NEW YORK STATE

Office of Mental Health | Office for the Aging
Office of Addiction Services and Supports | Department of Veterans' Services

Interagency Geriatric Mental Health and Substance Use Disorder Planning Council

2024 ANNUAL REPORT

Geriatric Mental Health and Substance Use Disorders

TABLE OF CONTENTS

INTRODUCTION

New York has the fourth largest population of individuals aged 60 and older in the nation at 4 million. In 2025, the population of individuals aged 60 and over is projected to account for 25% of all people in 33 counties and 30% of all people in 18 counties. Older New Yorkers and baby boomers make up 65% — $481 billion — of all the household income generated in New York State (NYS). They support local businesses, Medicaid and schools through home ownership, contributing significantly to the local and state economy and care economy. Approximately 935,000 New Yorkers over the age of 55 contribute more than 495 million hours of community service at an economic value of more than $13.9 billion annually; 80% of the state retirement system payouts stay in New York State at a value of $10.6 billion annually; and 64% of New Yorkers aged 60 and over own their own homes and have no mortgage.

As part of the 2024 State of the State address, Governor Kathy Hochul expanded her commitment to tackling the mental health crisis for people of all ages. Governor Hochul's initiatives focused on addressing untreated serious mental illness across the lifespan; continuing to increase inpatient psychiatric bed capacity; taking aggressive action to bolster insurance coverage of mental health services; and going after insurers that do not comply with New York State laws.

This 2024 Interagency Geriatric Mental Health and Substance Use Planning Council Annual Report details some of the work accomplished by state agencies and other interested and engaged stakeholders to address the mental health, substance use, and aging services needs of older adults in New York State.

2024 Annual Report Highlights

Mid-term analysis on round five of the geriatric service demonstration grants, Partnership to Support Aging in Place for Communities Severely Impacted by COVID-19, has identified several positive impacts that the demonstrations have had on the lives of older adults receiving services, including reduced social determinant of health-related needs as well as reductions in severity of depression, anxiety, and loneliness.

- Cross-service system education focused on older adults was delivered through trainings provided by the Adult Abuse Training Institute, the Association for Community Living, the Alliance for Rights and Recovery, the Healthy Aging Academy for Supportive Housing Providers, the Home Care Association of New York State, and through the Internships in Aging Project out of SUNY Albany.
- Data analysis of populations served by Office of Mental Health services shows the prominence of clients who are older adults engaged with a variety of programs, including Mental Health Outpatient Treatment and Rehabilitative Services (formerly mental health clinic), Assertive Community Treatment teams, Safe Options Support teams for homeless individuals, and OMH's Suicide Prevention Center of New York.
- Significant progress has been made by the State Office for the Aging on the Master Plan for Aging, with the goal of bringing together State agencies that are members of the Council as well as other interested stakeholders, to provide policy recommendations to improve the lives of older adults.
- The State Office for the Aging has prioritized the innovative utilization of technology to increase access to services and supports and engage with individuals across the lifespan. This approach is shown to help older

adults remain in their homes, connect with loved ones, engage with their communities of choice, support caregivers, and participate in activities across a variety of platforms.

- The Office of Addiction Services and Supports has continued to support the establishment and expansion of programs that provide person-centered, trauma-informed care that is responsive to the unique needs of older adults including addiction prevention efforts and work on new guidance on older adults and substance use.
- The NYS Department of Veterans' Services and the NYS Dwyer Peer to Peer Veteran Support Program provided numerous services for older adults in 2024. Population data suggests that more than half of the Veteran population in New York State is aged 65 or older with needs ranging from disability compensation, non-service-connected pension, preventing food insecurity, restoring honor to Veterans who received unjust military discharges, providing social connection, and supporting veterans with emergency housing.

Geriatric Mental Health Act

New York State enacted the Geriatric Mental Health Act in 2005, which authorized the establishment of an Interagency Geriatric Mental Health Planning Council (the Council), a Geriatric Service Demonstration Project, and an annual report to the governor and the Legislature highlighting current work and recommendations to meet the behavioral health and aging services needs of state residents. New York State first approved funding to establish the geriatric service demonstration project during the Fiscal Year 2007 budget. Geriatric service demonstration projects focus on the following areas to support older adults: community integration, improved quality of treatment in the community; integration of aging services and behavioral health services; workforce development programs and the use of peer support; family and caregiver support; financing methodologies; cultural minorities and Veterans as specialized populations; development of an information clearinghouse; and ongoing staff training initiatives.

Subsequent amendments to the Geriatric Mental Health Act expanded the scope of the Council; changed its formal name to the Interagency Geriatric Mental Health and Substance Use Disorder Planning Council; increased membership from 15 to 19 members; added the commissioner of the Office for Addiction Services and Supports and the director of the Department of Veterans' Services as co-chairs of the Council; added the adjutant general as an ex-officio member of the Council; and changed requirements for recommendations and joint annual reports to address geriatric mental health, aging service needs, and problem gambling and substance use disorder needs. An amendment in 2018 acknowledged the desire for most older adults to age in the place of their choosing and was added to foster the collaboration between licensed or certified providers of home care services and mental health providers for the integration of physical health and mental health care.

Council Membership

The Interagency Geriatric Mental Health and Substance Use Disorder Planning Council is composed of the following 19 members:

- Commissioner of the Office of Mental Health, co-chair of the Council.
- Director of the Office for the Aging, co-chair of the Council.
- Commissioner of the Office of Addiction Services and Supports, co-chair of the Council.

- Commissioner of the Department of Veterans' Services, co-chair of the Council.
- The adjutant general, Division of Military and Naval Affairs.
- One member representing the Office for People with Developmental Disabilities.
- One member representing the Justice Center for the Protection of People with Special Needs.
- One member representing the Department of Health.
- 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.
- Two members appointed by the speaker of the Assembly.

Council Collaboration and Cross Service Systems Work

In 2024, the Council and its members continued their long-standing collaboration with other state agencies and community stakeholders in several important areas affecting the behavioral health, physical health, and psychosocial needs of older adults across the state.

- The Office of Mental Health (OMH) hosted virtual Council meetings on February 29th, June 4th, and September 26th, 2024, that included discussions and reporting on work related to:
    - OMH updates on round five of the Geriatric Service Demonstration grants, *Partnership to Support Aging in Place in Communities Severely Impacted by COVID-19,* and the program focus on a triple partnership of mental health, substance use, and aging service providers.
    - State Office for the Aging (NYSOFA) updates, preliminary report, and next steps for the Master Plan for Aging. Key discussion areas included social determinants of health and increasing equitable access to care; leveraging existing technologies to support older adults in the community; and promoting early detection of aging services needs and linkages to care with equitable access for older adults.
    - Office of Addiction Supports and Services (OASAS) updates on substance use treatment and resources for older adults. Key discussion areas included the increasing older adult population in New York State, additional risks that older adults face when taking medications that may interact with alcohol, and binge drinking among older adults.
    - Panel discussions on Mental Health and Substance Use Disorder Services for Older Adults; Dementia and Brain Health for Older Adults in New York State; and the Wellness Initiative for Senior Education-Screening, Brief Intervention and Referral to Treatment (WISE-SBIRT) screening and treatment program model.
- Master Plan for Aging collaboration among various State agencies including the NYS Department of Health (NYSDOH), NYSOFA, and OMH in response to the Governor's initiative to focus on the health of older adults.

- Department of Veteran's Services (DVS) and OMH collaborate with other stakeholders in a multiagency Dwyer Peer to Peer Program Workgroup that meets weekly to discuss Veteran related topics, including support and outreach to Veterans as they age. Nearly 70% of New York State Veterans are aged 55 and older.
    - The Dwyer Peer-to-Peer program offers a variety of non-clinical supports delivered by Veterans to Veterans to reduce social isolation and loneliness, build community, and promote pro-social activity.

Geriatric Service Demonstration Projects Round Five

2024

The latest Geriatric Mental Health Act service demonstration grants, the Partnership to Support Aging in Place in Communities Severely Impacted by COVID-19 (PSAP), targets the ongoing negative impact caused by the COVID-19 pandemic on the mental, behavioral, and physical wellbeing of older adults. Through a competitive process, six grants were awarded which run from January 1, 2022, through December 31, 2026. Each site was awarded up to $300,00.00 per year. Programs aim to support older adults aged 55 years and older with aging in the communities of their choosing. These individuals may be unconnected or inconsistently connected to a system of care; may have diagnosed, undiagnosed or subacute behavioral health needs; have chronic medical conditions; and their tenure in the community may be at risk.

The program model requires the development of a triple partnership between an Office of Mental Health (OMH) licensed provider, an Office of Addiction Services and Supports (OASAS) provider, and a local Area Agency on Aging. Program objectives include, but are not limited to:

- Analysis of community need and identification of community-based resources;
- Community outreach and education to identify and refer at-risk individuals, linking them to services;
- Assessment of behavioral and physical health needs, environmental and social needs to support aging in place;
- Mobile and community-based services to increase access to support services;
- Care coordination including linkage to aging services and other provider agencies as needed;
- Peer services to improve outreach and engagement, reduce social isolation, loneliness, and the negative impacts of stigma;
- The use of technology to increase outreach while improving access and participation in care;
- Funding to support aging in place and independence based on a person-centered approach.

The service demonstration grantees have developed innovative and integrated models of care for older adults with mental health, substance use, and aging services needs. Programs funded by these grants are expanding on those models that integrate behavioral health treatment as well as aging services, with an emphasis on reaching out to older adults severely impacted by COVID-19, not connected with site-based service systems, and leveraging technology and peer services to improve access and better serve this population. Lessons learned from the geriatric service demonstration projects are being incorporated into the New York State Master Plan for Aging.

Table 1. Partnership to Support Aging in Place Service Demonstration grantees

Primary Agency	Partnership Name	Location
Orange County Mental Health	EWOGI	Orange County
Ohel Children's Home and Family Services	LACES	Queens County
Central Nassau Guidance Center	Link-Age	Nassau County
Common Point Queens	MIST	Queens County
Jamaica Hospital	SAIL	Queens County
SPOP	STRIVE	Kings County

Program Development

The first two years of the grant implementation process comprised of program planning and development, partnership development, public outreach and marketing, identification of target population, testing workflows, and program innovation. The program partnerships entered the third year of the grant in 2024 and engaged in refining their program models, targeting services to the identified population, reporting individual and program level data, and identifying best practices for serving older adults and supporting aging in place. Programs also focused on building sustainability plans to continue the program after the grant period ends. A mid-term grant analysis was completed in 2024 (see Program Evaluation) and a round five final report will be delivered at the completion of the grant cycle in 2027, detailing the impact and outcomes of the geriatric service demonstrations.

Utilizing the triple partnership of mental health, substance use, and aging services providers, the programs increase access to a collaborative and cohesive service system by applying person-centered, community-specific approaches to address urgent and emerging needs impacting an individual's continuing ability to age in place. Programs provide both in-community services and mobile outreach. They also make use of regulatory changes related to the COVID-19 public health emergency by providing tele-mental health services, live-streaming town halls and training events, and both in-person and virtual social engagement opportunities as a regular part of the service array. Programs provide services directly or facilitate linkage to existing supports and services in the community. The requirement to provide peer support services for mental health and substance use in this round of grants provides a critical component to support engagement and reduce social isolation and loneliness.

Each triple partnership was required to set aside grant funds to provide wraparound services not available through existing resources and reimbursement channels, including goods or services to support aging in place. Examples include but are not limited to technological supports for aging in place, home modifications such as ramps and handrails, nightlights to help prevent falls at night, large print calendars so clients can remember doctor appointments, and other low-tech items that support aging in place. Grantees must also leverage partnerships with key local community agencies, including home care agencies, Expanded In-home Services for the Elderly program providers, Office of Mental Health supportive housing, and other local older adult and section eight housing programs to facilitate aging in community settings.

Program Descriptions

Enhanced Welcome Orange Geriatric Initiative (EWOGI)

The Enhanced Welcome Orange Geriatric Initiative includes several local agencies that provide specific expertise. The Orange County Department of Mental Health collaborates with substance use provider Catholic Charities of the Hudson Valley, and the Orange County Office for the Aging to provide holistic, integrated services. The triple partnership utilizes the Mental Health Association of Orange County as a gatekeeper organization that facilitates client matching with a range of partner agencies based on their needs. Community partners include Independent Living Inc. for peer services and personalized supports promoting independence; Jewish Family Service of Orange County for friendly visiting, counseling, and transportation; Rehabilitation Support Services providing medication management; and Orange County Adult Protective Services.

All partners can access clients' Electronic Health Records to streamline coordination of care. The project serves those who have been traditionally underserved through increasing stabilization in the community and reducing avoidable emergency department, hospital, and nursing home admissions. EWOGI matches individuals with services and supports based on their unique needs, supporting older adults to improve their wellbeing, and leveraging technology to better serve the population. Services are provided both in the community and in clients' homes for those with mobility or transportation challenges.

Sustainability planning in 2024 focused on maintaining key program components including home modifications, peer services, in-home therapy, and the gatekeeper role. It was determined that home modifications lack alternative funding sources, while in-home therapy has the potential for sustainability through insurance billing. The gatekeeper role is partially sustainable through care management services, with opportunities to explore PACE and Medicaid Advantage Plus for more intensive options.

Linking Aging and Community With Everyday Services (LACES)

The mission of Ohel's Linking Aging and Community with Everyday Services program is to connect older adults with a full array of services so that they can successfully age in the place of their choosing. This model connects older adults to evidence-based mental health, substance use, and aging services through its triple partnership of Ohel Children's and Family Home, LSA Recovery, and NYC Aging. The multi-disciplinary team conducts outreach, engagement, field-based screenings, and assessments in clients' homes and throughout the Far Rockaways, a community that is geographically isolated from many service providers. LACES maintains an on-site presence within the Far Rockway communities at Older Adult Centers, health fairs, and cultural events. Using a person-centered approach, the program connects individuals to physical health supports outside the Rockaways, when necessary; personalized assistance when applying for benefits; and a wide range of technology, including artificial intelligence robot companions and virtual assistants; and durable medical equipment not covered by insurance to promote independence and wellbeing while reducing social isolation and loneliness.

Sustainability planning in 2024 focused on embedding LACES services within Ohel's standard operating procedures. The LACES program has been successfully integrated into the agency's intake and referral process, with staff well-versed in its procedures. Standardized policies for intake, screenings, and language interpretation services are in place. Successful collaboration with other organizations, such as those assisting with SNAP applications, is helping address multifaceted client needs (e.g., combining mental health support with food insecurity assistance).

LINK-Age

The Link-Age program is a triple partnership between the Nassau County Office for the Aging, the Family and Children's Association, and Central Nassau Guidance & Counseling Services. Link-Age aims to pre-empt and address the social isolation of older adults aged 55 and older living in Nassau County whose independence, tenure or survival in the community is in jeopardy because due to behavioral health needs. The program assists with challenges related to aging, difficulty connecting with services, and addresses access and connection to medical care. The program provides referrals to long term care resources and support to improve the safety and overall quality of life for older adults. Link-Age offers both in-person and telehealth support to the client, technology education, short term counseling, case management, peer support, and health education. A Certified Recovery Peer Advocate offers substance use education and recovery maintenance services, while clinicians and social workers provide individual mental health counseling and complex case management.

A registered nurse attends to medically related needs and offers health advocacy and education. The Link-Age program implements a person-centered, trauma-informed, and culturally responsive approach to the clientele they serve. Program staff work to accomplish this through individualizing approaches for each client, serving a myriad of racial, ethnic, and cultural identities, and responding with care and compassion to each case.

Sustainability planning in 2024 focused on ensuring that every client with a need is fully connected to the appropriate resources, regardless of service system or payor source. While there are ongoing questions about sustainability of specific service components due to billing limitations and service eligibility, the Family and Children's Association is integrated with aging, mental health, and substance use providers. The Association is now also a Certified Community Behavioral Health Clinic making it well positioned to sustain critical program components, including peer services.

Maintaining Independence and Safety Through Technology (MIST)

Maintaining Independence and Safety through Technology engages older adults with screenings in clients' homes or communities. Based on an individual's behavioral health, physical health, and aging service needs, MIST connects clients with services and technology to reduce social isolation and loneliness. Mental health clinic services are provided by Commonpoint's CAPE MHOTRS (Mental Health Outpatient Treatment and Rehabilitative Services) program. Rego Park Counseling accepts substance use warm hand-off referrals for treatment, and a NYC Aging consultant provides personalized support in connecting individuals to needed aging services. In some cases, this means purchasing new laptops or computers for clients who cannot afford them and teaching clients how to use the technology. An individualized plan of care is created for each client, including a home safety assessment, with clinical social workers, a registered nurse, and Certified Peers. The program also offers intensive transitional care coordination, only discharging clients when they are bridged to longer term services and supports to address their holistic needs.

Sustainability planning in 2024 identified that the NYC Aging partnership includes a built-in case manager within the program, but expansion to a full case management program would require additional funding to operate independently. MIST staff will explore grants from organizations such as the John A. Hartford Foundation and the NY Health Foundation to this end. Collaboration with Office of Mental Health housing and managed care providers as well as partnerships with hospitals will help to bridge gaps for uncovered services under Medicare or Medicaid. Sustainability plans also include leveraging Medicare Health Equity Services to bill for Peer Support roles under Principal Illness Navigation (PIN-PS). This will require partnerships with physicians, clinics, and independent practice associations.

Successful Aging for Increased Longevity (SAIL)

The Successful Aging for Increased Longevity program mission is to decrease mental health and substance use disorders among at-risk older adults living in the Jamaica, Queens community. Jamaica Hospital Medical Center partners with Flushing Hospital Medical Center and NYC Aging to provide culturally attuned, on-site mental health, substance use, and aging services in the client's preferred language. The program aims to decrease avoidable episodic care in the emergency department as well as maladaptive behaviors that contribute to poor mental and physical health. The program also implements a twelve-week Fitbit program for older adults with embedded curriculum developed by NYC Aging. The Fitbit programming focuses on both physical and mental health including ongoing discussion and support in a group setting. To support older adults to successfully age at home in their preferred community, the SAIL program provides resources for necessary items such as bedrails, blood pressure monitors, and gift cards to address food insecurity.

The SAIL program is uniquely located in a hospital system and leverages this position to provide outreach and access. In collaboration with the patient navigator based in the hospital ambulatory care clinic, the program's social worker and peer specialist can easily identify and reach older adults with mental health and substance use disorder service needs.

Sustainability planning in 2024 identified that collaboration with partners like MediSys, Healthfirst, and Chinese Physicians IPA position the SAIL program well for integration into broader health systems. However, billing limitations and service eligibility criteria pose barriers to sustaining specific program components. Transitioning to billable services through the Streamline platform will require coordination with the billing team and Streamline system integration. The SAIL team plans to explore partnerships with organizations like SOMOS to expand sustainable service offerings and pursue state and federal grants to fill funding gaps and consider Medicaid and Medicare reimbursements to support ongoing services.

Support, Treatment, Recovery, Independence, Voice, Education (STRIVE)

The Support, Treatment, Recovery, Independence, Voice, Education (STRIVE) program utilizes the Service Program for Older People to support aging in home and community settings by offering person-centered services to reduce premature institutionalization of older adults. STRIVE employs a Psychiatric Nurse Practitioner to provide individual substance use treatment; behavioral health services are offered through the Metropolitan Center for Mental Health's Family and Individuals in Recovery substance use clinic that employs a Certified Recovery Peer Advocate. NYC Aging provides personalized aging service consultation. The STRIVE program offers integrated services related to overall health and psychological well-being by connecting clients to socialization opportunities and community-based programs. STRIVE addresses concrete needs through intensive case management services and access to mental health clinical treatment complemented by the support of an Office of Mental Health Certified Peer Specialist. STRIVE holds weekly drop-in hours to provide technology support, education, and social engagement for clients as well as twice-monthly Peer-led support groups. The program also addresses emergency client needs and promotes independence through providing resources for home modifications, Metro Cards, and grocery store gift cards, among other essential items for older adults.

Sustainability planning in 2024 highlighted the need for legislative advocacy to secure additional funding for aging services. In leu of additional federal or state funding, STRIVE plans to create a strong value proposition to promote STRIVE services to private and nonprofit funders. STRIVE also plans to collaborate with local police precincts and fire departments to integrate aging services and referrals within the community.

Program Evaluation

OMH's Office of Population Health and Evaluation is conducting an ongoing implementation and outcomes evaluation of the Partnership to Support Aging in Place (PSAP) program. The implementation evaluation employs qualitative data collected through documentation, semi-structured interviews, and observation to assess developing program models, partner cohesion and collaboration, and implementing planned program activities. The outcomes evaluation utilizes client-level data collected through a secure web-based portal to describe the population being served and assess effectiveness at meeting the needs of older adults enrolled in the program. This data includes a comprehensive screening package, which is used to assess need in five key areas (1) mental health, (2) substance use, (3) loneliness and social isolation, (4) social determinant of health needs, and (5) aging service needs. The assessments are repeated every 90 days to track behavioral health outcomes and service needs such as improved mental and behavioral health, improved social connection and support, aging-related needs met in a variety of domains, increased stability and tenure in the community.

Client level data is collected through the web-based portal and includes:

- The number and characteristics of individuals served;
- Mental health screening data (PHQ-9, and GAD-7);
- Social isolation screening data (DeJong Gierveld Loneliness Screening);
- Substance use screening data (NIDA Quick Screen and SMAST-Geriatric Version);

- Social determinants of health inventory data (e.g., food and housing security, appropriate access to healthcare, transportation, financial needs, etc.); and
- Aging services needs screening data.

Table two displays the number of clients screened and served in 2024, and the total number of clients served from the beginning of round five in January 2022 through December 2024. Mid-grant analyses, aimed at identifying client outcomes from admission to their most recent follow-up screening, identified a 2.1-point decrease in the average PHQ-9 score ($p<0.001$) indicating improvements in depression symptom severity among clients. Similarly, the average GAD-7 score decreased by 2.0 points ($p<0.001$). Significant declines in the percentage of clients needing mental health services ($p<0.001$), substance use services ($p=0.001$), technology-related services ($p=0.01$), and home safety-related services ($p=0.002$) were also identified.

Note: This table reflects data submitted to the data portal as of January 15, 2025.

Table 2. Program Activities

	January 2024-December 2024	**January 2022-December 2024**
Admissions	289	755
Discharges	197	446
Clients Served	315	755
Clients Screened		
PHQ-9 (Depression)	324	629
GAD-7 (Anxiety)	323	626
DeJong Gierveld Loneliness and Social Isolation	309	555
NIDA Quick Screen	314	579
SMAST-G[1]	76	128
Social Determinants of Health Inventory	298	534
Aging Service Needs Inventory	287	581

[1]Prior to September 2024, only clients reporting at least one instance of heavy drinking in the past three months were eligible to receive the SMAST-G screening. Expanded SMAST-G screening is anticipated following the removal of this requirement.

The implementation evaluation of the PSAP programs revealed several highlights, including the need for clearly defined partner roles and workflows. Programs that established clear workflows in the early stages of implementation were best positioned to begin service provision, even as the established workflows evolved. Additionally, providers often referenced the ability to spend more time with clients building rapport as a highlight of the program model as compared to other behavioral health programs. A comprehensive mid-grant evaluation report describing early program implementation and preliminary outcomes will be published in 2025.

Highlights from 2024 Mid-Term Grant Analysis

The mid-term grant analysis in 2024 evaluated the impacts that the geriatric service demonstrations have had on the lives of older adults receiving services during the first half of the grant cycle. The final grant analysis will compare variances between program outputs from each of the six sites to identify lessons learned and which program models were most effective in producing positive outcomes.

Figure 2. Social Determinants of Health Screening of 151 Clients

Figure two illustrates that caregiving is the most frequently indicated need at the most recent follow-up, with a statistically significant increase from 38% at admission to 48% at follow-up (p=0.02). Food insecurity shows a statistically significant decrease from 38% at admission to 28% at most recent follow-up (p=0.005). Housing needs decreased from 46% at admission to 38% at follow-up. Transportation needs show a statistically significant decrease from 33% at admission to 27% at last follow-up (p=0.008).

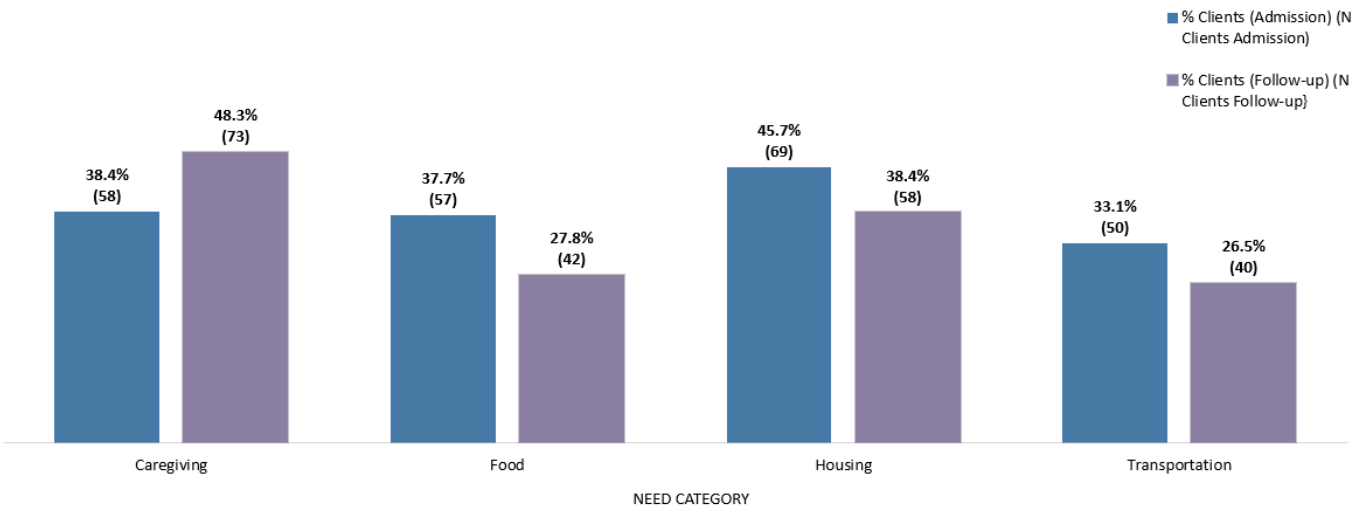


Figure 3. Depression PHQ-9 Screening of 224 Clients

Figure three illustrates that the greatest change in depression screening from admission to most recent follow up was in the None-Minimal category, which increased from 21% to 37%. Moderate symptom severity or above decreased from 46% at admission to 34% at follow up. The mean depression score dropped from 9.7 (between mild and moderate) to 7.6 (mild) ($p<0.001$) from admission to follow up.

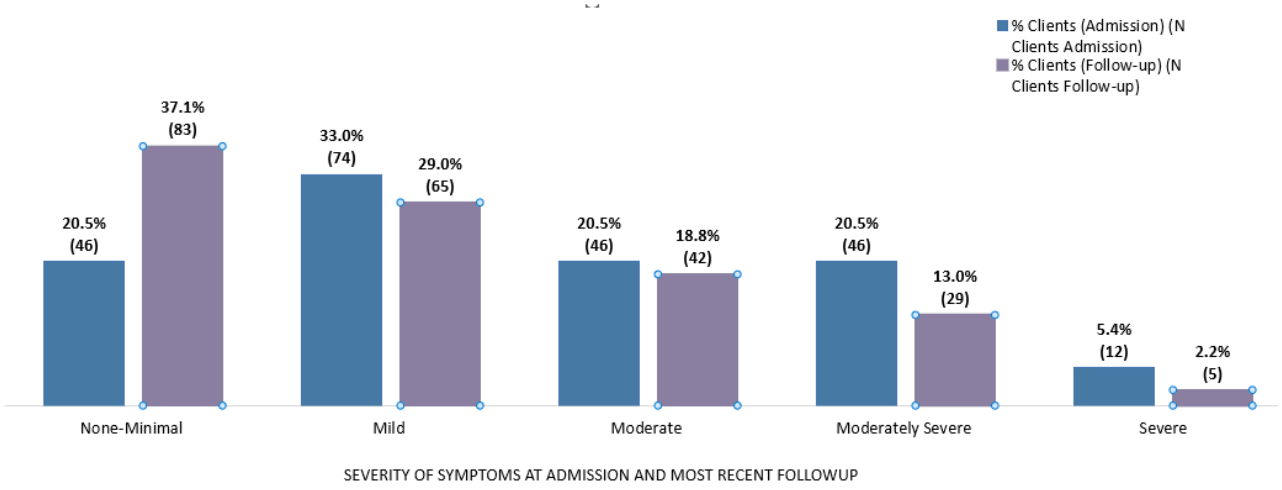


Figure 4. Anxiety GAD-7 Screening of 230 Clients

Figure four illustrates that the greatest change in severity of anxiety symptoms was in the None-Minimal category which increased from 27% at admission to 40.9% at most recent follow-up. Moderate symptom severity or above decreased from 43.9% at admission to 29.1% at follow-up. From admission to follow-up the mean anxiety score dropped from 9.1 (between mild and moderate) to 7.1 (mild) ($p<0.001$).

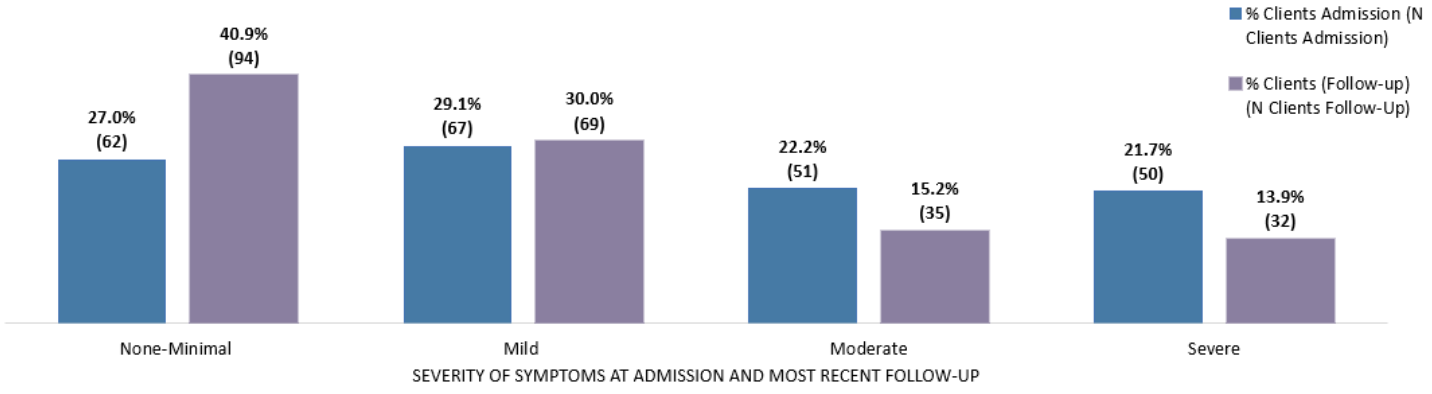
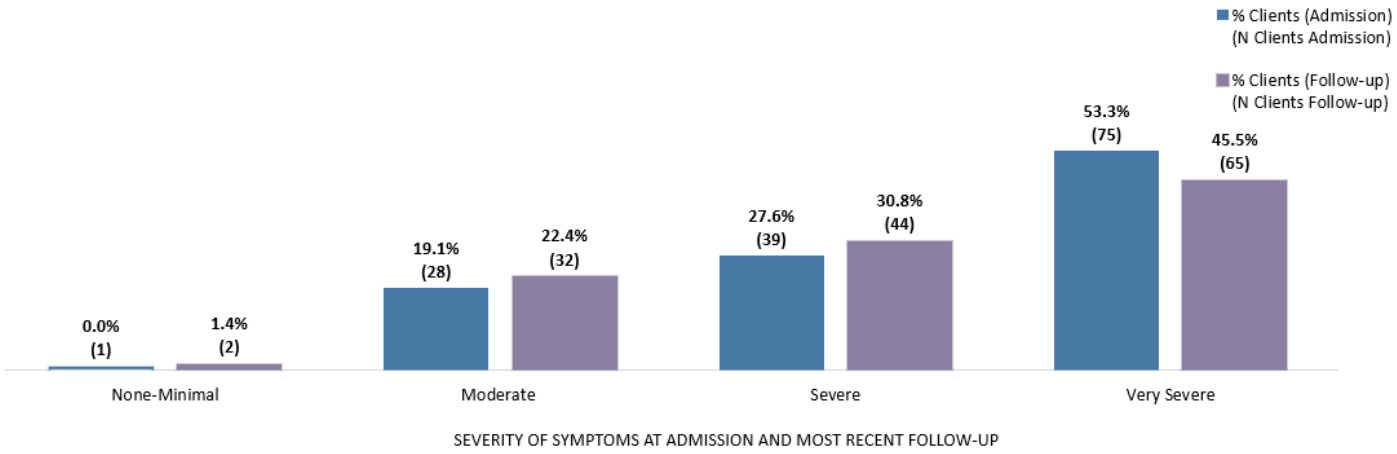


Figure 5. DeJong Gierveld Loneliness Screening of 143 Clients

Figure five illustrates that older adults receiving services from the geriatric service demonstration grants face significant and persistent feelings of loneliness. Symptom severity of Moderate or higher was 100% at admission and 99% at most recent follow-up. The Very Severe symptom category showed the greatest change, decreasing from 53% at admission to 46% at follow-up. The mean score remained 10.87 (between severe and very severe) from admission to follow up.



Program Supports

OMH's Division of Adult Community Care supported the geriatric service demonstration programs in 2024. This work included consultation, project oversight, contract management, monitoring contract deliverables, reviewing requests for program and budget modifications, collaborating with field office staff, facilitating communication with additional subject matter experts at various state agencies, serving as project advocates, and helping to problem solve program implementation as needed with the triple partnerships.

OMH staff also collaborated with staff from the New York Academy of Medicine contracted for the operation of a Geriatric Technical Assistance Center (GTAC). Established by the agency in 2012, the center provides training and technical assistance focused on programmatic and fiscal strategies to support the planning, implementation, operation, evaluation, and sustainability of the programs.

- The Center's work with the Partnership to Support Aging in Place programs in 2024 included:
- Development of a virtual resource library accessible by all PSAP programs in 2025;
- Monthly coaching calls with each triple partnership;
- Quarterly Affinity Group meetings providing targeted support for Program Directors, Program Managers, and Peer Specialists;
- In-person Learning Collaborative with virtual presentations, triple partnership presentations, roundtables, and discussion on March 12, 2024; and
- In-person visits for extended discussion and review of program data, program implementation, and sustainability plans with each triple partnership.

Cross-Service System Education and Training Focused on Older Adults

Adults aging with mental health and substance use challenges have needs across different service systems, including behavioral health, aging, and long-term care. Therefore, they face complex service navigation compounded by complicated options for payment (Medicare, Medicaid, commercial insurance, etc.). Social determinants of health such as food and housing often become more difficult to maintain with lower income, adding to this population's vulnerability. The education and training highlighted is made available through the collaboration of State Agencies and provides resources and tools to address the cross-service system needs of vulnerable adults aging with mental health and substance use challenges.

The Adult Abuse Training Institute

The Learning and Development Projects at the Silberman School of Social Work and the Office of Children and Family Services held the 31st Annual Adult Abuse Training Institute on October 8-10, 2024. The 2024 theme, *Red Flags: Raising Awareness about the Intersection of Financial Exploitation, Abuse, Neglect and Self-Neglect,* focused on the persistent and growing problem of financial exploitation commonly experienced by vulnerable populations, such as older adults, and how this type of abuse can increase risk for already vulnerable individuals by obscuring other significant coinciding risks.

Beginning with a plenary session on *Article 81: Guardianship* for APS Clients, the Institute included over 35 workshops facilitated by 48 presenters and was attended by more than 300 professionals in adult protective services, aging, criminal justice, health care, law enforcement, mental health, public health, and domestic violence. Workshops included:

- Repeat offerings of *NARCAN Training and Mindfulness and Resiliency on the Go;*
- *The NYS Master Plan for Aging: Highlights for Vulnerable Populations;*
- *Recognizing and Preventing Scams that Target Older Adults;*
- *Older Adults with Substance Use Disorders: Best Practices for Identifying Older Adults Who Abuse Substances and for Supporting Their Recovery;*
- *Elder Abuse Outreach in Low-Income Senior Residential Facilities;*
- *E-MDT Strategies for Addressing Social Isolation, Loneliness, and Financial Exploitation;*
- *Hidden Helpers: Caring for Secondary Victims of Elder Abuse;*
- *Sex Ed Doesn't End in High School: Destigmatizing the Discussion of Sexual Abuse of Older Adults;*
- *Abuse and Exploitation in Individuals with Alzheimer's or Dementia: Effective Communication Strategies to Build Rapport;*
- *Tips for Successful Collaboration: Building Bridges Between Services; and*
- *Supportive Communication Skills for Frontline Workers.*

The Association for Community Living

The Association for Community Living Agencies in Mental Health is a statewide membership organization of not-for-profit agencies that provide housing and rehabilitation services to 48,000 people diagnosed with serious and persistent psychiatric disabilities. The association's Aging in Place Survey found that approximately 42% of individuals living in Office of Mental Health (OMH) housing programs, representing approximately 22,000 beds, are age 55 and up and would benefit from aging in place services.[1]

The Association held its 45th annual conference in November 2024: Meeting the Defining Challenge of Our Time. At the annual conference, OMH had the opportunity to present on topics affecting individuals across the lifespan, including:

- *Navigating Public Systems to maximize Wellbeing: Advocacy Tips for OMH Housing Providers.* This presentation discussed how to help residents living with serious mental illness to age in their preferred setting, the advocacy required to navigate public systems, and understanding how to support residents through assessment and eligibility determinations.
- *Safe Options Support.* This program utilizes the Critical Time Intervention model to provide intensive outreach, engagement, and care coordination services to individuals of all ages experiencing homelessness. Approximately 42% of Safe Options Support clients are aged 50 or older.
- *Hospital and Community Connections: Tools for Housing Collaborations.* This workshop aimed to collect feedback from housing providers on tools, workflows, and templates to support communication processes between residential programs, hospital emergency departments, Comprehensive Psychiatric Emergency Programs, and inpatient psychiatry units for individuals across the lifespan. Of note, almost 500,000, over 35%, of emergency room and/or inpatient hospital visits by adult OMH Housing residents are individuals aged 55 or older, making this a pertinent topic for all providers serving older adults.[2]

The Alliance for Rights and Recovery

The Alliance for Rights and Recovery is a state and national change agent dedicated to improving services, public policies and social conditions for people with mental health, substance use and trauma-related challenges, by promoting health, wellness, recovery, with full community inclusion, so that individuals of all ages may achieve maximum potential in the communities of their choice.

The 15th Annual Recovery and Rehabilitation Academy: *Narratives of Hope: The Power of Personal Stories in Recovery,* was held in November 2024. OMH presented *Addressing the Silent Crisis: Reducing Mortality from Comorbid Conditions.* This presentation discussed how comorbid mental and physical health conditions, such as depression, anxiety, heart disease, and diabetes, contribute to increased mortality rates and diminished quality of life particularly for older adults who often have multiple co-occurring conditions. When previously surveyed, Peers aged 50 and older comprised approximately 55% of the Peer workforce, consistent with other surveys administered to Peer workers by OMH, OASAS, the Department of Health, and the New York City Department

[1] https://aclnys.org/wp-content/uploads/2024/06/ACL-AGING-IN-PLACE-SURVEY-RESULTS.pdf
[2] PSYCKES: Age Range 55 to 100 AND Housing – OMH Oversight Housing/Residential – Any (Source CAIRS) OR ER – ALL OR Inpatient - ALL

of health and Mental Hygiene. This underscores a significant resource for providing specialized Peer support to older adults.

Healthy Aging Academy for Supportive Housing Providers

A free six-session Healthy Aging Academy was offered in June and July 2024 to New York State supportive housing providers through a collaboration between the Corporation for Supportive Housing and the Association for Community Living, two organizations that have presented to the Interagency Geriatric Mental Health and Substance Use Disorder Planning Council previously on initiatives and analysis conducted on aging in OMH housing. The series with presenters including representatives from OMH and mental health providers covered topics such as:

- *The Aging Process:* Overview of aging, ageism and bias, specific needs of older adults, and warning signs for elder abuse;
- *Navigating Public Systems:* Medicare and Medicaid, fair housing and reasonable accommodations, local benefits and key agencies;
- *Transitions & Navigating the Medical System:* Care planning, HIPAA considerations and communication, hospital discharges and continuity of care, higher levels of care;
- *Crisis Intervention:* Harm reduction and crisis intervention;
- *End of Life Planning & Legal Considerations:* Power of attorney and guardianship, palliative and hospice, funeral planning and death; and
- *Supporting Staff: Self-Care & Advocacy:* Navigating grief, scope of work for care workers, and self-care.

Home Care Association of New York State

The Home Care Association is an advocacy and technical assistance organization for community-based care, representing providers and home care workers. The organization provides information, professional development, education, and training opportunities for members. Their mission is to promote and enhance the quality and accessibility for health care and support for individuals at home.

For the past two years, OMH has been collaborating with the Home Care Association and the University of Rochester Medical Center on *Addressing Health Disparities Through Home Care,* an initiative funded by the Mother Cabrini Health Foundation that has provided training and resources for providers who serve individuals living with co-occurring physical health, mental health, and substance use needs.

In February 2024 the Home Care Association shared a webinar on *The 3D's Delirium, Dementia, and Depression.* This presentation provided an overview of a new point-of-care tool to help direct care staff understand the differences between dementia, delirium, and depression through real-world case examples from the field. This presentation reached approximately 125 providers and staff across multiple state agencies.

Throughout 2024 OMH, the Home Care Association, and the University of Rochester Medical Center collaborated to develop an integrated model care plan for behavioral and physical health in home and community care settings. The Integrated Model Care Plan was shared with OMH Housing providers at the November 8, 2024, Corporation for Supportive Housing Aging forum, along with the 3D's: *Delirium, Dementia, and Depression,* and other mental health training resources. The purpose of the Integrated Model Care Plan is to create a framework for Home and Community Based Service providers to improve the well-being of individuals with co-morbid physical and mental health conditions. This is achieved by integrating substance use treatment, addressing social determinants of health, and fostering collaboration. The Integrated Model Care Plan was shared with the Interagency Geriatric Planning Council in early 2025.

The Mental Health Training of tools and training is available on Home Care Association's Education and Research Learning Center website.

Internships in Aging Project

The Internships in Aging Project is a specialized internship program at the University at Albany designed for Master of Social Work students interested in geriatric social work. It provides hands-on experience in aging-related services in both macro and micro settings. As part of the program, interns are placed in various settings including OMH. These students contribute to projects focused on mental health, aging, policy, advocacy, and service sustainability. The program aims to prepare social work students for leadership roles addressing the complex needs of older adults.

In 2024, participating Internships in Aging Project interns placed at OMH worked on several projects including:

Map Project

Created an electronic map of New York State that displays geographic data to identify the round five geriatric service demonstration grant sites. The map also serves to highlight the mental health, substance use, and aging service provider triple partnerships offering integrated care in the program catchment areas.

Sustainability Resources Webinar

Provided a technical assistance webinar on sustainability strategies and resources for geriatric service demonstration grantee reference. The webinar provides details on specific resources to support long-term service implementation.

Sustainability Questionnaire

Created a questionnaire to analyze sustainability strategies used by round four geriatric service demonstration programs to improve effectiveness of the next grant cycle. The questionnaire will be used to collect feedback to inform future rounds.

Catchment Project

Using Excel, the Geriatric Dashboard in PSYCKES (a HIPAA-compliant web-based application designed to support clinical decision making, care coordination, and quality improvement in NYS), and the American Community Survey, students collected and analyzed geriatric service demonstration program data to identify the catchment areas for each site based on the race and ethnicity of the population aged 60 and older. Analyzing

this data based on zip code and demographics will identify the specific populations being served by each program and opportunities for greater engagement with older adults of diverse racial and ethnic backgrounds who are severely impacted by the Covid-19 pandemic.

Office Of Mental Health Support for Older Adults

The Office of Mental Health (OMH) oversees an array of services to New York State residents across the lifespan including older adults. Many recipients of these services often have complex needs that are not met in traditional site-based services.

Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) – formerly known as clinic – is a common access point for mental health assessment and treatment offered in individual and group formats. Restructuring in November 2022 moved clinic services under the Medicaid State Plan Rehabilitative Services benefit renaming the program Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS). New services were authorized providing more flexibility that is particularly meaningful to aging adults. For example, MHOTRS can now bill Medicaid fee-for-service and Medicaid Managed Care (including Medicare and Medicaid dually eligible plans) for services including peer support and offsite services as well as MHOTRS-based Intensive Outpatient Program (IOP). Over the past year over 92,000 adults aged 55 and older, or 28% of adult program recipients, have received MHOTRS services.[3]

Another common access point, Certified Community Behavioral Health Clinics (CCBHCs), are a federal demonstration expanding in NYS that offers immediate access to integrated mental health and substance use services with coordinated access to primary care. These characteristics make this model particularly beneficial for older adults. Over the past year the program has served almost 13,500 adults aged 55 and older, nearly 25% of all adult program recipients.[4]

Psychiatric Rehabilitation, utilizing the Personalized Recovery Oriented Services (PROS) model is a comprehensive, team-based program of skill building, treatment and support, offered at the program site and in the community. There are PROS programs offered exclusively for this older adult population via telehealth and in-person at locations throughout Manhattan, the Bronx and Brooklyn. These older adult programs focus on productivity, cognitive health, skill building, and social isolation and loneliness while addressing issues such as transportation, home care, and accessibility supports. Over the past year more than 2800, 30% of program recipients, were adults aged 55 or older.[5]

Care Coordination provides linkage to needed services and supports, outcome monitoring, and individual advocacy for complex needs. Older adults often require intensive complex care coordination due to multi-service needs. Implemented in New York's Medicaid State plan in 2012, Health Homes provide comprehensive case management for Medicaid members who have designated complex chronic conditions, including individuals living with serious mental illness (SMI). In 2014, the New York State Department of Health (DOH), in collaboration with OMH, implemented an enhanced service and rate code package for Health Homes called Health Home Plus. Health Home Plus (HH+) is an intensive Health Home Care Management service designed for populations living with SMI, as well as individuals who are HIV+ and virally unsuppressed, who meet additional high-need criteria. OMH-designated Specialty Mental Health Care Management programs, administered by Specialty Mental Health Care Management Agencies (SMH CMAs), provide services to the HH+ population with specific requirements for increased in-person contacts. Over the past year nearly 3600 individuals, almost 30% of HH+ enrollees, were adults aged 55 or older.[6]

[3] PSYCKES: Age range 55-100 AND Clinic – MH Specialty
[4] PSYCKES: Age range 55-100 AND Outpatient MH – CCBHC
[5] PSYCKES: Age Range 55-100 AND PROS MH Specialty
[6] PSYCKES: Age range 55-100 AND Health Home Plus

OMH also offers a full range of Living Support/Residential services that provide individuals with serious mental illness with short-term to permanent housing including apartment-based or congregate setting. OMH Housing offers individualized levels of support based on client need, from supervised, intensive treatment to independent, supportive models. In the past year nearly 7100 adults aged 55 and older received Supportive Housing Community Services comprising over 49% of adult program residents.[7] In the past year more than 3000 adults aged 55 and older, almost half of all adult program residents, received Supportive Housing Single Room Occupancy services.[8]

Inpatient care is provided for individuals with higher stabilization and treatment needs what can be provided in the community. Inpatient services are also provided on inpatient psychiatric units of general hospitals, at private psychiatric hospitals, and in residential treatment facilities. More than 7500, nearly one fifth of inpatient mental health patients, were adults aged 55 or older in the past year.[9]

Crisis services provide rapid stabilization for individuals in the community who present a danger to themselves or others. More than 220 crisis programs in New York State served nearly 2050 adults aged 55 or older in the past year.[10]

Programmatic highlights specific to serving older adults in 2024:

Assertive Community Treatment

Assertive Community Treatment (ACT) teams are an evidence-based approach to provide comprehensive treatment, support, and rehabilitation services for older adults. These teams have a low individual-to-staff ratio with multidisciplinary teams that include the use of peer services. Many services are provided by staff directly and in the community where the individual lives, increasing access for older adults who have not found site-based, single disciplinary services to be successful. Over the past year the teams have served nearly 1900 adults aged 55 and older, and more than 26% of all adult ACT service recipients were older adults.

Older Adult-Serving ACT Teams

OMH recently awarded funding to The Jewish Association for Services for the Aged to develop a second Older Adult Assertive Community Treatment team serving the Bronx. The association serves older adults in New York City, providing critical services to over 40,000 people annually. The goal of this team is to serve older adults with serious mental illness who have not been successfully engaged by the traditional mental health treatment and rehabilitation system in the state. These individuals may also be high utilizers of emergency and/or crisis services, have co-occurring substance use disorders, are isolated from community supports, are unhoused or in danger of losing their housing, or have histories of involvement with the criminal justice system.

Safe Options Support Program: Critical Time Intervention

Safe Options Support (SOS) teams across the state help individuals who experience chronic homelessness connect with the services and supports designed to bring them lasting housing stability. The program uses Critical Time Intervention, an evidence-based practice that helps connect vulnerable individuals in crisis to housing and supports, including critical mental health services. Older adults are the fastest growing group of homeless individuals, and experience more severe health-related concerns and higher rates of mental health

[7] PSYCKES: Age range 55-100 AND Housing – Supported Housing Community Services (Source: OMH CAIRS)
[8] PSYCKES: Age range 55-100 AND Housing – Supported Housing Single Room Occupancy (Source: OMH CAIRS)
[9] PSYCKES: Age range 55-100 AND Inpatient MH
[10] PSYCKES: Age range 55-100 AND Crisis Service - Any

and substance use disorders. According to most recent population estimates there were nearly 14,500 adults aged 55 and older in New York State experiencing homelessness in 2024. Approximately 42% of Safe Options Support clients are aged 50 or older.

In 2024, OMH awarded grant funding to The Bridge, an organization that offers supportive housing and behavioral health services to vulnerable New Yorkers living with mental health, substance use, and aging services needs. This funding will allow The Bridge to provide services to adults aged 50 and older, the medically fragile, and those with existing chronic medical conditions who have unmet age-related needs. The Bridge is in the process of staffing the program and executing the Safe Options Support contract.

Office of Mental Health Suicide Prevention Center of New York

OMH's Suicide Prevention Center of New York is the lead entity in suicide prevention in the state. The Center provides technical assistance that advances the New York State Suicide Prevention Plan. Their mission is to promote, coordinate, and strategically advance suicide prevention across the state with the aim of reducing suicide attempts and deaths among New Yorkers of all ages.

The agency began work in 2024 to institute a pilot program in primary care practices with an initial focus on older adults aged 55 and older identified with depression. This pilot seeks to address social isolation and loneliness in primary care settings through the Connection Planning Intervention in practices that have existing Collaborative Care Model (CoCM) infrastructure. Connection Planning was developed in the Department of Psychiatry at the University of Rochester Medical Center and has been used in the Veterans Administration and other sites across the country. Rooted in the recognition that overall health is social-relational, Connection Planning serves as an upstream safety plan, addressing social isolation and loneliness drivers of suicidal risk.

OMH hopes to demonstrate that Connection Planning aligns closely with the Collaborative Care Model workflow and can be a useful tool for Behavioral Health Care Managers. The intervention will be piloted at a subset of practices already focusing on patient's behavioral health needs and providing Collaborative Care. Pilot practices are currently receiving training in evidence-based protocols for screening, assessment, and management of social isolation and loneliness, as well as how to collect data on the feasibility and acceptability of utilizing Connection Planning in the Collaborative Care Model. If successful, the pilot program could serve as a blueprint for systematically addressing social isolation and loneliness in older adults throughout New York State.

Office for the Aging Support for Older Adults

The New York State Office for the Aging (NYSOFA) is a lead state agency council member with a record of accomplishments and established goals addressing the mental and behavioral health needs of older adult adults in 2024. This work is helping to generate the opportunity for this growing age cohort to receive access to services to improve their quality of life. Discussions among the state agencies and other partners on the Interagency Geriatric Mental Health and Substance Use Disorder Planning Council will continue to raise awareness. This work helps link older New Yorkers to the mental health, substance use, and aging services they need and deserve.

Through the work of this Council word is spreading that behavioral health challenges are not a normal part of aging or of living with a disability. Older people and people with disabilities are less likely to be screened and referred to treatment for mental health or substance use. This can lead to co-occurring physical and mental health disorders which have a significant impact on an individual's quality of life. This lack of screening and treatment also impacts the ability of older adults to live independently, increases mortality, and has a tremendous impact on health care spending.

This understanding has facilitated longstanding action by NYSOFA and its network of aging service providers to develop an awareness that anyone, regardless of age or ability, can experience a behavioral health condition such as depression, anxiety, substance use disorder, or suicidal thoughts. Further, the agency's comprehensive assessment tool has included a screen for depression, anxiety, suicide risk, social isolation and alcohol and drug misuse for over a decade.

New York's aging services and support network has many programs that are aimed at combatting the root causes of social isolation – a major risk factor for suicide – and supporting caregivers who may be susceptible to suicide due to burnout and related distress. In fact, a 2021 study by the U.S. Centers for Disease Control and Prevention found that 85% of adults who were both parents and unpaid caregivers for adults experienced mental health symptoms, and 50% reported suicidal thoughts.

Data from the National Council on Aging shows that nearly a quarter of suicides are among individuals aged 65 and up nationally. Understanding of the impact of loneliness and social isolation has led to NYSOFA raising awareness about suicide while connecting people with help. According to the National Council on Aging, older adults comprise approximately 16% of the population, but they account for 22% of suicides. In 2022, among the nearly 49,449 suicides that took place in the U.S., 10,433 were attributed to people aged 65 and up. Potential suicide risk factors for older adults can include declines in physical and cognitive functioning, changes in mental health, and other experiences often associated with getting older, like bereavement, loneliness, and lack of social connectedness, according to the CDC.

These challenges can also lead to substance abuse by older adults as they seek to live independently. NYSOFA has been working with members of the Council to enhance the ability of the aging network and substance use provider community to identify and treat older adults who have unique needs, especially individuals who may be isolated, struggling with medical conditions, or experiencing other difficulties. The service and outreach programs being supported today are effective because they are attuned to these specialized needs while also helping to overcome the added burden of social stigma. The agency continuously works with the Council to support efforts including medication safety, evidence-based interventions, and screening to help older adults overcome alcohol or drug misuse.

Master Plan for Aging

NYSOFA is working in partnership with the Department of Health in the development of a Master Plan for Aging, which was established by Governor Hochul under Executive Order No. 23 signed on November 4, 2022.

The goal of the Master Plan for Aging process is to bring together aging, government agencies, and other interested stakeholders, including the State agencies that are members of the Council, to develop policy recommendations to improve the lives of older adults. This process seeks to coordinate existing and new state policies and programs for older adults and their families, while also addressing challenges related to communication, coordination, caregiving, long-term care financing, and expanding access to innovative models of care. Recommendations being proposed include strategies for addressing the behavioral and mental health issues that older adults experience.

This work has integrated an understanding that experiences, opportunities, and traumas early in life have a cumulative impact on how successfully a person ages. The plan will offer a holistic and proactive focus, addressing needs and providing supports for individuals from childhood to mid-life to older age across programs, services, and policies. The Master Plan for Aging has provided an unprecedented opportunity to convene experts in the field of mental health and substance use treatment, advocates for the aging and long-term care, and services to consider how best to support older adults and people of all ages, while building on a longstanding foundation of existing coordinated work in New York.

The governing structure includes a state agency council comprised of leaders from agencies across state government to address the needs of aging New Yorkers across all state programs and policies. A stakeholder advisory committee of over 300 leading experts and the public at large have strong input into the Master Plan for Aging and help establish guidelines for age-friendly policies. An association resource committee enables state associations to bring statewide and regional issues to the process. There were eight subcommittees and over 30 workgroups established. These bodies worked for over a year to identify and address challenges related to communication, coordination, caregiving, long-term financing, and development of innovative approaches to assist older adults. A specific focus on behavioral health issues was a topic addressed by workgroups established as part of the Health and Wellness subcommittee.

This work has resulted in the assembly of a comprehensive Interim and Advisory Report with recommendations to the State Agency Council for actions that could be taken in New York over the next 10 years to fulfill the goal of enabling all New Yorkers to age in good health with dignity in the community of their choice. To develop recommendations across the aging and long-term services and supports spectrum, the eight subcommittees focused on the following topics:

- Long-Term Services and Supports
- Home and Community-Based Services
- Caregivers – Informal
- Caregivers – Formal
- Health and Wellness, including Mental Health and Substance Use Disorders
- Housing, Community Development, and Transportation
- Safety, Security, and Technology
- Economic Security

This is a blueprint of strategies for government, the private sector, and the non-profit sector that will support individuals to live in the most integrated setting appropriate to their needs. Accomplishing this goal will require harnessing the power of all state agencies and their networks to coordinate policies and programs.

Some of the key mental health and substance use disorder issues the subcommittees are addressing include social determinants of health and increasing equitable access to care; leveraging existing technologies to support older adults in the community; and promoting early detection of aging services needs and linkages to care with equitable access for older adults, particularly those from marginalized communities who may face barriers to accessing health care. Other proposals prioritized prevention strategies, collaboration and healthy aging to address safe and affordable housing, transportation, and secure access to nutritious food. By addressing these social determinants, people of all ages benefit from improved overall health outcomes.

Proposals have prioritized strategies that promote prevention and healthy aging by incorporating social determinants of health and establishing linkages and coordination between services, recognizing that greater coordination and integration can help improve overall health outcomes for older adults. Linkage to primary care physicians and social service providers to better identify and address mental health conditions that are common in older adults, such as depression and anxiety, have been shown to improve overall quality of life and reduce the risk of chronic disease in older adults. This also promotes better coordination and access through social care networks and the 1115 waiver to Office of Mental Health programming and housing supports. This work includes measures to reduce loneliness and social isolation, promotion of peer-to-peer programming, and improving data capture around cognitive and behavioral health to better identify and link to services.

The importance of engaging in this work was magnified during the COVID-19 pandemic, as many older adults in New York were unable to connect to others due to a lack of internet services, devices, or knowledge. This resulted in limited access to telehealth services, information sources, and COVID-19 vaccine appointments. The plan will leverage existing technology and community-based technology education programs to increase knowledge and comfort with digital devices among older adults. It includes highlighting the Office of Mental Health's mental health program directory and NY Connects as search tools for services and supports and establishing community linkages to improve mental health service awareness and foster healthy aging within the community.

The Office of Mental Health Master Plan for Aging Priorities

Throughout 2024 representatives from the Office of Mental Health (OMH) participated in dozens of Master Plan for Aging (MPA) workgroups. The MPA OMH representatives put forth several proposals including three which highlight synergies with policy goals established by the New York State Policy Academy regarding the need for equal access to resources to facilitate resilient aging, regardless of age, disability, or setting.

- *Support Older Adults Aging in Place in Office of Mental Health licensed and permanent housing:* This proposal seeks cross-agency collaborations to allow a comprehensive understanding of the existing challenges and opportunities in these settings, and to address the needs of older adults with mental illness.
- *Coordination of Homecare and Aging Services at OMH Housing Through 1115 Waiver:* This proposal seeks to create a demonstration program for individuals being discharged from hospitals to coordinate home care and aging services for individuals with co-occurring long-term care and mental health and/or substance use needs who are transitioning back to or newly being transitioned to community-based OMH housing.
- *Diversifying LTC Facility Services:* This proposal seeks to improve the mental health and substance use services available to individuals residing in a skilled nursing facility or nursing home.

Further Policy Work on the Master Plan for Aging

The New York State Policy Academy on Supporting Individuals to Live as Vibrant Elders in Recovery (S.I.L.V.E.R.) held three virtual sessions on July 1, October 29, and December 2, 2024, with representatives from Council partner agencies, the Home Care Association of New York, the Association for Community Living, and the Alliance for Rights and Recovery. The focus of the sessions was on a) data-driven identification of the gaps in current services; b) identification of feasible, actionable strategic goals; and c) specification of a strategic plan by and for cross-sector state-level systems.

- OMH has proposed merging the Policy Academy workgroups with the Master Plan for Aging proposals that have common goals to promote equity in accessing resilient aging resources regardless of age, disability, or setting. Cross-sector partners identified the following settings and policy strategies to address data-driven service gaps for older adults with mental health needs.
- Setting: OMH Housing

    1. *Homecare:* Rate add-on/value-based payment/bundled payment pilot to foster mutually beneficial partnerships between homecare agencies, OMH housing providers, managed care plans, and hospitals. Assign home care agency staff to serve specific cohorts of residents identified as at-risk of losing community tenure due to co-occurring physical health conditions and frequent hospital visits.

    2. *Peer support/ Peer Bridger:* Fund through rate add-on/value-based payment/bundled payment and existing Medicaid and Medicare reimbursement streams, maximize use of peer support and Peer Bridger services for both mental health and substance use to provide support to residents facing challenges in aging in place.

    3. *Existing community-based services:* Utilize housing case managers, direct homecare staff, and peer "triple teams" to provide support to residents in accessing the statewide NY Connects No Wrong Door and the 1115 Waiver Social Care Networks.

- Setting: Skilled Nursing Facilities/Nursing Homes

    - *Review Options for Mental Health & Substance Use Disorder "Specialized Add on Services":* Review Medicaid State Plan's definition of specialized mental health services, options for redefining, and adding "specialized add on services" within the nursing facility to include:

        1. Peer support/Peer-Bridger services to enable residents and staff to benefit from the advocacy provided by peers through sharing of their lived experience.

        2. Expert interdisciplinary consultation and services from the currently OMH-funded Skilled Nursing Facility Enhanced Supports Program (SNF-ESP) that includes University of Rochester's TeleECHO (virtual, interactive "grand round" sessions) as well as telepsychiatry and teletherapy for residents.

        3. Provision of peer and SNF-ESP services as "specialized add on services" within the nursing facility would enable providers to receive an enhanced rate with a federal matching that is higher than the current funding level.

- Critical to strategies identified in both settings

    - Cross-sector multidisciplinary provider training using resources made available through the existing Interagency Geriatric Mental Health and Substance Use Disorder Planning Council established by the Geriatric Mental Health Act and consultation with Peers and Peer Bridgers well versed in the lived experience of maintaining community tenure and resiliency while aging.

    - Development of a mutually beneficial value-based relationship that facilitates assignment of inter-disciplinary, cross service system care teams.

- Recognition of high-risk populations that would benefit from the interdisciplinary framework proposed, including residents who have served in the military and have not been connected to Department of Veteran Service (DVS) benefits, making them more vulnerable to experiencing inequitable access to healthcare, Post Traumatic Stress Disorder and suicide. Adult home class members also live and transition to and from these settings and would gain from a cross-sector collaborative approach.

The Master Plan for Aging's Future

The Master Plan for Aging (MPA) Council, made up of the State Agencies, will review and prioritize the proposals developed and deliver a final report to Governor Hochul in 2025. The Master Plan for Aging is a living document and implementation of specific proposals will be coordinated through the MPA Council in partnership with stakeholders from groups and communities across the State. The proposals and latest activities for the MPA will be posted to the Master Plan for Aging website.

NYSOFA-Funded Innovations

To increase access to services and supports and engage with family caregivers across the age spectrum, the Office for Aging has prioritized the identification, promotion, and utilization of technology and digital tools across service delivery. This approach helps older adults remain in their homes, connect with loved ones, engage with their communities of choice, support caregivers, and participate in activities across a variety of platforms.

These actions were undertaken as the understanding evolved that social isolation and loneliness have profound health and emotional impacts for older adults:

- The health effects of social isolation are equivalent to smoking almost a pack of cigarettes a day and are associated with more than $7 billion in Medicare spending each year for treatment.
- Social isolation significantly increases a person's risk of premature death and a 50% increased risk of dementia, according to the Centers for Disease Control and Prevention.
- There are an estimated 4.1 million caregivers in New York State providing roughly 2.68 billion hours of unpaid care; 61% of caregivers worry about caring for a loved one; 70% of caregivers reported at least one mental health symptom during the pandemic.

Technology partnerships are being evaluated to ensure accessibility by and for older adults, to ensure they can better serve the interests of those they care for or who care for them and measure their efficacy.

The following are just a few of the technology-based partners NYSOFA has engaged with to expand access to services including apps and other innovations that can help to improve quality of life for older adults and their caregivers:

The NY Caregiver Portal – Trualta: Trualta teaches critical skills to reduce caregiver stress levels and increase confidence in one's caregiving abilities. NYSOFA offers Trualta's web-based caregiver education and support platform at no cost to caregivers of all ages in New York State. Nearly 3,000 caregivers have engaged with the portal with 17,955 content views. The most viewed content includes "How to Apply for Benefits and Services", "Balancing Work & Caregiving", and "Caregiver Guilt".

ARCHANGELS: ARCHANGELS works to reframe how caregivers are seen, honored, and supported using a combination of data and stories, through public and private partnerships. In New York, this is done through the Any Care Counts campaign that helps caregivers self-identify based on marketing that appeals to people who

perform tasks for loved ones.

The Caregiver Intensity Index is designed to engage all caregivers, even those who do not identify themselves in the role. The platform provides each caregiver with an intensity score that not only validates their experience but connects them to state and local resources.

Caregivers least likely to self-identify in the role have a 320% increase in self-identification after completing the intensity index and 79% of people who do not identify as a caregiver before going through the intensity index see themselves as a caregiver after completion.

In 2024, NYSOFA expanded the Caregiver Intensity Index statewide through the federal National Family Caregiver Support Program, to assess caregivers who are connected to an older adult receiving agency administered services.

Blooming Health: The Blooming Health platform is used to send personalized and targeted communications to older adults and caregivers through text messages, voice calls, or email.

Blooming Health has significantly improved community outreach to older adults in New York, enrolling over 130,000 older adults across 40 counties. The platform enables instant two-way communication about vital information such as weather alerts, program deadlines, event reminders for evidence-based programs, nutrition education, wellness programs, and social engagement opportunities in over 80 languages. The initiative has led to a 10% reduction in social isolation, 7% increase in self-rated quality of health, 500% increase in SNAP benefit access, 200% increase in engagement, and has saved up to two hours per day per case manager by reducing call volume.

Discover Live: Discover Live offers premier virtual tours to incredible locales across the globe. Since 2017, this service has utilized live HD video (e.g. Zoom, WebEx, Teams, etc.) to connect older adults with expert tour guides. More than 100 senior centers, congregate dining sites, and Naturally Occurring Retirement Communities are providing older adults social enrichment experiences through this unique travel experience. As of July 2024, Discover Live provided 36 tours to an average of 1,000 older adults a month through this initiative.

GetSetUp: GetSetUp is a dynamic learning and discovery platform offering virtual classes tailored exclusively for older adults. With over 5,000 classes across 40 categories including technology, fitness, nutrition, cybersecurity, health and wellness, and social activities, it caters to diverse interests and needs.

In New York, GetSetUp has made a remarkable impact with over half a million class attendances and over 700,000 older New Yorkers supported. Eleven counties in New York have imbedded GetSetUp classes on their Office for the Aging websites providing instant access.

Older New Yorkers have found tremendous value in classes focused on technology and health and wellness, reflecting the community's commitment to staying connected and healthy. In fact, the top 10 classes/courses taken by older New Yorkers revolve around improving their own health.

Virtual Senior Center: The Virtual Senior Center was created in 2010 by SelfHelp Community Services to help homebound and socially isolated older adults stay connected to their community. The Center offers robust programs designed for older adults, managed by social workers who provide intentional engagement. The platform goes beyond just creating classes and content by fostering an inclusive and engaging environment where older adults can connect with one another from wherever they call home.

Since the start of the Virtual Senior Center's partnership with NYSOFA in 2021, 423 homebound older adults throughout 17 counties in upstate New York have been onboarded and are engaging with older adults from around the country. As a result of the programs and intentional engagement, 84% of participants reported a decrease in loneliness, and 76% reported feeling less depressed.

Intuition Robotics – ElliQ: ElliQ is an AI care companion robot designed to foster independence and provide support for older adults through daily check-ins, assistance with wellness goals and physical activities, and more using voice commands and/or on-screen instructions.

ElliQ is proactive and personalized. It initiates conversation, suggests activities, and remembers what users tell it. ElliQ encourages and works with users to set and help achieve goals. It is designed to convey empathy to create trust and drive engagement and behavior change. Older adults can also use the platform to contact family or other trusted individuals identified by the user, including Offices for the Aging case managers. All such communications are user-directed.

NYSOFA's program made 834 units available to older adults In the community. In 2023, the agency issued a report showing a 95% reduction in loneliness and great improvement in well-being among older adults using the platform. ElliQ users throughout New York have also demonstrated exceptionally high levels of engagement consistently over time, interacting with their ElliQ over 30 times per day, 6 days a week. More than 75% of these interactions are related to improving the older adults' social, physical and mental well-being.

Ageless Innovation – Joy for All: Since 2018, NYSOFA has provided more than 31,500 animatronic pets to older adults who experience social isolation. These plush, lifelike robotic pets are designed to make realistic sounds and motions, providing comfort and companionship to individuals.

The animatronic pet initiative started as a pilot in 2018 with 60 participants in 12 counties. NYSOFA found that 75% of older adults receiving these pets reported a reduction/significant reduction in loneliness as well as a 75% decrease in pain. The study was performed using the DeJong Loneliness Scale at different time intervals (pre-adoption of the pets and at three, six, and 12 months).

Onscreen: Onscreen turns TVs into interactive care hubs, making family video calls, telehealth, and virtual social events easily accessible for older adults that struggle with technology.

The platform also includes a TV-based AI companion that helps with regular check-ins and provides companionship, simplifying daily interactions and enhancing quality of life for older adults and caregivers.

Onscreen delivers a 59% improvement in self-evaluated happiness in users and a 76% improvement in self-evaluated happiness in caregivers. In addition, 88% of caregivers believe that Onscreen is helping their loved ones feel less lonely.

Oasas Support for Older Adults

Adults aged 65 and older continue to be one of the fastest-growing demographics in New York and across the nation. Rates of substance use and substance use disorders have risen significantly among older adults. This trend, coupled with age-related health issues, places older adults at greater risk of negative outcomes, including cognitive decline and disability. At the same time, older adults are being increasingly impacted by the opioid overdose epidemic: in 1999, adults aged 55 and older accounted for just 5 percent of overdose deaths, by 2021 they accounted for 28 percent. Aging adults face considerable barriers to accessing effective substance use disorder prevention, treatment, harm reduction, and recovery services. The Office of Addiction Services and Supports (OASAS) continues to support the establishment and expansion of programs that provide person-centered, trauma-informed care that is responsive to the unique needs of older adults, their families, and their communities.

Addiction Prevention Efforts

Through the federal Substance Abuse Prevention and Treatment Supplemental Grant, OASAS was awarded more than $1.3 million in funding in 2022 to support the expansion of addiction prevention efforts for older adults. Eight OASAS prevention providers were selected to engage with older adults through two evidence-based approaches to addiction prevention: the Wellness Initiative for Senior Education (WISE), a program focused on healthy aging and making healthy lifestyle choices, and Screening, Brief Intervention, and Referral to Treatment (SBIRT), a comprehensive public health approach that helps identify those at risk of developing substance use disorders and delivers early intervention and treatment services to individuals who exhibit habits of risky use of alcohol and other substances.

Providers made significant strides in reaching older adults for screening and SBIRT services. The OASAS WISE-SBIRT Initiative is being successfully implemented in over 100 diverse settings, including community centers, churches, independent living facilities, and town halls. As a result, more than 1,700 older adults have participated in the WISE program, and over 1,600 received a screening or SBIRT services. In addition, providers and participants consistently shared positive feedback regarding their experiences with these interventions. Preliminary data indicate that participants report an increased perception of harm from substance use/misuse, changes in health behaviors, increased social connectedness and community involvement, and a reduction in alcohol consumption among those who drink. Pairing WISE with SBIRT fosters opportunities for providers to build rapport with older adults which is crucial for increasing screening services and SBIRT in the population.

Developing New Guidance on Older Adults and Substance Use

In 2024, OASAS contracted with a national subject matter expert on the behavioral health needs of older adults, Dr. Frederic Blow, to develop comprehensive guidance for substance use disorder prevention, treatment, harm reduction, and recovery providers on best practices for working with older adults who use substances. The content of this document was informed by focus groups held with substance use disorder treatment providers, as well as an extensive literature review of current evidence-based practices and approaches for serving this vulnerable population. Key topics covered in the document include, but are not limited to, strategies for outreach and engagement, harm reduction approaches, suggestions for how to make current treatment approaches more responsive to the needs of older adults, and special considerations for diverse populations, including people of color, the LGBTQIA+ community, and women.

Once the document is finalized, OASAS will utilize the guidance to develop other materials, including trainings for providers, and educational resources for older adults and their families about substance use disorders and treatment. This package of resources and materials will expand access to high-quality, age sensitive care for all aging New Yorkers impacted by substance use.

Department of Veterans Services Support for Older Adults

The United States Department of Veterans Affairs estimates that New York State was home to 637,542 Veterans in 2024. Estimates further indicate that 445,073 of these Veterans were aged 55 and older (table three). The largest age demographic of Veterans in New York are between the ages of 75 and 79, which includes 93,897 individuals. This age range covers the large number of New Yorkers who served on active duty during the Vietnam War.

Table 3.

Estimated Veteran Population as of September 2024	New York State	United States
Number of Veterans	637,542	17,921,241
Percent of Adult Population that are Veterans	19.1%	6.9%
Number of Veterans Aged 55 and Older	**445,073**	**11,576,494**
Percent of Veterans Aged 55 and Older	**69.8%**	**64.6%**

The work of the New York State Department of Veterans' Services (DVS) in 2024 included the development of several new initiatives, and the sustainment of multiple ongoing programs, to best serve New York State's Veterans, Service Members, and Military Families. In addition to filing more than 40,000 claims for Veterans and Military Families to obtain federal benefits ranging from disability compensation to non-service-connected pension, the Department's work in 2024 included:

New York State Veterans Emergency Housing Fund

In February 2024, the Department launched the pilot program of the New York State Veterans Emergency Housing Fund, developed to provide rapid short-term assistance to Veterans who are unhoused or confronting imminent risk of homelessness. In this program's first day of existence, the Department granted seven applications from Veterans across the state who were in dire need. This work continued to accelerate throughout the duration of the pilot program. By the time the pilot program ended, the Department had granted applications for housing-related assistance for 91 Veterans in 28 counties.

Notably, the applications from most of these Veterans represented their first-ever contact with DVS. Each applicant received an individualized screening from an accredited Department Veterans Benefits Advisor, with many of these screenings demonstrating that the Veteran was eligible not only for this short-term fund but also for longer-term federal and state benefits. In each case, the Department represented the Veteran successfully in the claim for the benefit(s) for which they were eligible, providing a sustained long-term impact on their lives.

Based on the success of this pilot program, DVS launched the full Veterans Emergency Housing Fund program on Veterans Day 2024. To date, the Department has provided $402,783.41 in direct assistance through this program to Veterans and Military Families facing dire housing needs. At present, 62% of the Veterans receiving funds through this program are aged 55 or older.

Preventing Food Insecurity For Veterans, Service Members, and Military Families

Food insecurity is a public health threat affecting nearly 7.3 million older Americans and 13.7 percent of adults aged 60 and older in New York State. Up to half of older adults are at risk of malnutrition, a dangerous health condition that can lead to hospital costs 300% higher than for individuals who receive adequate nutrition. Economic disadvantages cause an additional strain, making it less likely that older adults have access to private transportation or can afford the cost of paying for trips to the grocery store. Veterans are also less likely to apply for financial assistance benefits such as the Supplemental Nutrition Assistance Program, exacerbating the impact of food insecurity for the older adult Veteran population.

In June 2020, DVS joined forces with the Governor's Anti-Hunger Policy Coordinator to establish the Meals with Meaning: Veteran Feeding Veteran program amid the difficulties of the COVID-19 pandemic. This initiative focuses on preventing food insecurity among Veterans, Service Members, and Military Families. Veterans face food insecurity at above-average rates, with post-9/11 Veterans confronting food insecurity at nearly twice the rate of their non-Veteran counterparts. New York State was able to develop a pipeline of meals to Veterans, Service Members, and Military Families in need of this assistance by establishing a partnership with donations provided by the meal kit company HelloFresh, in collaboration with community-based partners. This partnership has provided more than 1,800,000 nourishing meals to Veterans, Service Members, and Military Families. These collaborations continue in addressing this ongoing need as this initiative reached the 2,000,000-meal milestone in April 2025. More than 60% of program recipients are aged 55 and older.

Restoring Honor To Veterans Who Received Unjust Military Discharges

Since 2020, the Restoration of Honor Act has empowered DVS to reinstate State Veterans Benefits for those with Other-Than-Honorable Discharges. Factors such as Post-Traumatic Stress Disorder, Traumatic Brain Injury, Military Sexual Trauma, and former federal policies that instilled prejudice against sexual orientation and gender identity are considered. More than 50 benefits become accessible with an "honorable" determination, prompting DVS to aid in upgrading discharge statuses, and unlocking further life-changing programs.

To date, 56 Veterans, including many survivors of military sexual trauma and those adversely impacted by biased policies, have received favorable Restoration of Honor decisions, recognizing the true nature of their honorable service to our state and nation. DVS Commissioner Viviana DeCohen contacts each Restoration of Honor Act recipient personally to share this life-changing news with them, and whenever possible hand-delivers the award letter to the recipient. At present, nearly 40% of the Veterans who have received favorable Restoration of Honor Act determinations are aged 55 or older.

PFC Dwyer Peer to Peer Veteran Support Program

Older adults have the highest rates of suicide in the U.S. population, but most well-known national suicide prevention organizations do not have easily accessible prevention resources targeting this population, according to a new study led by researchers at McLean Hospital. Their findings highlight the urgent need for suicide prevention efforts that address the unique health care needs of older adults. Since 2003, the number of deaths by suicide among older adults aged 50 or older has increased by 83% across the nation. New York State, home to nearly 640,000 military Veterans in 2024, has consistently reported one of the lowest Veteran suicide rates in the nation. However, despite extensive prevention efforts, suicide continues to be a challenge among Veterans statewide. Recently released data from the U.S. Department of Veterans' Affairs show that suicide rates among Veterans increased from 2017 to 2022. New York Veterans die by suicide at a rate nearly twice as high as civilians.

Figure six illustrates that the suicide rate for Veterans aged 55 and older represents an area of significant need for intervention at rate of 33.2 per 100,000.

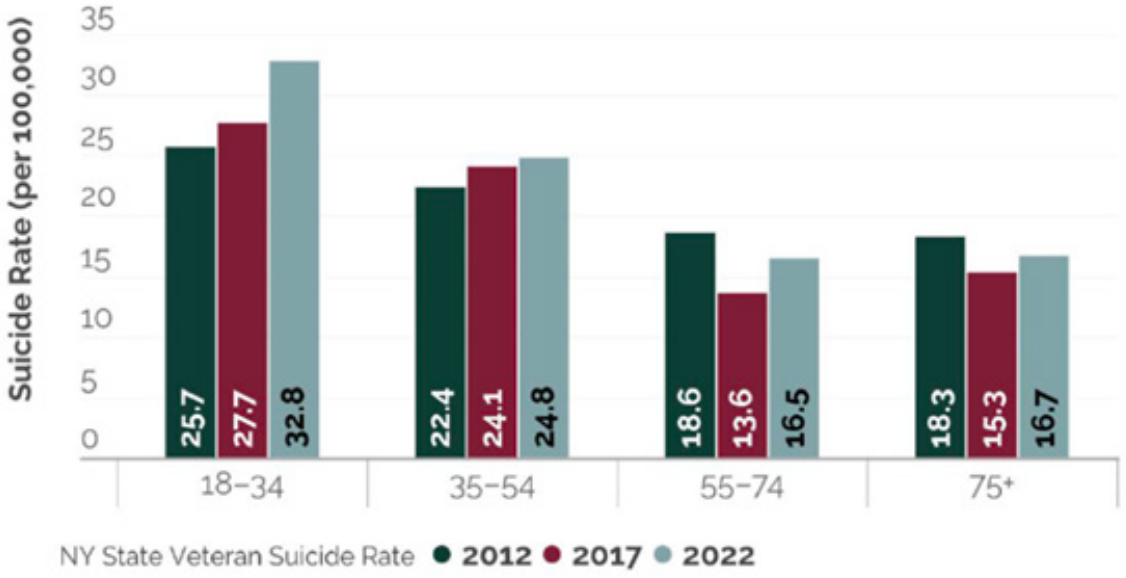


Figure 6: NY Health Foundation Data Snapshot: Veteran Suicide in New York State 2012-2022

With population data suggesting that more than half of the Veteran population in New York State is aged 65 or older, it follows that a significant proportion of those served by Dwyer programs are also in this age bracket and older adults are an important focus population.

Originally created to address the risk of suicide among Veterans, the mission of the Dwyer Peer to Peer Veteran Support Program now includes empowering Veterans and their family members to find passion, purpose, and hope as they transition from military to civilian life. Regardless of discharge status or era of service, the Dwyer Program brings U.S. Armed Forces Veterans, service members and their families together through Veteran-to-Veteran mentoring relationships, social activities, and community service for Veterans of all ages. The program offers a variety of non-clinical supports delivered by Veterans to Veterans to reduce social isolation and build community while promoting pro-social activity. These support services address the range of challenges Veteran's face in the community, including but not limited to Post-Traumatic Stress Disorder, suicidal ideation, traumatic brain injury, substance use disorders, depression, anxiety, and/or other mental health challenges. Each county's Dwyer Program uses a locally designed and highly flexible approach to support Veterans in their communities.

The University at Albany's School of Social Welfare is contracted by OMH to serve as the principal evaluator of the Dwyer Programs and their implementation. The evaluation process includes monthly service delivery data collection and analysis, regular consultation with Dwyer Program Directors, and summary evaluation reports for each county. The evaluation team also participates in a collaborative initiative, a multiagency Dwyer Workgroup, that includes weekly coordination meetings with representatives from DVS, OMH, the School of Social Welfare Dwyer Evaluation Team, and the Statewide Dwyer Coalition Director. The evaluation team held an in-person annual conference in November 2024.

The evaluation team also created an implementation guide and new program checklist for those counties included in the statewide expansion and has published two articles in peer-review journals to date with several

others in progress. Outcome data show that the program has made significant differences in the lives of Veterans and their family members across the state.

Preliminary summary data from 2024 indicate that over 42,500 individual units of support services were delivered in person to Veterans across the state by their local Dwyer programs during the calendar year. Over 140,000 units of support services were delivered via telephone, email, text, or virtually through a computer. The various Dwyer programs offered over 1500 support group sessions, with a total reported attendance of 11,490 Veterans. The programs also offered supports to family members of Veterans, with over 44,000 units of service delivery reported. A wide range of social activities and recreational activities were also held by each program, designed to reduce social isolation and build supportive peer-based networks. It should be noted that the data above are incomplete. Some county Dwyer programs are still in the process of compiling service delivery data, while others contain missing data in their reports. These should thus be viewed as underestimates.

SUMMARY

According to the U.S. Census Bureau, the New York State population of older adults aged 65-84 years grew by more than 33% between 2010 and 2020. The New York State population of older adults aged 85-99 years grew by more than 12% during the same period. Older adults have unique healthcare and service needs to address factors such as co-occurring chronic health conditions, activities of daily living, income, housing, food and nutrition, transportation, cognition, and social support. Community and home-based care models have been shown to improve the access, quality, and affordability of care for older adults. To meet the increasing and complex needs of older adults, many successful aging service program models leverage innovative technology, provide mobile outreach, utilize peer advocates, and cultivate cross-sector partnerships.

Older adults make valuable contributions to their families, their communities, and the state's economic health. The collective strengths and lived experience of older adults should be utilized to combat social isolation and loneliness and promote meaningful life activities as New Yorkers age. Equitable access to mental health, substance use, and aging services needs requires effective communication and collaboration between multiple state agencies and community-based partners. The Interagency Geriatric Mental Health and Substance Use Disorder Planning Council promotes these collaborative efforts and champions the use of holistic integrated care to support older adults and reinforce New York State's commitment to strengths-based age-friendly communities.