



Interagency Geriatric Mental Health and Chemical Dependence Planning Council

Office of Mental Health

| Office for the Aging

| Office of Alcoholism and
Substance Abuse Services

| Division of
Veterans' Affairs

2017 Annual Report

to the Governor and Legislature of New York State
on Geriatric Mental Health and Chemical Dependence





Interagency Geriatric Mental Health and Chemical Dependence Planning Council

Office of Mental Health |

Office for the Aging |

Office of Alcoholism and
Substance Abuse Services

| Division of
Veterans' Affairs

INTRODUCTION

New York State continued to make significant progress addressing the mental health and chemical dependence needs of its older adults in 2017.

The Geriatric Mental Health and Chemical Dependence Planning Council (the Council) and its members collaborated in a number of important areas affecting the behavioral, physical, and psychosocial health needs of the state's older adult population. Initiatives to address geriatric health and behavioral health needs included a federally funded Certified Community Behavioral Health Clinic demonstration program and a Mental Health and Aging in Place initiative to better support and enable older adults with serious mental illness age in place. Two examples of state Council member agencies with a record of accomplishments and goals that address geriatric health and behavioral health needs of the residents of New York are noted in this report, as are a dozen illustrations of the work they accomplished and a sample of goals they set for 2018.

Finally, a fourth round of eight new geriatric service demonstration program grants was initiated during the year, and information about them includes updated project descriptions; project operational supports; and programmatic and fiscal technical assistance.

BACKGROUND

New York State enacted the Geriatric Mental Health Act in August 2005. The law, which took effect in April 2006, authorized the establishment of an Interagency Geriatric Mental Health Planning 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.

Funding to establish the geriatric service demonstration program was first approved during the state's 2006-07 budget year, the legislation calling for service demonstration projects in areas such as community integration, improved quality of treatment in the community, integration of services, workforce development, family support, finance, specialized populations, information clearinghouse, and staff training.

Amendments to the Geriatric Mental Health Act in 2008 expanded the scope of the Council to include chemical dependence and veterans. The amendments changed the name of the

Interagency Geriatric Mental Health Planning Council to the Interagency Geriatric Mental Health and Chemical Dependence Planning Council, increased membership of the Council from 15 to 19 members, added the Commissioner of Alcoholism and Substance Abuse Services and the Director of the Division of Veterans' Affairs as co-chairs of the Council, added the Adjutant General as an ex-officio member of the Council, and changed requirements for Council recommendations and joint annual reports to address both geriatric mental health and chemical dependence needs.

COUNCIL MEMBERSHIP

The Council consists of the following 19 members:

- 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 (DVA), Co-chair of the Council;
- One member representing the Office for People with Developmental Disabilities;
- The Adjutant General;
- One member representing the Justice Center for the Protection of People with Special Needs (Justice Center);
- 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 (OCFS);
- 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.

COUNCIL COLLABORATION

The Council and its members continued to collaborate with others in a number of important areas affecting the behavioral, physical, and psychosocial health needs of older adults in New York State in 2017. Council meetings included presentations, agency updates, and reporting on work related to:

- Certified Community Behavioral Health Clinic demonstration projects in New York State;
- The Health Across all Policies initiative;
- Health disparities for older Asian Americans;
- NYSOFA's partnership with Boston University and the Association on Aging in New York for online course work focused on older adults leading to a case management certificate;
- An OMH long-term care initiative;
- Personalized Recovery-Oriented Services for older adults;
- The prevalence and significance of late life addiction;
- Reducing costs while improving behavioral health care in six western New York counties;
- Substance use and addiction in older adults;

- Technical assistance and partnership building in eight new *Partnership Innovation for Older Adults* service demonstration projects;
- Telepsychiatry regulations;
- Tools to assist adult protective staff conduct financial exploitation investigations; and
- The tenth anniversary of New York State's geriatric service demonstration program.

Council member agency staff also supported a number of statewide conferences and other education and training initiatives related to older adults by assisting in planning programs, delivering presentations, and serving on expert panels.

Of note was the 2017 Adult Abuse Training Institute on *Social Isolation: Our Clients & Our Work*, which was presented by the Brookdale Center for Healthy Aging on behalf of OCFS and brought together more than 400 participants from public, non-profit, and private sector service providers. Staff from four Council member agencies served on the institute's steering committee, and staff from DOH, DVA, the Justice Center, NYSOFA, OASAS, OCFS, and OMH conducted a number of workshops, including "Law Enforcement and the Aging Population," "The Social Determinants of Mental Health," "Social Isolation and Withdrawal Among Veterans," and "Older Adults and Opioids: A Statewide Response."

INITIATIVES

Two examples of initiatives to address the geriatric health and behavioral health needs of the residents of New York State in 2017 included (1) the state's selection by the U.S. Department of Health and Human Services as one of eight states in the country to participate in a two-year Certified Community Behavioral Health Clinic demonstration program, which started in July, and (2) the beginnings of an initiative to better support and enable older adults with serious mental illness age in place.

Certified Community Behavioral Health Clinic Demonstration Projects

The Certified Community Behavioral Health Clinic (CCBHC) program model is designed to provide a comprehensive array of mental health and substance use disorder services "across the life span," i.e., for people of all ages including older adults. Treatment is age-appropriate for the consumer's phase of life and development; in fact, the model identifies older adults as one of four specific age groups for whom life stage and functioning may affect treatment, so that when service planning for older adults, an individual consumer's wishes and functioning are considered in determining and providing appropriate evidence-based treatment services.

CCBHCs are required to provide a broad array of nine services, some of them directly and some of them through referral or formal relationship with another provider or Designated Collaborating Organization (DCO). Whether directly provided by the CCBHC or by a DCO, the CCBHC is ultimately clinically responsible for all care provided. The nine core services are:

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization;
- Screening, assessment, and diagnosis, including risk assessment;
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning;
- Outpatient mental health and substance use services;

- Outpatient clinic primary care screening and monitoring of key indicators and health risk;
- Targeted case management;
- Psychiatric rehabilitation services;
- Peer support and counselor services and family supports; and
- Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

An integral component of the CCBHC program model is care coordination with other providers and systems, including but not limited to criminal justice, foster care, child welfare, education, primary care, and hospital service providers and systems.

The two-year CCBHC demonstration program includes provisions for community-based behavioral health care for members of the armed forces and veterans that could help address the unmet mental health and substance use treatment needs of many of the state's veterans, nearly 441,000 or 53 percent of whom are age 65 or older. Veterans who inquire about CCBHC services will be offered a referral to enroll in Veterans Health Administration (VHA) programs for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA, including clinical guidelines contained in the Uniform Mental Health Services Handbook.

DVA, in partnership with OASAS and OMH, presented an overview of veterans benefits for CCBHC providers in March 2017 to support their plans and enhance their abilities to serve the state's veteran population. Presentation topics included agencies and organizations already serving veterans, the federal Department of Veterans Affairs and its three administrative divisions, the definition of a veteran, state and federal veterans benefits and benefit advisors, and OASAS providers with programs that include veterans services.

Regardless of condition, CCBHCs are to provide services for all who seek help and may not refuse service to any individual on the basis of ability to pay or place of residence. Populations for which services should prove particularly valuable include individuals with serious mental illness, those with severe substance use disorders, and those with co-occurring mental health, substance use, or physical health disorders.

New York State's 13 Certified Community Behavioral Health Clinic demonstration program providers are:

- BestSelf Behavioral Health, Buffalo, NY;
- Bikur Cholim, Monsey, NY;
- Central Nassau Guidance and Counseling Services, Hicksville, NY;
- Citizen Advocates, Malone, NY;
- Endeavor Health Services, Cheektowaga, NY;
- New Horizon Counseling Center, Ozone Park, NY;
- PROMESA, Bronx, NY;
- Samaritan Daytop Village, NY, NY;
- Services for the UnderServed, NY, NY;
- Spectrum Human Services, Buffalo, NY;

- Strong Memorial Hospital, Rochester, NY;
- Syracuse Behavioral Healthcare, Syracuse, NY; and
- VIP Community Services, Bronx, NY.

Mental Health and Aging in Place

OMH dedicated additional staff resources to work in the area of long-term care to complement efforts already underway in 2017 as a result of a new round of geriatric service demonstration grants and to help establish an initiative to better support and enable older adults with serious mental illness age in place.

A series of conference calls with OMH residential providers was conducted over a period of several months on the home care service needs of individuals with mental illness. Providers shared what they learned about the resident needs they identified, barriers to accessing services, and strategies to increase access to home care and make aging in place possible.

At the annual conference of the Association for Community Living Agencies in Mental Health in November 2017, OMH co-facilitated a panel discussion with the Home Care Association of New York State on “Aging in Place – Utilizing Community Long Term Services and Supports in OMH Residential Programs” for participants that included home care agencies and housing providers. The panel and those in attendance identified the following common needs of individuals seeking to age in place:

- More assistance with housekeeping, personal care, home health care, skilled nursing and specialized therapies, environmental modifications (such as grab bars), access to elevators, and medication management and administration;
- When transitioning to a more independent setting, assistance with adapting to the new, more independent living environment and to community integration;
- Assistance with re-establishing, applying for, and coordinating benefits across multiple systems (such as aging, physical health, and behavioral health) and with benefits from sources such as Medicaid, Medicare, Supplemental Nutrition Assistance Program, Home Energy Assistance Program, and the Department of Veterans' Affairs;
- Assistance with managing chronic disease and making healthy lifestyle choices; and
- Respect for a resident's wishes to die with dignity in the setting of his or her choice at end of life.

Under consideration at the present time are pilot projects that foster close partnerships and working relationships between behavioral health housing providers and home health/personal care agencies to better serve individuals with serious mental illness and long-term care needs. An integrated, person-centered team approach to in-home services, combined with wrap around community supports, is expected to facilitate transition to more independent settings in the community and reduce unnecessary emergency department and inpatient hospital visits.

The pilots will offer integrated provider teams an opportunity to see what works best and what benefits accrue as a result of working together. It will also give them real world experience in planning for the provision of long term services needed to enable the individuals they serve – and others like them – successfully age in place.

ACCOMPLISHMENTS AND GOALS

DOH and NYSOFA are two examples of state Council member agencies with a record of accomplishments and goals that address geriatric health and behavioral health needs of the residents of New York State. Presented below are a dozen illustrations of the work they accomplished on behalf of older adults in 2017 and a sample of the goals they set for 2018.

Health Across All Policies

Using social determinants of health and DOH's Prevention Agenda to improve health and reduce health disparities, the goal of this 2017 state initiative involving DOH, NYSOFA, the Department of State, and others has been to embed health and healthy aging into state agency decision making, resulting in more livable communities for people of all ages. In a related development, the American Association of Retired Persons (AARP) and the World Health Organization named New York the first "age-friendly state" in the country based on eight domains of livability that influence the quality of life of older adults.

Reducing Social Isolation

Social isolation and loneliness in older adults is a growing public health concern. Because meaningful relationships reduce the negative impact of isolation and loneliness and improve physical and mental health, DOH and NYSOFA have been planning to establish regional hotlines based on a successful "Silver Line" program in the United Kingdom to support older adults in the community or in institutional settings who are socially isolated or lonely. Part of a larger program that will expand to other areas of the state, a pilot project funded by AARP to establish such a hotline in the Rochester area is expected to start in 2018.

Future of Family Caregiving Summit

Co-sponsored by AARP, DOH, NYSOFA, the New York State Health Foundation, and the United Hospital Fund, more than 70 participants from public, private, and nonprofit organizations attended a summit on the *Future of Family Caregiving* in 2017 that included presentations on the need to develop innovative ways to support family caregivers. One such presentation noted DOH's "Aging Innovation Challenge," which is offering a total of \$50,000 for five finalists and one grand prize winner from college and university communities in the state to come up with new tools to help aging New Yorkers complete activities of daily living in the future.

Alzheimer's Caregiver Support

More than half of New York's Alzheimer's patients live at home, and 75 percent of those who live at home do so with a family member or friend who provides care. DOH community-based initiatives providing clinical services and supporting the caregivers of those with Alzheimer's disease or other dementias (AD/D) include ten Centers of Excellence for Alzheimer's Disease, six Alzheimer's Disease Community Assistance Programs, ten Alzheimer's Disease Regional Caregiver Support Initiatives, and 15 Alzheimer's Disease Caregiver Support Initiatives for Underserved Communities. An evaluation of the first year of these initiatives found:

- 20,389 consultation services were provided for 6,234 caregivers;
- 5,174 participants attended 3,217 new support group sessions;
- 12,803 participants attended 1,770 education sessions;

- 5,076 new medical diagnostic assessments were conducted for AD/D;
- 18,359 physician referrals were made to community providers;
- 23,505 Helpline calls were received serving 12,596 individuals; and
- 49,897 hours of respite care were provided for 1,888 caregivers.

Money Follows the Person

The Money Follows the Person demonstration program administered by DOH is part of federal and state initiatives designed to rebalance long-term care services and promote consumer choice. The program funds transition specialists and peer support to assist individuals transition out of institutions, such as nursing homes and intermediate care facilities, and into qualifying community settings. In 2017 DOH saw that a variety of trainings were held for transition specialists and peers, as well as presentations and support for nursing home residents transiting into the community.

Managed Long-Term Care

Managed Long-Term Care (MLTC) is a system that streamlines the delivery of long-term care services to individuals who are chronically ill or disabled and wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through MLTC plans that are approved by DOH. While enrollment may be mandatory or voluntary depending on individual circumstances, the entire array of services to which an enrolled member is entitled can be received through the chosen MLTC plan. A total of 219,392 individuals were enrolled in the program by the end of 2017.

Nursing Home Transition and Diversion Waiver

Administered by DOH, this Medicaid waiver program utilizes Medicaid funding to provide supports and services to assist individuals with disabilities and seniors with successful inclusion in the community, whether they come from a nursing facility or other institution (transition) or choose to participate in the program to prevent institutionalization (diversion). Waiver services may be considered when available supports and services are insufficient to assure an individual's health and welfare in the community or when they are a more efficient use of Medicaid funds. In 2017 the program served 2,432 individuals and offered housing support to 542 individuals.

Traumatic Brain Injury Waiver

This waiver program, also administered by DOH, provides 11 Medicaid funded services needed to assist eligible individuals with a primary diagnosis of traumatic brain injury (TBI) or similar non-degenerative condition that results in deficits similar to a TBI live in community-based settings and achieve maximum independence. A Regional Resource Development Specialist oversees enrollment in the program, assists individuals select a services coordinator, and approves service plans. The program served 3,112 individuals and offered housing support to 907 individuals in 2017.

Mental Health First Aid

Because many of the older adults that NYSOFA serves exhibit risk factors or warning signs of mental health problems often found among seniors, such as symptoms of anxiety or depression,

the agency contracted with the Mental Health Association of New York State in 2017 to provide Mental Health First Aid training to nearly 300 aging services professionals in nine regions across the state. The eight-hour course used role playing and simulations to demonstrate how to offer initial help in a mental health crisis and how to connect individuals to appropriate professional, peer, social, and self-help care and resources.

Case Management and Behavioral Health in Aging Certificate Programs

In partnership with the Association on Aging in New York and Boston University's Center for Aging and Disability Education and Research, NYSOFA instituted an online Case Management Certificate Program in 2016 to promote enhanced core values, knowledge, and skills essential for care managers serving older adults in New York. Added in 2017 was an online Behavioral Health in Aging Certificate Program to address mental health and substance use conditions and concerns involving older adults. More than 865 aging service professionals have completed one or both of the 19-hour trainings, each of which requires testing and competency evaluation.

Aging Concerns Unite Us Conference

NYSOFA's 2017 annual conference, sponsored by the Association of Aging in New York, was attended by more than 500 professionals from New York State who provide services for older adults and their caregivers. Largely focused on innovative programs and technologies from the state's aging services network that promote aging in place, the conference featured workshops on replicable practices such as aging with HIV, dementia care coaching, tips from healthy living research, innovative caregiver practices, navigating MLTC, partnering with disability organizations, protection from senior scams, and telehealth intervention programs.

Aging Mastery Program

Developed by the National Council on Aging, Aging Mastery is a 10-session engagement and behavior change program designed to educate, encourage, and support older adults improve their health, financial security, and overall well-being. NYSOFA expanded the program to 12 counties in 2017 following a research trial in New York whose preliminary results found that participants who completed the core curriculum significantly increased their physical activity levels, healthy eating habits, use of advanced planning, social connectedness, and participation in evidence-based self-management programs.

Reducing Depression and Improving Quality of Life

A number of local offices for the aging in NYSOFA's aging services network established a Program for Encouraging Active Rewarding Lives (PEARLS) for Older Adults in their counties. Designed to be part of existing community-based programs that already deliver care and provide resources to individuals, PEARLS for Older Adults is an evidenced-based treatment for minor depression and dysthymic disorder in adults age 60 or older that utilizes in-home problem-solving treatment, social and physical activation, and pleasant activity scheduling to teach the skills necessary to move to action and make lasting life changes.

Technology in Support of Older Adults

NYSOFA's Aging Services mobile app – the first of its kind in the country – was introduced in 2017 to link older New Yorkers and their families to local community resources and services, information and assistance on long-term care services and supports through New York

Connects, and timely news and updates on state and federal programs affecting older adults. Also, the agency has been working with Older Adults Technology Services to support programs across the North County that enable older adults to access, adopt, and use broadband and internet technologies to increase social connectedness and reduce social isolation.

Sample of DOH Goals for 2018

- Ensure implementation of the Assisted Living Demonstration Pilot Project, which would allow residents with dementia who have exhausted their financial resources the ability to remain in their residences rather than have to move to more costly and restrictive nursing homes
- Advance early detection of Alzheimer's Disease and other dementias
- Conduct a program evaluation of year two of the New York State Alzheimer's Disease Caregiver Support Initiative to determine the impact of services and support interventions

Sample of NYSOFA Goals for 2018

- Expand PEARLS and Mental Health First Aid training throughout the state
- Facilitate local partnerships to continue to reduce social isolation through expanding the Aging Mastery Program, supporting the expansion of the Village to Village movement, and expanding transportation options
- Pilot the use of iPads for older New Yorkers who are socially isolated
- Significantly increase behavioral health screenings through the state's expanded and enhanced No Wrong Door system
- Strengthen relationships between local area agencies on aging and behavioral health providers to increase referrals for treatment

SERVICE DEMONSTRATION PROJECTS

A fourth round of geriatric service demonstration program grants made possible by the Geriatric Mental Health Act was initiated in January 2017. Entitled *Partnership Innovation for Older Adults*, a total of eight awards were made for five-year projects to create local "triple partnerships" of mental health, substance use disorder, and aging services providers to innovatively address the unmet needs of older adults for such services.

Project Requirements

Each of the new service demonstration projects is required to form a local "triple partnership" of mental health, substance use disorder, and aging services providers; include the local Office for the Aging as a member of the partnership with partnership responsibilities or as an organization with a key role in carrying out the program; and serve the target population, which is older adults age 55 or older whose independence, tenure, or survival in the community is in jeopardy because of a behavioral health problem. In addition, each new project is to:

- Access behavioral health services to meet the needs of older adults in aging services programs who need them;
- Access home and community-based, non-medical, aging support services to meet the needs of older adults in behavioral health services programs who need them;
- Identify at-risk older adults in the community who are not connected to the service delivery system and those who encounter difficulties accessing needed services. Mobile Outreach

and Off-site Services are to be used to assess unmet needs for behavioral health and aging services – as well as unmet needs related to areas such as physical health, cognition, social isolation, self-neglect, abuse, housing, financial resources/benefits, and legal issues – and see that needed services are provided; and

- Utilize one or more technological innovations to better serve the target population and help the program and its staff innovatively address the unmet needs of the target population.

Project Descriptions

Central Nassau Guidance & Counseling Services' triple partnership includes the Family & Children's Association and the Nassau County Department of Health and Human Services' Office for the Aging, with each of the three agencies responsible for delivering a specific set of services. The program, called the Link-Age Project, is designed to identify the need for mental health, substance use, and aging services and utilizes care coordination to provide connections to a range of supports delivered by more than 75 agencies in Nassau County. The Link-Age Project is focused on older adults 55 and older throughout the county, with an estimated 40 percent of service recipients expected to be black or Hispanic.

Formerly Putnam Family & Community Services, **CoveCare Center's** triple partnership includes the Putnam County Office for Senior Resources and the National Council on Alcoholism & Other Drug Dependencies/Putnam. The project provides care management, behavioral health treatment, and recovery coaching for older adults. Most services are delivered on-site in the homes of seniors or elsewhere in the community to support living in place. In addition, telehealth monitoring is used to monitor medical and behavioral health conditions in order to address issues and challenges as they arise in the lives of the program participants and to decrease hospitalizations.

Family Services of Westchester's triple partnership, which includes the Westchester County Department of Senior Programs and Services and the Lexington Center for Recovery, has as its overarching goal reduction of the isolation and decline that can accompany untreated behavioral health conditions. The project provides older adults with care management and behavioral health and aging services, delivering in-home services and utilizing telehealth monitoring to engage individuals who historically have been disconnected from services. A special focus of the program is assisting older adults enhance the quality of their lives while helping them live independently in the community.

Flushing Hospital Medical Center's triple partnership includes the New York City Department for the Aging and Arms Acres. The project provides culturally and linguistically competent behavioral health and aging services for a population of older adults in a community-based senior center that serves a racially and ethnically diverse neighborhood of Flushing, New York. The program utilizes outreach and engagement strategies to link older adults to services and social support opportunities, as well as health monitoring technology to assist individuals create behavioral modification objectives to improve their health and mental health outcomes and overall quality of life.

The **Institute for Family Health's** triple partnership includes the Ulster County Office for the Aging and Step One Child & Family Guidance Center Addiction Services. The project utilizes mobile outreach to engage older adults who are not connected with the county's traditional behavioral health and aging services and provides care navigation and behavioral health and aging services to older adults to increase access to services and reduce barriers to engagement

in services. The program also increases access to services by providing transportation for individuals who need it and by utilizing telehealth technology to deliver in-home behavioral health services.

With the Niagara County Office for the Aging and Northpointe Council as partners, the **Niagara County Department of Mental Health's** triple partnership is focused on creating a strong, connected network of behavioral health and aging services providers and leveraging other existing supports to meet the needs of at-risk older adults in Niagara County, helping them not only remain safe in the community but also flourish. The project is utilizing community-based case management staff to ensure the ability to reach isolated individuals and those who are reluctant to reach out because of cultural beliefs or stigma.

The **Onondaga County Department of Adult & Long Term Care Services** and its partners, Liberty Resources and Syracuse Behavioral Health, formed a triple partnership to expand services for a diverse population of older adults. The program, called the Senior Health and Resource Partnership Project, seeks to increase the integration of aging and behavioral health services while addressing natural and manufactured barriers to service accessibility. One innovation being tested is the utilization of remote mobile technology to provide in-home mental health and substance use counseling for individuals who are not emotionally or physically able to visit behavioral health agencies for on-site services; the equipment being tested can also be used by those with low vision or who are hard of hearing or deaf.

The **Orange County Department of Mental Health's** triple partnership includes Catholic Charities of Orange County and the Orange County Office for the Aging. The project offers older adults behavioral health assessment and treatment services, as well as linkages to existing aging and other community-based services. In addition, it utilizes mobile outreach strategies, in-home service provision options, and telepsychiatry technology to increase engagement among individuals who have difficulty accessing place-based services and treatment. The program also provides training for all partners on cultural competence, suicide prevention, and screening for behavioral and primary care health needs.

Project Supports

As they did for the first three rounds of geriatric service demonstration program grants, OMH staff in the Division of Adult Services' Bureau of Program and Policy Development provided ongoing program operational support for the service demonstration projects in 2017. Bureau staff have responsibilities for assigned projects that include on-site and off-site consultation and project oversight and work closely with staff responsible for the operation of New York State's Geriatric Technical Assistance Center (GTAC).

OMH established GTAC in 2012 to provide programmatic and fiscal technical assistance for the service demonstration projects. Staffed by the National Council for Behavioral Health, GTAC's work with the eight new *Partnership Innovation for Older Adults* projects in 2017 included:

- Hosting an introductory webinar for all of the service demonstration projects;
- Visiting each of the project sites for half a day in the spring;
- Conducting quarterly individual project coaching calls;
- Conducting group coaching calls as needed on topics such as troubleshooting implementation challenges, executing action plans, and using the Patient Health Questionnaire as a clinical tool;

- Hosting three face-to-face Learning Community meetings in Albany that covered topics such as “Creating a Vision for Healthy Aging and Services to Support It,” “Older Adults and the Intersection of Aging, Mental Health, and Substance Use: An Overview of Challenges, Strategies, and Evidenced-Based Practices,” and “Key Considerations for Substance Use and Addiction in Older Adults”;
- A monthly *Partnership Innovation for Older Adults* newsletter;
- Hosting and cross-promoting webinars relevant to working with older adults; and
- A Listserv to encourage sharing and discussion among projects.

SUMMARY

Planning to address the mental health and chemical dependence needs of older adults in New York State is taking full advantage of the collaborative efforts of the Geriatric Mental Health and Chemical Dependence Planning Council; a number of federal and state initiatives; state Council member agency accomplishments and goals; and new *Partnership Innovation for Older Adults* service demonstration program grants to create local partnerships of mental health, substance use disorder, and aging services providers to innovatively address the unmet needs of older adults these services.