Marianne Scheinholtz: I want to introduce the other staff person Danielle Nelson who is with the administration on aging.

As I mentioned this current grant program which was in effect of 2011 had -- next slide please. We have a number of people -- for four of the programs we have the program directors who will be talking to you today about their project and particularly about partnership. One of the caveats for the current program all have to identify and have a relationship with a partner in the community, and that had to be an aging partner. I know many of you come from aging networks so that was a grant requirement. They couldn't just say we talk to these folks. They actually had to have a partner.

Let me introduce the program directors to you and they will go in one at a time. Theresa Legault in Jefferson County in California. -- [INAUDIBLE] rainbow years. Christopher Kerr and Anne Robinson and from Houston Texas. WIN is the integrating network and Jewish family in California and Vivian is going to be speaking from that agency and oasis older adults with the services and Pontiac Michigan and the director will be speaking today.

Next slide. I will turn to over to Danielle.

Danielle Nelson: Thank you Marianne. On behalf of administrator I would like to welcome everyone to today's webinar. We are participating with Sam is that is in this initiative and provide opportunities and tools for the network over the coming months.

Next slide please. As some of you may be aware the Administration on Aging became aware of a new agency still within the Department of Health and Health Services that is called the Administration of Community Living or ACL. The goal is increase access to support and participation and focusing on unique needs of Older Americans and people with disabilities of all ages. We will focus on programs and needs of individual groups. This includes older individuals with or at least for behavior issues. We have brought together through agencies into one.

ACL is working toward access with services, efficiencies and gaining influence for all programs. At the administration of aging remains intact with the same focus. ACL moved programs into a line of business, so the day to day management of all three agency program remains

relatively unchanged with the current staff retaining their assignments. The vision for the collaboration very much aligns with the goals of our organization community for community living so with that said I would like to pass things along now to Alex McNeill.

Alixe McNeill: Good afternoon. I am with the national council on aging where I lead the behavioral work of our organization.

Next slide please. This afternoon I'm going to offer a brief overview of partnerships, what some research has been telling us before we get into hearing from the four grantee and it is three lessons they have learned with partnership.

Next slide. To set the stage we believe that partnerships are valuable because the collaborative process brings different kinds of people and organizations together making it possible for them to accomplish much more than they can on their own. Partnerships between behavioral health and aging services can be powerful in addressing the needs of older adults.

Next slide. Partnerships are crucial at every stage of evidence based programming. Part of the planning process

is identifying potential partners and forming the right partnerships to ensure the success and sustainability of services. The value in partnerships is the results that can be generated from partnerships are many and varied. Through partnerships we can see, reach, increase more older adults served, more older adults screened thus increasing the health impact of the service. We find additional types of populations reached. We also find that as more organizations partner on behavioral health work we can decrease stigma as both the staff and clients are familiar with the issues of behavioral health and how do address concerns. Community support generated through partnerships helps secure future funding and partnerships can build a foundation for health and community service integration.

Next slide. Several years ago the national council on aging conducted a study of best four practices in building and maintaining partnerships. We looked for what makes partnerships work and what are the best practices. We assessed community programs that were using partners and also called on national experts and reviewed the literature in this regard. We found six common themes in looking for best practices and partnerships and they are here.

Partners are successful when they have common goals, when there is regular communication, when there is an agreement upon roles and an agreement how to assess the progress against goals. Partnerships are additionally successful when there is a full staff orientation, not only the lead executive office developing the partnership but the staff and the financial staff as well as the outreach staff and the consumers involved in the organization need an orientation to the purpose of the partnership and how each can be supportive. And we know that recognition is very important, bottle high profile recognition as well as more subtle quiet recognition of partners and their support of our program, and we all know in partnership work that it takes time.

Next slide. Colleagues of ours have recently published an article on establishing community partnerships to support late life anxiety research. The lessons that they have learned include the use of an expansion of existing relationships to develop partnerships, working with faith based organizations. It's important to treat community partners as five individuals in the different organizations have different needs. In forming community partnerships

it's important to maintain ongoing communication, strive for this and build reciprocal relationships. I think we hear this time and time again but in a busy schedule we can recognize the importance of communication and building the relationship. It allows us to take the time that is needed.

Next Slide please. For a number of years the Robert Johnson Foundation has supported an effort "mobilizing action towards community health". Robert Wood Johnson and its grantees found that the characteristics that build and sustain partnerships have social value -- that is, value beyond just that for an individual or for the lead organization, but it has some community value. They have common goals. Again there are rewards and incentives very explicitly set out from the outset and that there is a comprehensive and coordinated approach to obtaining community health.

Next slide. The national council on aging and others are looking at a new model of partnerships called collective impact. This model for large scale social change uses broad cross sector coordination by government, nonprofits and business. The collective impact model was described in

a recent Stanford social innovation review. The five features of this model include a common agenda. We hear this again, shared goals and shared measurement systems agreeing how to assess achievement of the goals, mutually reinforcing six activities and continued education as well as a dedicated organization to provide the background and support for the effort.

Next slide. As partner organizations seek to get in step with each other we offer several resources, the national council on aging for healthy aging as quite a long list of partnership resources, tools, articles. Please see this website for that assistance. Our website also has many tools for partnerships. Please search for partnerships on their website and then I'm also noting a partnership self-assessment tool right here.

Now, we're going to move to the four SAMSHA grantees to see what they have experience the in developing partnerships. We asked each grantee to discuss briefly their lead organization and the specific services that were funded under the grant and ask them to identify the needs that they decided to address through partnerships. The key partner organizations they have found, the lessons they

have learned and upon developing the partnerships as well as the community benefits of partnerships as they have experienced them, and now we just want you to know that after the four speakers there will be 15 minutes for questions and answers. We ask that you type in your questions to the chat box that you can find at the top of your screen. This webinar will be recorded and the recording and slides will be made available to those that registered for the webinar and now I'm moving to the first speaker Theresa Legault from Colorado.

Theresa Legault: Thank you for joining us today.

Next slide please. I'm going to speak about Senior Reach. Senior Reach's program is built on partnership so it's very exciting to be part of this webinar. Jefferson for Mental Health is the lead agency and partnered with the resource center which is a large community center and mental health person partners and collectively they provide mental health counseling, welfare services and in care management and resources across five diverse counties. Thanks to the expansion of funding it allowed to expand into six primary offices and target seniors at risk for suicide,

experiencing depression, and issues of alcohol or prescription drugs.

Next slide please. Senior Reach is built on a gatekeeper model and which means we train community partners to identify where seniors need help but they're not coming to the attention and seniors serving agencies and asking for help on their own behalf. We are excited about the new partnership with the primary care providers which integrates behavioral health with physical health by screening seniors in a safe and trusted location which of course is their doctor's office. The tools that we're using that are new is a screen for alcohol and prescription misuse and a model that helps the client set self-management goals and follows up with them around that.

There is increased focus on suicide prevention and this really matches well with our gatekeeper model because it's training gatekeepers on that aspect of identifying, responding to suicidal situations, and then of course we continue our traditional Senior Reach in-home services which were listed on the previous slide.

Next slide. Partnerships are such a key component of senior reach. We really couldn't do it alone. We needed to identify the seniors not seeking services on their own behalf and how could do we do? Who would help us spread the word and educate the seniors? We wanted to help and identify the seniors that could help. Who could we partner with along those lines? And really how are we going to access these older adults? They're not coming to our attention willingly and how do we get inroads talking to seniors and such as [INAUDIBLE] and doctors office and of course we wanted to build the collaborative community fabric -- we knew what each of us were doing with our work with seniors and we could provide other service and identify gaps and respond to those. I would like to note while our partnerships that I talk about today are kind of grass root and community-based, our area agency on aging, Denver regional council of governments, and county chancellor; are very important, but I'm not going to be focusing on those. You will hear about those partnerships later as well.

Next slide please. With Senior Reach day keepers are our community partners and we have broken them up into two main

groups. First traditional community partners. That would be your partner on area on aging, law enforcement. The folks that work with seniors daily and they know what to do when a senior needs help, but the second group is really a vital referral base for us and that's the folk when is they see a senior that needs help they don't know what to do about it, so our outreach and training networks these folks into partners in a community all working to better serve seniors. For instance, this could be the neighbor. It could be someone at the church. It could be someone driving the meals on wheels fan and they scratch their head and "I know she needs help. What do I do?" And this is replicated by mental health of this and able to get a grant but unable to attend today as a presenter. They have a program and between this and outreach the training efforts have reached 35,000 people since 2006 so that just shows you – you can imagine the impact that would have on reducing stigma around a senior asking for services, and particularly around seeking mental health assistance. With the expansion project our primary partner has been the primary care providers, and with the program the expansion of key partners is an agency -- kind of a collaborative

program and triad and group of folks that meet and seniors, folks working with seniors and law enforcement and that has been a really good partnership for Kansas.

Next slide please. Lessons in developing partnerships. Needless to say you can imagine with gate keep are model how many partnerships you're working with and there will be lessons pointed out. One of the things I learned is that you always have to keep on identifying community partners. Just because you start out the grant, you have everybody at the table you're not done. It's important to continually evaluate, develop new partnerships and nourish those existing partnerships and as part of that you have to be really clear about what you can provide and what you cannot provide, and at the same time understand your partners.

What do they need from you? What can they provide? What can't they provide? And part of that if you think about the value of each partnership -- spend some time really understanding what that partnership brings to your program, what you bring to it and really thinking that piece through. I think one of the funniest parts of being a partner in a group is to participate in each other's activities. Attend the special advance support, attend the

fundraisers. Just get in there and be involved and get active in the community you serve, and especially in rural communities. They're very closed and they don't want strangers coming in. You have to be part of the community to build those partnerships and go ahead and staff a table a community fair. Hands out keys at the food bank and make a presence and be active, so next slide is on lessons on maintaining partnerships, and I have to say one of the parts of my job I value most is maintaining and working on partnerships.

As far as lessons learned in maintaining the ones that floated to the top for me was realizing how vital the partners can be as advocates for my program. You know educate your partners on what you're doing, why you're doing, what you're doing. Educate them on outcomes. Update them. Keep them current on what is happening with your program and provide them brochures and it's amazing the places that advocates for our program have gone out and talked about Senior Reach that was networked into and promote their services in return. I enjoy recognizing partners at every opportunity whether it's publicly or individually. It can be formal, at a meeting. It can be

informal cup of coffee and it's important and continual and genuine and you do it, and in order to ensure open communication I think the first thing you need to do is listening and see what people are saying. Feel free to ask for help if you need it and offer help when it is needed. While you're doing all this good work and we're trying to balance all the balls in the air I think it's important to have fun and sometimes we forget that piece, and if you have fun you're fun to be around, and work seems to be less work.

Next slide. So the community benefits of partnerships is the final thing I'm going to talk about, and you we have heard quite a bit leading up to this, and you guys can probably share many lessons with us as well, but certainly the better use of resources and expertise is one thing that comes to mind. For example, Senior Reach staff will teach a class at a local senior center here and both agencies advertise for the class and all of a sudden we are reaching an audience we haven't been able to access before. We are getting free space at the senior center to have a class on aging or depression and the senior center is benefiting by getting the diverse programming and we're not paying for

the space so the variety and benefit to the relationship and all of that is an example of how sharing resources and each other's expertise can help. Better community infrastructure to support seniors working together. If we know what each of us is doing and we're working in partnership and networking together, we can make those referrals. We can bring in resources and better serve those that are in our community, and this I think is reducing stigma. The more we get the outcomes out there, the more we talk to folks that aren't involved in community and behavioral health, and the more they understand what our work is, and they're there when you need it. We had one of the major counties come out with a budget that didn't include any mental health financial support, and we put the word out to community partners and quickly got feedback to this agency that resulted in the budget line item being added in, so it's just -- those partnerships come in and are valuable at times that you would least expect. That also helps with building a case for services. I was talking to our funder and one of the volunteers seniors on the panel, and I'm not sure what role he played. They asked "what partnerships do we have? How do we

network in the community?" And I answered the question and this person who I don't know spoke up and said "we see senior reach out there -- he told a story that was far better than I have said, so it's at partnerships really do play out for you, and of course especially a gatekeeper model better case finding is important for us and getting the word out there. This is what is happening and this is how you can access those services, so anyway that's my piece of this, and I thank you for listening, and I'm going to turn it over to Chris and Anne and Montrose counseling center.

Anne Robinson: Thank you Theresa. Very well said and we can echo that. This is Anne Robinson and Chris and Rainbow Years is kind of a wink to the senior gay community in Houston. Our mission is to empower our community and LGBT individuals and their families to enjoy healthier and more fulfilling lives and we do that by providing as affirming and culturally appropriate services as possible. Next slide please. Thanks. We're a behavioral health clinic first, but we're also involved in the primary care behavioral health integration grant that we're doing and we have been leveraging that to work with our -- with this

grant and the services that are involved with our general behavioral health services are obviously counseling, master lest and Ph.D. counseling and case management and means all of the case managers are licensed. We are an outpatient substance abuse treatment program. We have extensive outreach services and Chris will talk about the specific ones for this program but we do HIV and substance outreach. We have social and recreational services and a lot of that is kind of leveraged with our wellness services that we're doing under our integration grant. Chris let's take it over to you.

Chris Kerr: Next slide please. So the current services that we're providing under this grant to prevent elder suicide and drug abuse prevention -- it starts with a social media awareness campaign to try to affect the LGBT community and the attitudes and outcomes with suicide and drug abuse and we are using several evidence based practices. We are doing adult education and with the program "get connected" and similar and mixing those a bit and that is for the drug abuse or misuse prevention. We're also doing for the suicide prevention question persuades refer. That's a very short -- most an hour long lay oriented program to help

people intervene when someone is thinking or talking about suicide and offering them referrals effectively and it's meant to be done like CPR, to as many communities as possible and survival of heart attacks or survival from suicide thinking and is also as part of that general outreach we have volunteer outreach workers who are to go into the community, establish relationships one-on-one and with groups and from that use the PHQ2, two questions as a screening for depression and the cage aid and the screening for alcohol and drug abuse, and those people who are positive for that are offered referrals into our program, and the intervention of that program is healthy ideas. Kind of a brief intervention program that is counseling but focused on behavioral activation and you could look up a quick Google search if they're not familiar and find descriptions of them as evidence based practices.

Next slide please. The needs that we have addressed, and for us what is really essential and important is the need for outreach. What we discovered in a previous grant providing mental health services to the LGBT population is one that we don't have a community partners -- say the doctors' offices or medical centers that have a stream of

LGBT elders coming in and we can screen and into our program. You would think if you put out a sign in front of your agency "free counseling for LGBT elders" And people would beat a path to the door, and we found that wasn't true and there was resistance and fear for LGBT elders in the community and talk about their issues. Remember this is the generation that grew up when it was illegal to be gay and lots of stigma attached to that and real consequences and they carry that into the fear of outing themselves as they seek services so outreach is essential for us to go into the community to establish relationships with our partners and LGBT that have long histories in the community and social associations and informal groupings like that, and so in doing that outreach we are working with this hard to reach marginalized and elder served population that is difficult to reach particularly through the traditional mental health providers and particularly for LGBT elders the doctor's office is not a safe place and especially to out themselves and they're not talking about that or things that are deep like that. They may talk about aches and pains but not other things for fear of outing themselves in some way so that wasn't the

traditional way, so for our outreach we're using an indigenous leader model and taking LGBT peers and training them and sending back into the community. We recruit them and calling them advocates. They were trained in active listening and suicide prevention and how to make casual, social contacts into helping conversations and possibly screening and referral. In doing this too we found that for volunteers to do that that was kind of intimidating and we started with a less intimidating level and ambassadors and people to talk about our adult education and get individuals or groups to volunteer to do those trainings and be gatekeepers for us and also to find other people willing to be advocates and that was part of our -- >> Yes and our sustainability for financing -- because we use master level clinicians we are able to bill Medicaid and Medicare for service but we do have a contract in the air for the aging and provide services for people between 60 or 65 and maybe uninsured. We have foundations and individuals in the community that really like this program. It's kind of a favorite -- our youth and senior program are favorites of community members to support.

Next slide please. Our area on aging has been supportive. It took a couple of years to figure out theirs is system and get engaged with them and they have been supportive. The new part that has come out about evidence based practices they have encouraged and welcome us to apply to continue our funding for our healthy ideas under that. We do have a partnership with federally qualified health center under our primary care and neighborhood integration grant and they're just a few blocks away and we have leveraged that to help get our consumers that we bring in into psychiatry and into primary care if they don't have a provider so that has been essential and we find sometimes when people are depressed they don't take care of their physical being as well. And as Chris said there are organizations in the community and one is lesbian over 50 and a group that exactly what it says it is. Prime timers and a group of senior men that have social events and four seasons which is another group of men that meets every quarter and has a party. Now, we have found that the women are much more interested in engaging with us in the community. The men just want to have fun and that's been a

bit of a challenge but that is why we have our outreach workers to work on that. Okay.

Next slide. So the lessons that we have been learning and upon developing these relationships we can't under estimate the need for trust and with this LGBT population or another hard to reach population establishing trust is very much what is kind of appear outreach program or something that really addressing one-on-one people's issues and fears and eventually introducing them into the services. We are lucky here at the counseling center because we have a long track record of working with the LGBT population. We have been here since 1978. We do have a good record of being a confidential, being involved in helping in different ways, and pretty successful word of mouth kind of campaign. A lot of our counseling referrals already across the age spectrum from the LGBT community comes from word of mouth and people talking about a place they were safe to be themselves and talk about their issues. I think we also found that we had to listen to the community even if we thought we were experts on the field being here, and for example this is a little antidote, but when we were devising the name of the program we did a focus group and

the seniors said if you call the program anything it can't mention mental health or counseling. It shouldn't say anything about gay but needs a code word so gay elders can recognize it's probably a gay program so they came up with the word SPRY and come and not necessarily talk about the program. And what we found in terms of the support group the men and women wanted separate groups. The first peer counselors were an older male and female we trained and the women said they really didn't want the man, the male counselor in the group, so we have kept those segregated groups as part of listening to what they're willing to participate in. One of the pitfalls we found in working with the social groups in these non-professional groups is that they have their ups and downs. With the men's group there is leadership changes and for us that loses continuity and have to start over and developing a trust relationship with the new leadership.

Next slide please. Yes. Some of the other lessons learned if we want something from them we have got to offer them something so we have a nice big new building with meeting space on the first floor and storage space, so we offered the groups that were helpings -- they get reduced fees or

free meeting space and they get to store their stuff for the meeting and we are negotiating with the women's' group about moving their library, their extensive library and we took two of them to the grantee meeting in Bethesda to tell their story. They got a treat to go on a trip but they were helpful to us in spreading the work we're doing and the message. We try to recognize people at high profile events. Give them awards. We thank them when it's appropriate to do that and not breaching confidentiality and something clever that we did was Southwest Airlines is one of our sponsors and they give us a number of free airline tickets every year to do with as we need to in fundraising and training and that sort of thing, so we set aside five tickets for people who would agree to be ambassadors for us that they're entered a chance -- there is really -- I think there is only 15 of them so they have a one in three chance of getting a free airline ticket.

Next slide please. One other benefit that is helpful there is people from those different social groups have come into our support groups, a large number come into the support groups taking advantage of case management or copying and go back and tell their friends about it and working with

the counseling center has given us access to the programs at no charge and it's helping me and that is a benefit they spread and more people come and they go back and tell more people, so it's kind of spreading out exponentially from there, so we do end up reaching the broader population through the groups or individual words of mouth, and again we can't under estimate or stress that if you're trying to reach a hard to reach or hidden or resistant population the outreach program is essential and one person at a time. We tried to address the initial resistances and to counseling and "I don't need counseling. It didn't work when I was a kid when they gave me medication or shock therapy. How can you help now?" And addressing those questions and the fear if I come in -- this is a federal program and the federal government will know I'm gay and something bad is going to happen and teaching them and establishing the confidentiality that we have and letting the word of mouth spread that we do keep the information confidential. And we build services with them and they come back and tell us more of what they need. One of the feedbacks they told us behavior formal counseling there is a need for more of a social program and we have been working with them and

learning that. They can be put into the service and we're not demons and seek services where it's not so threatening and the social programs can be therapeutic in themselves and for some people actually what they need. I think we used up our time and more minutes and we will turn this over to Vivian in Los Angeles for her presentation.

Vivian Sauer: Thank you so much. We're happy to be participating in the webinar in such a critical topic.

Next slide please. We are a non-sectarian agency and serve individuals of all ages with a heavy concentration of services devoted to the older adult population. Our previous funding really allowed us to integrate our social services with more recently acquired mental health practices. Some of our core services are listed on the slide, but more and more we're finding that we're focusing on health and behavior health services really for all ages.

Next slide please. So our program is called win, wellness integrated network. Like the other grantees we are providing screening and intervention. For the potential alcohol and medication misuse we are providing the expert screening and the tool as an intervention. For suicide

prevention we're particularly focused on screening through this and particularly on question nine of the PHQ-nine and similarly for depression we do that screening and the preferred intervention we're using is professional solving therapy is our intervention. I listed outreach and engagement. I want to mention that even though it's not an actual intervention. We found this to be an effective tool in identifying older adults who need mental health intervention. The outreach is conducted in ways that educate and culturally sensitive way, non-threat threatening. Similar community venues and as a result we're seeing more acceptance in the communities that we serve, so even though it's not an actual service it's a way we're providing intervention that is particularly successful for us.

Next slide please. So the needs that we see for partnerships and why we're so focused on it -- obviously like everybody else we had to expand our service network because one of the goals is reach as many seniors as we can, and the partnerships help with raising awareness on a more community-wide level. The integration of health care -- this national trend which we're seeing is a very

strategic issue for us and speaks to some of the sustainability issues and we're on site and as well as hospitals and this has really opened some new screening venues which we haven't been before and strengthen existing partnerships and they are critical now and in the future as well. Another need that we have seen in L.A. is to break down the silos, to integrate the aging delivery system and the mental health system. These are two large funding streams for older adults in L.A. one through the area agencies on aging and one through the department of mental health, and there is actually a growing recognition that there is a need for some level of integration and this doesn't exist previously. Often we find that the clients cross over systems. They're the same clients. Or they could benefit from the services that each -- and expand our reach to different communities, different language groups and that's been very helpful for us. Our department of mental health has been a very critical and very active partner both in funding and in sustainability of some of the service we started under our previous grant. Fortunately SAMSHA priorities parallel some of the department's priorities and worked to our advantage and

opened up a good dialogue for us and obviously the area agency on aging and one for the city and one for the county and both are partners in this project and this opens up opportunities with the entire department of aging and community service provider network. There are a lot of local agencies and senior centers that belong to those particular networks.

Next slide please. So what if we tried to do in developing these partnerships. We first built on our first relationships. We have been part of some of these networks for many years, and this has given us really the credibility to leverage these relationships with newer entities and sometimes we find we need to be more proactive and sitting at different tables rather than just the traditional ones so we can listen for the new partnership opportunities and this has been particularly helpful with the health care entities. We've tried to be again proactive in building new relationships in the health care environment. We have been looking at where our agency might need to focus in the future and some of this has driven some of the relationship building and paving the way for collaborations that we actually are engaged in now that

we have not been engaged before. It's how we can help the partner and we can them and sharing expertise and having the system more cost effective. Particularly with our relationship with the hospitals we had to demonstrate to them that partnering will help them derive a financial benefit for themselves, and we also have learned to formalize the relationship in writing. It really enables both parties to understand their respective roles and you can refer back to the written document and clarifies things more. Makes it a little more formal.

Next slide please. So in maintaining partnerships what we find is what everybody finds. Relationship, relationship, relationship. It's no different than in other areas. Really respecting the contribution that each party makes. Understanding these relationships take an investment of time and energy. They just can't be relationships on paper, and again what has been critical for us is making the time to seek out different partners, to attend network meetings as was pointed out. Partners appreciate when you take the time to attend their meetings, their events and you're sitting at the table with them. If you can seek funding together it's a really useful way to bond and it creates a

win-win situation. We have been able to do that and write grants on behalf of our partners. We also find that we had to learn each other's language. Our experience for example with the developing health care partnerships has demonstrated to us that sometimes the language even though we're saying the same words has different meaning in each system and a learning process. For instance, if you use the word "care management" In social services it's one thing and other areas it means something different. We learned it's not always the top person in the organization who is the critical person. It might be a senior manager or middle manager and someone who has the clients on the ground so we have to identify -- you have to get the buy in from the top but sometimes it's more helpful to work with people not quite as busy.

Next slide please. Thank you. And finally the community benefits -- L.A. is a very big city so we have to take it in small bites and we have been able to reach additional populations who had limited access to mental health services both through our own engagement and engagement of the partners. It's been very exciting for us to see the potential for systemic change and we are seeing that in

areas where we're working. It's also lead us to understand how the need for research partnerships to get that hard data which will drive that systemic change will be more important for us and we are seeking out those partnerships and probably a topic for a different webinar. Sharing best practices with our partners, either providing the actual intervention or helping others get trained. Raising the value of evidence base practice and everyone is talking about it and it's not just one system or another and everyone is talking about the need and talking about the same evidence base practices and breaking down the silos and a goal for us. We are seeing more understanding in the aging and mental health systems we're dealing with the older adult community that has some of the same issues. There has been a greater willingness to develop programs and they're engaged in and more community services and this is a bonus for us and really gratifying and again thank you for listening and I will turn this over.

Micheline Sommers: Thank you Vivian. Good afternoon everyone.

Next slide please. A little bit about Oakland family services first of all. We're a five zero 13C and celebrated 90 years of service in the community. We are a

licensed mental health and treatment center. We have three programs and one for women and one for adolescents and older adults. We have foster care agency. We have a preschool and day care and utilize the services of older adults in the day care. We have specialized services for youth with the local authority to provide intensive treatment with families with a child or adolescent suffering from emotional or behavioral stress and accredited by the council on accreditation and the national association of young children.

Next slide please. Our latest round of funding for in home adult services has allowed us to provide education on alcohol and prescription misuse to our client base as well as treatment for anxiety, depression and substance abuse and misuse. Our program is based on the community outreach model. We provide these services here in the office, out in the community and also in the client's home and we're providing education on suicide prevention to not only the clients but older adult service providers as well. We are working with local emergency room staff and our area agency to help them develop awareness about suicidal factors when working with the older clients. Next slide please. In

developing our program we addressed partnering with key service providers looking at their capacity for outreach. In other words, how many isolated older adults did they have access it to promote the availability of the oasis program? We knew we couldn't reach every person in the community that could benefit from the program so we needed our partners to have that capacity to market as well and although we provided older adult services for 20 years we wanted to have partners with the latest information on community resources available for us to serve our clients. It never ceases to amaze me when I hear about a program and it's the best kept secret and they didn't want oasis to be a best kept secret. We decided that the most advantageous relationships would be with those that most often touch the lives of isolated home bound adults so we worked with two senior centers that provide 25,000 home bound meals annually in the community and we developed a reciprocal relationship with them over the years. We provided training to the drivers and identifying symptoms of anxiety, depression or substance abuse and they in turn would inform their supervisor when they thought they saw or recognized those symptoms in their clients and the

supervisor would call and ask if they're open to have them talk to them from the program. Other partners that we utilized were two local health systems. One recently opened specialized rooms in the hospitals and we were fortunate to have one in our backyard. Another hospital system has a geriatric clinic and family families take an older adult to be evaluated and there have been a significant referral source and not only when they identify depression but when they have early stage dementia clients. We work closely through networking groups and service providers from every discipline and we always had the 30 second elevator speech prepared for them. Many took advantage the education programs for their staff or volunteered to sponsor us in older adult communities so we could get the word out. We work with them to train the service providers and case managers and have been a part of the mandatory quarterly training.

Next slide please. We also recognize like everyone else that it's not just about receiving referrals to the partners but providing them to them and when they have a client crying about family issues or aging concerns or unmotivated for treatment and not sure what to do with the

client they can call us and reach a live person to respond to their concerns. Similarly when we run across someone who needs a caregiver, meals, transportation, or help with Medicare or prescriptions we know who to call as well. It's important to know what the partners need so we can refer to them and let others know about them in the community. Memorandums of agreement have been extremely beneficial because they not only develop a formalized relationship but they have clear criteria into what you will be doing for each other.

Next slide please. We shared our data with everyone we could and every chance we had so the partners were savvy about the mental health needs of older adults and aware of the benefits and treatment. Our goals were to improve the recognition and understanding of depression, anxiety and misuse of prescription drugs and substance abuse and the community and reduce barriers to treatment and meeting them in their home. We anticipated 350 referrals over the life of the program and we actually received over 700. From previous experience we also expected that only half would engage in treatment but that -- it actually rose to 70% by our second year. We believe that it was due particularly

due to the continued efforts in talking about the benefits of treatment and also the word of mouth from those that successful completed our program. We sent out fliers in every meal that went out in the community several times asking, how are you feeling lately? Would you like someone to come and talk to you in and we wanted to improve obviously the symptomatology of the clients and we used that scale and our clients improved on average of four and a half points and the functioning score and improved anywhere from five to 15 points. We also asked the persons who were using our services whether they were a consumer or a referral source if they would be advisors to our project and their input has been invaluable in the development and growth of the program. Recognizing our partners at any venue we participated in brought them not only recognition they deserved but really create some friendly competition that other providers wanted to participate in. The same partners have offered their written support as we sought out other funding opportunities.

Next slide please and finally we taught our partners about mental health and substance abuse treatment and what an impact it was having on our clients and whether

participating at a senior center or compliant with the health care treatment plan. We believe we are having an impact on the stigma of mental health treatment and they're recognizing that and think of whether other funding opportunities come up. We are currently partnering with our local area agency on a CMS demonstration project to reduce the recidivism rate for hospitalizations of Medicare recipients through coaching and part of the sustainability plan was to build for services and provision of treatment. We began to provide services on site at the original partner center centers not only for the convenience of the client but maximize the therapist's time and reduce travel which is not reimbursable. It starts out as a two block of time once a month and eight hour day once a week with back to back appointments. We have begun this service at five other locations and words of benefits are getting out through their communication networks they are contacting us to implement the service. We have room for growth. So we feel that we have been able to address the stigma of mental health and provide the service in a consumer friendly atmosphere and begun to be reimbursed for the services and

the best of both worlds and thank you for your interest in the programs and I will turn it back over to Alex.

Alex McNeill: Thank you and thank you all -- to all of the speakers. It's so rewarding to learn about the

partnerships and to learn about the exciting work that is going on, not only that it can go on but that it is going on. We had a few questions about providing questions, and we would like to receive a few more questions, so I'm just going to suggest for people that would like to offer a question please move the cursor to the green bar at the top of the screen. It says "viewing Alaysia's desk top". When you touch it a drop down box will drop down and click on "chat" And type your question into that box and send it and we will get the question and very shortly we will start answering those questions. We have certainly learned many things from the grantee organizations that have presented this afternoon. I think some of the key lessons that we have learned about developing and maintaining partnerships include understanding partner needs, building trust and reciprocal relationships, listening and responding to partner needs, whether they're exactly on target or what the lead organization is doing or not, using memorandum of

agreement, sharing aggregate client's impact data to show results. I think we heard and learned from other partnerships as well that when all of the partners in the community can see the title impact that is being brought about because the partners are working together to implement evidence based programming it can be very encouraging to continue on to bring more of the people into the service. We have heard that genuinely recognizing partners and their efforts is very important, and that leveraging additional shared funding can be very helpful. In the department of partnership results we have learned about the outstanding results that grantee organizations have secured. We have heard that partnerships result in behavioral health and aging services reaching more older people, extending to new populations. We have heard about marginalized people who are initially resistance to receive care because of the partnership. We have also heard that partnerships can result in aging, behavioral health and primary health care services collaborating and moving towards integration, and that the communities are gaining improved infrastructure to support and serve older people, and now I'm going to move it to Kathy Cameron with JBS

International managing this webinar and who will handle the question and answer period. Kathy.

Kathy Cameron: Thank you Alex and good afternoon everyone. Yes we do have a couple of questions, but first I wanted to let everyone know that once again that everyone that registered for this webinar will receive an Email message with the PowerPoint slides as well as a recording of this webinar. Thank you. The first question is "how do Jewish family services of Los Angeles secure and develop a relationship or partnership with hospitals?"

Vivian Sauer: Okay. I will try to think back. We actually -- you know it started with the Affordable Care Act came out, and we realized that more and more were going to be needing to get into the arena of health care for sustainability, not only for some of our services, but our clients are going to be having to dealing with new systems and in order to be there to support our clients we really needed to learn about health care partnerships and to partner in a better way. It's not - they weren't our traditional partners. Our traditional partners were more social service and mental health and I think it fully started two years ago and we really did look for the opportunities for these and

hospitals who are engaged with SMS in thinking about how to deal with their older adults and we really needed to drive the point home to them that by partnering we're able to help people in the community and keep them there and that is the major thrust with the health care partners. We have the knowledge and expertise to keep people in the community and to avoid hospitalization or nursing home placement, so I think that's really been our way in, and we're continuing to explore those.

Kathy Cameron: Great. Thank you Vivian. Our second question is for Montrose in Texas and the question is about how many folks have you reached in your grant cycle? Maybe you need to talk about the different grant cycles and how many people you have reached in each?

Anne Robison: Well, that's a moving target. In the first grant target we did needs assessment with over 300 seniors and we provided – we have provided mental health services to about 200, and then over the period since 2005 until now. In our healthy ideas which is kind of the end point or the major evidenced base practice of this grant cycle I believe we have served about 10, and again very difficult bringing people in, very difficult to get them to vocalize their

problems around mental health or substance misuse, but the people that we have worked with we have seen really market change and the behavioral activation part, which is basically what healthy ideas is, has really done a lot to get them out in the community, less depressed, engaged in support group and stabilized. >> We have -- we had more numbers in contact with people in the training. That's going beyond that and I think one thing that we found in the interest of sustainability for this particular grant cycle we are trying to work with volunteer outreach workers. In the previous cycle we were able to hire part time workers and that is the learning curve for us is working with volunteers to motivate them to do the level of work and training that is needed to do this outreach work, so we're trading off on the speed of working with paid people with the sustainability over the long-term by cultivating volunteers.

Kathy Cameron: Thank you. Thanks Chris and Anne. The next question I think maybe addressed best to Theresa in Colorado, but others can answer the question as well. How are client confidentiality rules observed when using outreach workers?

Theresa Legault: Is that question pertaining to -- we're not using the outreach that I'm referring to as going out and talking to folks about how to help a senior in need, and provide services like that, and that's the same model that the gatekeeper model that Candice is using so we're not talking about individual data with that so I'm not sure I'm understanding the question exactly, but the outreach is considered training. It's just going in and networking with folks and saying these are the things you need to be concerned of. These are natural aging things. You don't need to be concerned about and if there are issues here is a phone number to call and access all these services, so I'm not sure if I am understanding the question correctly.

Chris Kerr: This is Chris in Houston. That might be directed to us since we're using outreach workers in the screening. The training program does stress the confidentiality aspects of it with a mental health organization and they are required to maintain confidentiality. It's a bit fluid in being a peer and they might go out to groups that they know people and talk to people they came across socially which they know and different from most mental health services and as a professional we don't make acquaintances

or friends or family members but with peers you're working with the community you live with and associate with, but they're trained in confidentiality and talking about their issues and maintaining the records. They keep a minimum list of names and contacts and referrals and follow ups on the referrals and they're trained how to maintain those in a safe place and keep the records here at the agency and how to not talk about other people's business and not to talk about their outreach with other outreach workers within hearing of these groups and we had a very good I think success rate with that too. They just know that they're -- they don't engage in gossip. They know the difference of out socially working as an outreach worker. I hope that helps answer that a bit.

Kathy Cameron: Thank you Chris. And our next question is addressed to you and Anne. I work in extremely conservative rural area. Do you have any suggestions in reaching LGBT seniors?

Anne Robison: Bless you. We're not in a rural area but its pretty conservative here too. I will let Chris talk about that.

Chris Kerr: Well, it's going to take patience and time. It helps to have peers and other LGBT people -- if there are gatekeepers are informants you can work with. It takes advertising. It takes outreach and finding the places with the LGBT associates and it maybe at a particular restaurant, club, or bar which in history have been traditional safe meeting places for LGBT people. It might need some publicity that has community recognizable symbols and the tri-rainbow and we're an agency and we're safe and accept people for who they are and not pass judgment but that's not in the mind of the person, especially the Eder person getting the services. They assume the opposite and they might not accept me. They might have had counseling experiences and someone tried to change their orientation and it needs to be spoken out ahead of time and we accept you for who you are and we won't pass judgment and looking for the community publications. Now days being on the internet to search on the community postings about meetings or social groups and we were -- I mean we joke and this is really joking but when we worked with the first group of outreach workers and tried to explain the indigenous leader mod and he will talks about the "gorillas in the midst”

Movie and in the areas where do LGBT people congregate? Is it this store or bar or restaurant and listening – they picked up there is a group that meets at lunch at this one restaurant and show up there and really patiently going into the community and also when you work with peers in this model often they will know where the communities are, and sometimes the really more conservative groups and we find that here in Houston with the different sub groups, like different ethnic groups and like the Asian gay community they are meeting in private houses and word of mouth and not going out into the community, so you really need somebody from that group that is willing to train with you and go back into that community.

Ann Robison: And I would just add that we have been around since 1978 and we have been pretty visible and vocal as much as we can be on policy issues. We are involved with mental health networks, substance abuse networks, and other networks. Chris is on the AAA advisory council here and everywhere we go we talk about LGBT elders and youth and everyone knows we're the place. They will send people to us. They will tell people about us if they don't already

know but we have been around so long it's pretty well known in the community that we're a safe place.

Chris Kerr: And our outreach workers – I think they told us later they didn't realize when they signed up they were outing themselves so the first time we sent them to the elder service provider network and meets with united way and introduced themselves as an outreach person for the LGBT person and realize they outed themselves and talking with the people out there and eventually word gets along. We use some of the space in the agency and offer to the community and in the building we have 12 step programs that meet here and the word spreads that way. We have the gay /lesbian museum and archives houses here and display things. Friends and they meet here and a religious group for LGBT people and from all aspects trying to infiltrate the community and getting that message when you come to us it's also safe.

Kathy Cameron: Thank you Chris and Anne for that answer. The next question is there a universal screening tool that anyone would share pertaining to general mental health and medication abuse.

Vivian Sauer: This is Vivian in L.A. I think the screening tools that we have discussed today are universal. I know that. We have been using the one for screening for depression since our first grants and it's embedded in the agency and I think many agencies whether mental health or not are using that as a screening tool for depression and that's available no charge, et cetera.

Kathy Cameron: Vivian thank you for that. And that's something we could send out with the PowerPoint presentation and the recording to all the registers for the webinar as an initial resource. Great. One of the questions came in and whether we're offering CEU's for this webinar and no we're not. We have a few more questions so if you have additional questions please type them into the chat box. I want to let you know that the next scheduled webinar available to professionals across the country is for September 19 and the topic will be reaching and engaging older adults in behavioral health services and from 2:00 and some of the future topics are sustainability and financing, behavioral interventions and family caregivers as family and clients in care.

Marianne Scheinhotlz: Hi. Can you hear me?

Kathy Cameron: Yes.

Marianne Scheinholtz: It's Marianne. I apologize but in the interim slide I wanted to mention that the older adults -- technical assistance center, which supports the grantees as well produces these webinars also produces issue briefs and I believe there are 14 issue briefs, 10 webinars and also policy academy meetings in five of the 10 health and human services regions across the country. The issue briefs and web webinars -- I believe Alex showed a slide where you could find those and I failed to mention that and I wanted to bring it up.

Alixe McNeill: Thank you Marianne. This is Alex. I'm not sure it was on a slide. We intended to but they're available from the administration on aging website on their behavioral health page and also at the national council on aging website on our behavioral health page, so that's AOA. GOV and look for behavioral health or NCOA. ORG and look for behavioral health. Thank you Marianne.

Kathy Cameron: Thank you Alex and we have no additional questions so that concludes our webinar and we look forward

to having you participate on the next webinar on September 19. And thank you to all the speakers who presented today.

Marianne Scheinholtz: Thank you.

Alixe McNeill: Have a good day.

Kathy Cameron: Thank you. Bye.