental Health Center of East Central Kansas, National Alliance for the Mentally Ill of Kansas, Office of Aging & Long Term Care School of Social Welfare-University of Kansas, Older Adult Consumer Mental Health Alliance, Prairie View Inc., Senior Prevention Intervention Counseling Education, and Washburn University.