

**2013 Annual Report
To the Governor and Legislature of New York State
on Geriatric Mental Health & Chemical Dependence**

I: Background

New York State enacted the Geriatric Mental Health Act on August 23, 2005. The law, which took effect on April 1, 2006, authorized the establishment of an Interagency Geriatric Mental Health Planning Council (the Council), a geriatric service demonstration program, and a requirement for an annual report to the Governor and the Legislature with a long term plan regarding the geriatric mental health needs of the residents of New York.

In 2008, amendments to the Geriatric Mental Health Act expanded the scope of the Council to include chemical dependence and veterans. The amendments (1) changed the name of the Interagency Geriatric Mental Health Planning Council to the Interagency Geriatric Mental Health and Chemical Dependence Planning Council; (2) increased membership of the Council from 15 to 19 members; (3) added the Commissioner of Alcoholism and Substance Abuse Services and the Director of the Division of Veterans' Affairs as Co-chairs of the Council; (4) added the Adjutant General for the State of New York as an Ex-Officio member of the Council; and (5) changed requirements for Council recommendations and joint agency annual reports to include the Commissioner of Alcoholism and Substance Abuse Services, the Director of the Division of Veterans' Affairs, and the Adjutant General and to address geriatric mental health and chemical dependency needs.

II: Council Membership

The Interagency Geriatric Mental Health and Chemical Dependence Planning Council consists of 19 members, as follows:

- The Commissioner of the Office Mental Health (OMH), Co-chair of the Council;
- The Director of the Office for the Aging (NYSOFA), Co-chair of the Council;
- The Commissioner of Alcoholism and Substance Abuse Services (OASAS), Co-chair of the Council;
- The Director of the Division of Veterans' Affairs, Co-chair of the Council;
- One member representing the Office for People with Developmental Disabilities;
- The Adjutant General (Ex-Officio Member of the Council);
- One member representing the Justice Center for the Protection of People with Special Needs;
- One member representing the Department of Health (DOH);
- One member representing the Education Department and the Board of Regents;
- One member representing the Office of Children and Family Services;
- One member representing the Office of Temporary and Disability Assistance;
- Four members appointed by the Governor;
- Two members appointed by the Temporary President of the Senate; and
- Two members appointed by the Speaker of the Assembly.

III: Health Integration Projects

The first round of health integration projects funded in accordance with the Geriatric Mental Health Act spanned the years 2007-2012. OMH initiated a second round in April 2011 when it solicited proposals to integrate health care for the elderly by co-locating physical health professionals in behavioral health care settings (Model 1) or behavioral health professionals in physical health care settings (Model 2) to assist older adults with mental health and/or substance use disorders in New York State. A total of 21 grant awards were made in two phases for these two-year service demonstration projects, all of which were active in 2013.

While a program evaluation of the second round projects will be conducted after the grant period ends in 2014, project descriptions were updated for this report and are included in Appendix A.

The third round of service demonstration program grants continued to focus on health integration. OMH solicited new proposals in August 2013 to integrate physical and behavioral health care for older adults in either behavioral health care settings (Model 1) or physical health care settings (Model 2).

Because previous rounds of geriatric health integration projects demonstrated that collaborative partnership models of integrated health care increased the probability of creating and sustaining effective programs, applicants were required to engage in at least one formal internal or external agency partnership in order to assure the on-site provision of integrated services.

Six interagency technical evaluation teams comprised of DOH, NYSOFA, OASAS, and OMH staff reviewed and scored the 31 eligible proposals received. A total of ten awards were made throughout the State for these three-year service demonstration projects, which are expected to utilize Core Implementation teams, fast-track pre-implementation and program installation tasks, and be sustainable and fiscally viable without OMH support by the end of the grant period. See Appendix B for current project descriptions.

IV: Service Demonstration Project Supports

OMH staff in the Adult Community Care Group's Bureau of Program and Policy Development continue to provide ongoing program operational support for the geriatric service demonstration projects. Bureau staff have responsibilities for assigned projects that include on-site and off-site consultation and project oversight.

Geriatric Technical Assistance Center

In addition, OMH established a Geriatric Technical Assistance Center (GTAC) in 2011 and contracted with the National Council for Behavioral Health to provide programmatic and fiscal training and technical assistance for the service demonstration program grants. GTAC's work to promote the bidirectional integration of physical and behavioral health care for the elderly includes:

- Helping grantees identify the best clinical model for their target population and organization;
- Troubleshooting implementation issues;

- Coaching grantees on change processes to help implement work plans and meet overall grant goals;
- Hosting face-to-face learning community meetings, webinars, and group calls to provide direct information and facilitate communication among grantees;
- Reinforcing principles of integration, sharing best practices from around the country, and disseminating clinical, organizational, and fiscal resources based on individual and group needs; and
- Helping grantees use data to drive practice improvement.

With lessons learned from the geriatric service demonstration projects, a focus on fiscal viability, and the potential for providers to replicate or otherwise create effective and sustainable programs, progress continues to be made to better address the needs of older adults for mental health and chemical dependence services in New York State.

V: Planning

The first round of health integration projects (2007-2012) successfully established an effective mental health presence in primary care settings. Screening protocols resulted in the identification of a substantial number of individuals age 60 or older with some level of mental health need. These individuals were linked to services at a very high rate, and patients identified as having moderate to severe symptoms of depression and/or anxiety showed very high rates of improvement.

Program planners seeking to successfully develop the integration of mental health and physical health care in primary care settings would benefit from reviewing the evaluation data included in the 2012 Annual Report and considering the recommendations that emerged from lessons learned in order to maximize the probability of success.

The 2012 Annual Report remains accessible on the OMH Geriatric Mental Health website at <http://www.omh.ny.gov/omhweb/geriatric/reports/2012.pdf>. Slides of the evaluation data and lessons learned presented by OMH staff at the Sixth Annual Conference of the Geriatric Mental Health Alliance of New York in May 2012 also remain accessible on the website at <http://www.omh.ny.gov/omhweb/geriatric/2012mhany.pdf>.

Health Integration Planning Guide

Based on its training and technical assistance work in New York State for the second round of 21 health integration projects (2011-2014), GTAC recently developed a geriatric health integration planning guide to assist providers plan and sustain health integration programs for older adults in either physical or behavioral health care settings. Plans are under consideration to utilize the document more widely in New York as part of training and technical assistance not limited to the service demonstration projects.

The guide, “Integrated Primary Care and Behavioral Health Services for Older Adults: Options for New York State Providers,” is accessible at <http://www.nationalcouncildocs.net/wp-content/uploads/2013/08/Integration-Options-for-NYS-Providers-FINAL.pdf>.²⁴ It focuses on many common areas of inquiry and concern expressed by providers in New York State seeking to integrate health care services, including:

- *Preparing for Integration* – Describes the purpose of the guide, what it contains, and summarizes “A Standard Framework for Levels of Integrated Health Care” – the Center for Integrated Health Solutions’ classification of integrated care settings outlining six levels of integration with key elements distinguishing one level from another;
- *Integration Options for New York State Providers* – Presents three options for integrating physical health care into mental health clinic settings and three options for integrating behavioral health care into primary care clinic settings, including the advantages and disadvantages of each option;
- *Financing Integration* – Identifies three important financing factors to consider when determining what array of services an organization or combination of organizations will offer their clients and summarizes information about Medicare and Medicare Part B services;
- *Resources* – Provides links to many key New York State and Medicare documents; and
- *Appendices* – Adds details regarding “A Standard Framework for Levels of Integrated Health Care,” Licensure of Clinics and Individual Practitioners, Required and Optional Article 31 Service Definitions and Guidance, Practitioner Reimbursement under Medicaid Part 599 and Medicare Part B, Article 28 Extension and Part-Time Clinics, and Medicare Part B.

VI: Coordination with Other State Integration Initiatives

Medicaid Redesign

The Council has worked closely with the Department of Health (DOH) Division of Long Term Care to ensure coordination with three initiatives that impact integration of physical and behavioral health for older individuals: the Fully Integrated Duals Advantage (FIDA) Program, Balancing Incentive Program (BIP), and expansion of Managed Long Term Care (MLTC) enrollment.

Integrated Licensing Project

The Council has also been engaged with the joint DOH, OMH, and OASAS initiative to improve quality and coordination of care and streamline regulatory approval and oversight at agency clinics seeking to combine services – for which the agency is already licensed – in the same setting.

SAMHSA/ACL

New York State’s Geriatric Mental Health Act was the subject of a national webinar sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration for Community Living (ACL), entitled “Advancing Older Americans: Behavioral Health Collaboration – Closing the Gap.” Presentations by the Geriatric Mental Health Alliance of New York, NYSOFA, and OMH focused on innovative programs in New York State that utilized the collaboration of community providers and agencies to integrate behavioral health and aging network services or primary care.

Appendix A
Second Round of Health Integration Projects (2011-2014)

Phase I
(October 1, 2011 - September 30, 2013)

Model 1 Projects: Integrated Care in Behavioral Health Care Settings

- **Clubhouse of Suffolk's** plans to operate an integrated health care program for adults age 55 or older with a serious mental and/or substance use disorder were partially implemented. With an emphasis on coaching for the prevention and management of metabolic syndrome, peer wellness coach mentors were trained and engaged members in healthy lifestyle choices. Clubhouse continues to work on plans with Family Residences and Essential Enterprises to provide physical health services at its Personalized Recovery-Oriented Services program.
- **Flushing Hospital Medical Center's** outpatient mental health clinic established an integrated health care program – still in operation after the grant period – that enabled their older adult patients to access primary care services at the clinic. An organizing principle to implement the program was a Metabolic Syndrome performance improvement initiative. An adult health nurse practitioner, who focused on preventive care and the interrelationship between a patient's medical and psychiatric illnesses, coordinated physical and mental health care.
- **Interborough Developmental and Consultation Center** implemented an integrated physical and behavioral health care program for the elderly – still in operation after the grant period – at its Flatbush outpatient mental health clinic. This site has high concentrations of older Russian immigrants seeking care. A nurse practitioner worked in collaboration with a physician to provide integrated care, which included physical exams, health wellness groups, complex care management, and integrated physical and behavioral health treatment plans.
- **Mercy Medical Center** renovated space at its outpatient behavioral health services site in Garden City to conduct physical examinations, added part-time physical health care staff, and reorganized procedures to integrate the delivery of care provided by both physical and behavioral health staff. The integration project – still in operation after the grant period – recently acquired the part-time services of physicians affiliated with the hospital to prepare for the transition of fee-for-service Medicaid behavioral health services to managed care.
- **Southeast Nassau Guidance Center** planned and initially implemented an integrated health care program operating within the model of a person-centered healthcare home in which a nurse practitioner and other specialty staff assessed and medically monitored adults age 55 or older receiving treatment in its outpatient mental health clinic. When the program's nurse practitioner resigned, Southeast Nassau was unable to recruit a qualified replacement and withdrew from the service demonstration program prior to the end of the grant period.

**Phase II
(July 1, 2012 – June 30, 2014)**

Model 1 Projects: Integrated Care in Behavioral Health Care Settings

- **Comunilife** established Mi Salud, a program of coordinated behavioral and physical health care management for Latino adults age 55 or older in an outpatient mental health clinic in the Bronx that serves primarily Latino adults, children, and families. A nurse practitioner was added to a designated clinical team that includes a bi-lingual psychiatrist and a number of part-time social workers and therapists to address behavioral, physical, and socio-economic needs of low income seniors with psychiatric disorders and chronic physical illness.
- **Coney Island Hospital** planned but was unable to staff an outpatient mental health clinic satellite it established at the Council Center for Senior Citizens in Brooklyn with a part-time social worker and nurse practitioner to integrate a variety of physical health services with behavioral health care for a multi-ethnic population of older adults that includes Jewish-Americans, Russian, and Asian immigrants. The hospital withdrew from the service demonstration program prior to the end of the grant period.
- **Hudson Valley Mental Health** is partnering with Hudson River HealthCare, an Article 28 health facility, to integrate physical health care into its outpatient mental health clinics. The agency began by integrating care at its Dover Plains site, where physical health care visits are provided by a nurse practitioner from Hudson River.
- **Institute for Community Living** co-located a part-time physician, nurse care manager, and peer wellness coach in its outpatient mental health clinic in Canarsie to provide on-site health assessment/monitoring and care management/coordination. The target population is elderly clients who do not have primary care providers, those who are not using primary care providers listed in their records, and those receiving treatment from multiple health providers without the benefit of care coordination.
- **The Mental Health Association of Nassau County**, in partnership with Nassau University Medical Center, co-located a physician at its behavioral health site in Hempstead. The expectation is that the co-location of a primary care provider in this setting will allow it to function as a health home for their consumers. For mental health consumers age 55 or older, the goals are to improve overall health, promote recovery, foster independence, and reduce public expenditures.
- **Monsignor Carr Institute's** integration program is providing health screening and assessment, as needed physical examinations, health monitoring, follow-up, and care coordination services for clients age 55 or older at its outpatient mental health and chemical dependency clinics in Erie County. The agency hired a full-time medical assistant and contracted for a part-time nurse practitioner, who maintains regular hours at the two clinics and also consults with mental health and chemical dependency staff on treatment options.
- **Montefiore Behavioral Health Center (formerly Sound View Throgs Neck Community Health Center)** provides primary health care screening, intervention, and treatment services tailored to individuals age 55 or older with serious mental health and substance use disorders at its outpatient mental health clinic in the Bronx. The integrated program includes

the employment of primary care health professionals as well as referrals for highly complex cases to Montefiore Medical Center.

- **Service Program for Older People's** health integration program utilizes a psychiatric nurse practitioner to coordinate all medical services for SPOP's outpatient mental health clinic and homebound clients, and expanded the hours of their psychiatrist to work in partnership with her. While the program serves adults age 55 or older who come to the agency for behavioral health services, it especially seeks to focus on hard-to-reach groups of older adults, such as the frail homebound elderly and Spanish-speaking older adults.
- **Union Settlement Association** added a full-time nurse practitioner to the staff of its Johnson Counseling Center outpatient mental health clinic and its satellite senior centers in East Harlem to integrate health care for their clients age 55 or older. Working as part of a team with each client's therapist or social worker and primary psychiatrist, the nurse practitioner provides on-site physical health assessments, screening, monitoring, treatment, and referrals to partners and others for additional health services.

Model 2 Projects: Integrated Care in Physical Health Care Settings

- **Adirondack Medical Center** integrated behavioral health care services for adults age 55 or older into its primary health clinics in Essex and Franklin counties. A psychiatric nurse practitioner is co-located at the clinics, completing assessments and consulting with care team members. The program has enabled the medical home care team – which consists of primary care providers, care coordinator, nutritionist, doctor of pharmacy, psychiatrist, and health educator – address a larger range of patient issues.
- **Bassett Medical Center** is integrating behavioral health care for the elderly into its primary care clinic in Cobleskill, which is also a satellite location of Bassett's outpatient mental health clinic in Cooperstown. Patients complete basic behavioral health screens that are scored by primary care nursing staff, who refer those with positive scores to an on-site LCSW; she then completes the assessment process, in collaboration with the primary care team, and provides behavioral health treatment services, including counseling.
- **Cayuga Counseling Services** is providing behavioral health services to residents of two recently merged nursing homes (formerly Mercy Health and Rehabilitation Center and the Cayuga County Nursing Home). A licensed psychiatric nurse practitioner provides medication consultation services, and two licensed therapists provide therapy for adults age 55 or older. Program goals include the alleviation of symptoms of depression, anxiety, and psychosis, and improving the quality of life of residents who live there.
- **Family Services of Chemung County** is adding behavioral health assessment and treatment services to primary care at Arnot Medical Services' Eastside Family Medicine primary care office in Elmira. The office is also a satellite location of Family Services' outpatient mental health clinic. Designed to serve as a blueprint for integrated treatment in Chemung County, the program emphasizes the importance of illness prevention, early intervention, and relapse prevention.
- **Henry Street Settlement's** health integration program targets low income adults age 55 or older in New York City's Community District 3, including the Lower East Side and Chinatown, with a focus on older adults living in the Vladeck Houses Naturally Occurring

Retirement Community. A LMSW is stationed at the agency's Article 28 medical health care facility, which is located in the same building as its outpatient mental health clinic, and facilitates the integration of physical and behavioral health care and senior services.

- **Kingsbrook Jewish Medical Center** utilizes a psychiatric nurse practitioner to integrate behavioral health care services for the elderly at the hospital's Pierre Toussaint Family Health Center in the Bedford Stuyvesant – Crown Heights neighborhood of Brooklyn. With integrated patient care teams, the program seeks to identify and treat behavioral health disorders more effectively, modify negative lifestyle behaviors, improve self-management skills for those with one or more chronic diseases, and prevent avoidable hospitalizations.
- **Lincoln Medical and Mental Health Center** employs an enhanced chronic care model for the integration of care in its medicine and geriatric outpatient practices. The model co-locates a full-time LCSW and a consulting psychiatrist with primary care staff in a primary care setting and uses a collaborative, integrated, holistic approach to more effectively identify and treat behavioral health disorders among older patients with both chronic physical and mental health conditions.

Appendix B
Third Round of Health Integration Projects (2014-2016)

- **Catholic Charities Neighborhood Services – Model 1**
Catholic Charities plans to partner with the Joseph Addabbo Family Health Center – a Federally Qualified Health Center – to provide integrated physical and mental health care for individuals living in Far Rockaway, Queens. The target population is mostly older adults receiving services at Catholic Charities’ Rockaway Mental Health Services clinic and Rockaway PROS program, where a part-time primary care provider from Joseph Addabbo will hold office hours to provide physical examinations and health monitoring and link clients to specialty outpatient care. Outreach is planned to identify additional individuals in the community who would benefit from integrated care, especially those in need in the aftermath of Hurricane Sandy.

- **Central Nassau Guidance and Counseling Services – Model 1**
For a population of new and existing older adults in its outpatient mental health clinic in Hicksville, New York, Central Nassau will partner with Nassau Medical Associates to increase access and utilization of needed physical health care services, diagnose and treat physical health conditions, and produce better health outcomes. The project is to integrate comprehensive behavioral health treatment services with on-site primary care. Other services include management and monitoring of identified health problems, referral and coordination of specialty services, and as-needed assistance with transitional care coordination.

- **Citizen Advocates – Model 2**
Citizen Advocates, Inc., North Star Behavioral Services will partner with Alice Hyde Medical Center to integrate behavioral health screening, assessment, and treatment services for older adults in health centers in northern Franklin County located in Malone, Chateaugay, Moira, Fort Covington, and St. Regis Falls. Using a coordinated care model, two licensed clinical social workers will provide on-site behavioral health services as part of an integrated care team. The model includes treatment for patients using evidence-based practices and monitoring using validated clinical rating tools, linkage to care coordination, and regular case reviews by the care team with consultation for patients who do not show clinical improvement.

- **Equinox – Model 1**
Equinox and the Whitney Young Community Health Center – a Federally Qualified Health Center – will collaborate to provide integrated health care primarily for older adults in Equinox’s outpatient mental health clinic and PROS program in Albany, New York. A full-time registered nurse is to complete health assessments and function as a health coordinator. A part-time nurse practitioner from Whitney Young will be posted at the Equinox clinic, join the interdisciplinary team, conduct physical exams and provide routine and emergent physical health care services for recipients marginally linked or not linked to primary care providers, and make referrals for more specialized care.

- **Erie County Medical Center Corporation – Model 1**
For a target population of older adults with serious mental illness in Buffalo and Erie County, Erie County Medical Center will partner with the State University of New York at Buffalo’s

School of Medicine and Biomedical Sciences Department of Internal Medicine to address unmet needs for primary care services in two outpatient mental health clinic sites. Physical care is to be provided by a primary care physician and nurse. The project will utilize the Chronic Care Model, the hallmark of which is collaborative care, and the evidence-based practice of Illness/ Wellness Management and Recovery. A peer advocate will be available at each site to support self-management of chronic diseases and wellness goals.

- **FEGS Health & Human Services – Model 2**
FEGS will work closely with its partner, Maimonides Medical Center, to embed FEGS behavioral health services for older adults in two of Maimonides' outpatient primary care settings in Southwest Brooklyn. FEGS staff, operating as integral members of an integrated care team, will provide behavioral health screening, assessment, treatment, and case management services. Project goals are to identify and treat behavioral health disorders among the target population of older adults, implement a fully integrated care model, reduce or stabilize the severity of chronic medical conditions exacerbated by behavioral disorders, and ensure recipient input into program services.
- **Glens Falls Hospital – Model 2**
Glens Falls Hospital's Behavioral Health Services will internally partner with the hospital's Adirondack Medical Services to integrate behavioral health care for older adults in two of the hospital's rural health centers in Washington County – the Greenwich Regional Medical Center and Granville Family Health – to serve a particularly vulnerable, high need population. Two full-time psychiatric nurse practitioners, two full-time licensed clinical social workers, and two full-time medical technicians will be added to the project. Integration is expected to improve direct access to care, improve communication among providers, potentiate mutual support of shared goals, and assure that care is well coordinated.
- **Liberty Resources – Model 1**
Liberty Resources plans to partner with Upstate Cerebral Palsy to introduce and integrate primary care in Liberty's Brownell Center for Behavioral Health, an outpatient mental health clinic in Syracuse, New York. Joining the partnership will be Syracuse Jewish Family Services, whose staff will conduct or coordinate PEARLS (the Program to Encourage Active Rewarding Lives) depression screens for older adults at the Brownell Center, as well as in their places of residence and at identified community locations such as senior centers and geriatric housing programs. Project objectives include effectively managing chronic health conditions to avoid acute care crises and fully engaging older adults in their own health care.
- **Niagara Falls Memorial Medical Center – Model 2**
Niagara Falls Memorial, in partnership with its Department of Psychiatry and The Dale Association, aims to improve clinical outcomes and quality of life for older adults by integrating physical and behavioral health care and senior services at one of the hospital's primary care settings, the Summit Family Care Center in Wheatfield, New York; the services of a part-time senior advocate in the integrated practice are intended to address the psychosocial needs of older patients through linkages with housing, meal, caregiver, and other services. To encourage its adoption, the project also aims to teach physicians in training, behavioral health care agencies, and other primary care providers in Niagara County about the value of integrated health care.

- **Odyssey House – Model 2**

Through an internal partnership, Odyssey House will locate a full-time geriatric social worker at its Article 28 diagnostic and treatment center in East Harlem to facilitate the integration of behavioral health care in a physical health care setting. The target population is older adults who access primary care services at the center and have substance use disorders or co-occurring mental health and substance use disorders. Working as a member of the medical team, the geriatric social worker will provide screening, assessment, and brief intervention services and serve as a behavioral health care manager to ensure appropriate referrals for pharmacotherapy, psychotherapy, and substance use treatment.