



# Interagency Geriatric Mental Health and Chemical Dependence Planning Council

Office of Mental Health

Office for the Aging

Office of Alcoholism and Substance Abuse Services

Division of Veterans' Affairs

## 2014 ANNUAL REPORT

### TO THE GOVERNOR AND LEGISLATURE OF NEW YORK STATE ON GERIATRIC MENTAL HEALTH & CHEMICAL DEPENDENCE

#### I: INTRODUCTION

With lessons learned from New York State's geriatric service demonstration program, a focus on fiscal viability, and the potential for providers to replicate or otherwise create effective and sustainable programs, continued progress is being made to better address the mental health and chemical dependence needs of older adults.

In addition, the Interagency Geriatric Mental Health and Chemical Dependence Planning Council met throughout the year and continued to collaborate on other state initiatives affecting the geriatric physical and behavioral health needs of the residents of New York, notably the Fully Integrated Duals Advantage Demonstration Project, the Balancing Incentive Program, and the newly established Integrated Outpatient Services regulations that further the integration of physical and behavioral health care in outpatient clinic settings.

A special focus of this report is on the second round of service demonstration projects (2011-2014) on the integration of physical and behavioral health care: planning recommendations; a summary of grantee experiences on the implementation, services integration, and sustainability of their projects; and a data summary. Also included are descriptions of ten new projects to integrate physical and behavioral health care for older adults that constitute the third round of service demonstration program grants that began in 2014.

#### II: BACKGROUND

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

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

changed requirements for Council recommendations and joint agency annual reports to include the Commissioner of Alcoholism and Substance Abuse Services, the Director of the Division of Veterans' Affairs, and the Adjutant General and to address geriatric mental health and chemical dependence needs.

### III: COUNCIL MEMBERSHIP

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

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

### IV: STATE INITIATIVES

The Council and its members continued to collaborate with others on a number of important New York State initiatives, such as those noted below, affecting the geriatric physical and behavioral health needs of the residents of the state.

- **Fully Integrated Duals Advantage (FIDA) Demonstration Project**

Through FIDA – a partnership between the Centers for Medicare and Medicaid Services and DOH's Division of Long Term Care – dual eligible individuals (Medicare and Medicaid) requiring 120 days of long-term care services and supports will have an option to be enrolled into this fully-integrated managed care plan. Key objectives are to improve the participant's experience in accessing care, deliver person-centered care, promote independence in the community, and improve quality through improvements in care and coordination. Dates for the demonstration period are January 2015 to December 2017.

The FIDA program has worked closely with OMH and OASAS to ensure the inclusion of behavioral health benefits in FIDA so that participants of the FIDA program have access to licensed OMH and OASAS providers via the FIDA plans' provider networks. FIDA plans are required to offer participants a choice of behavioral health provider where possible, and FIDA participants are able to continue seeing their existing behavioral health provider for

their current episode of care for up to two years to minimize any potential service interruptions. The FIDA program also incorporates many Nursing Home Transition and Diversion benefits which focus on both the behavioral and physical needs of participants who desire to stay in the community.

- **Balancing Incentive Program (BIP)**

Authorized by the Patient Protection and Affordable Care Act, BIP provides an enhanced Federal Medical Assistance Percentage of two percent as a financial incentive to states who are able to rebalance the delivery of long-term services and supports from institutional to community-based care. BIP requires states to make three changes to the structures of their long-term services and supports: (1) implementing a No Wrong Door/Single Entry Point, (2) utilizing Core Standardized Assessment instruments, and (3) establishing Conflict-Free Case Management.

Because BIP requirements apply to populations in need of long-term services and supports, a number of state agencies represented on the Council have been working on expanding the existing New York Connects Network established by NYSOFA and expanding New York's Uniform Assessment system to automate OMH and OPWDD tools that use the same core data set.

- **Integrated Licensing**

New York State established Integrated Outpatient Services regulations in January 2015 to further the integration of physical and behavioral health care in DOH, OASAS, and OMH outpatient clinic settings throughout the state. The identical regulatory language appears in the regulations of each of the three agencies and is the result of a nearly four-year collaboration that resulted in the development of clinical and physical plant standards, staffing requirements, and a single application and review process to improve the quality of care provided to consumers with multiple needs and reduce the administrative burden on providers.

The regulations were informed by an Integrated Licensing pilot project developed by DOH, OASAS, and OMH that consisted of seven providers and 15 clinic sites across the state (four of the seven providers were recipients of geriatric service demonstration program grants) and resulted in improving the overall coordination and accessibility of care.

The new Integrated Outpatient Services regulations further the core principles of the pilot project, which: (1) required a provider to possess licenses within their network from at least two of the three participating state agencies; (2) allowed the provider to deliver a desired range of cross-agency clinic services at a single site under a single license; (3) allowed the site's current license to serve as the "host"; and (4) facilitated the expansion of "add-on" services through request to the state agency currently possessing primary oversight responsibility for such services.

## **V: SECOND ROUND OF HEALTH INTEGRATION GRANTS (2011-2014)**

Planning to address geriatric mental health and chemical dependence needs continues to reflect Council discussions in 2008 that urged capitalizing on the service demonstration projects

authorized by the Geriatric Mental Health Act to identify lessons learned and innovative practices to set the base for geriatric behavioral health care in the future.

For the second round of service demonstration program grants (***Integrated Physical and Behavioral Health Care for the Elderly***), OMH solicited proposals to integrate physical and behavioral health care in either behavioral health care settings (Model 1) or physical health care settings (Model 2) to assist older adults with mental health and/or substance use disorders in New York State. A total of 21 awards were made in two separate phases for these two-year service demonstration projects, the last of which concluded on June 30, 2014.

The planning recommendations identified as a result of these projects are summarized below. Additional information is included in the appendices. See Appendix A for project descriptions; Appendix B for a summary of grantee experiences on the implementation, services integration, and sustainability of their projects; and Appendix C for a data summary.

### **Planning Recommendations**

- **Obtain High Level Organization Support**

Health integration sites need the commitment and day-to-day involvement of a consistent group of upper level management and cross-disciplinary team leaders in order to effectuate real organizational and clinical change.

- **Match Clinical Models with Patient Needs**

Integration sites should develop their clinical models based on the needs of their target populations, including an assessment of existing relationships that patients have with other health care providers and proactive development or organizational relationships with external health care providers.

- **Be Prepared**

Grantees who sought to integrate health care in behavioral health care settings (Model 1) had more difficult time than those who sought to integrate health care in physical health care settings (Model 2). The Model 1 projects had more challenges, many of them related to physical plant modifications, and required more approvals or authorizations from state agencies and others in order to provide on-site services.

- **Find a Partner**

This and the previous round of geriatric service demonstration projects related to health integration demonstrated that collaborative partnership models of integrated health care increase the probability of creating and sustaining effective programs.

- **Give Yourself Enough Time**

Three years is a more adequate length of time than two years (the duration of these grant projects) in which to plan, implement, operate, and evaluate a health integration initiative.

- **Invest Time in Implementation**

Time spent completing (1) pre-implementation tasks that need to be accomplished before the first patient is seen and in preparation for doing things differently and (2) initial implementation tasks when the program begins to function sets the stage for successful full implementation.

- **Develop the Back Office**

Given varied procedure and diagnostic code combinations necessary to meet individual payor requirements, integration sites need to develop an increasing level of sophistication in back office management in order to capture revenue for integrated health care services.

- **Identify Non-Fee-for-Services Sources**

Integration sites need to identify non-fee-for-service sources of support and/or funding to build increased capacity to provide services and cover activities not traditionally reimbursed, such as care coordination, interdisciplinary treatment team planning, and consultation services.

- **Make a Change**

Integration sites should approach change in a determined but incremental way. For example, be diligent about choosing an initial outcome target or risk factor or group to focus on, and use a data-driven approach to realize early success for the team and the organization.

- **Develop the Workforce**

Integration sites need to dedicate time to workforce development, including the development of new skill sets and cross-disciplinary team acculturation.

## VI: THIRD ROUND OF HEALTH INTEGRATION GRANTS (2014-2016)

The third round of service demonstration program grants (*Integrated Health Care for Older Adults*) continued to focus on health integration. OMH solicited new proposals to integrate physical and behavioral health care for older adults in either behavioral health care settings (Model 1) or physical health care settings (Model 2), requiring applicants to engage in at least one formal internal or external agency partnership in order to assure the on-site provision of integrated services and increase the probability of creating and sustaining an effective program.

A total of ten awards were made for these three-year service demonstration projects, which started in January 2014.

## **Project Descriptions**

- **Catholic Charities Neighborhood Services – Model 1**

Catholic Charities has been partnering with the Joseph Addabbo Family Health Center – a Federally Qualified Health Center – to provide integrated physical and mental health care for individuals living in Far Rockaway, Queens. The target population is mostly older adults receiving services at Catholic Charities' Rockaway Mental Health Services clinic and Rockaway PROS program, where a part-time primary care physician and a nurse from Joseph Addabbo hold office hours to provide physical examinations and health monitoring and link clients to specialty outpatient care.

- **Central Nassau Guidance and Counseling Services – Model 1**

For a population of new and existing older adults in its outpatient mental health clinic in Hicksville, New York, Central Nassau is partnering with Nassau Medical Associates to increase access and utilization of needed physical health care services, diagnose and treat physical health conditions, and produce better health outcomes. The project is integrating comprehensive behavioral health treatment services with on-site primary care provided by a physician and supported by medical assistants from Nassau Medical. Other services include management of identified health problems, referral, and care coordination.

- **Citizen Advocates – Model 2**

Citizen Advocates, Inc., North Star Behavioral Services is partnering with Alice Hyde Medical Center to integrate behavioral health screening, assessment, and treatment services for older adults in health centers in northern Franklin County located in Malone, Chateaugay, Moira, Fort Covington, and St. Regis Falls. Using a coordinated care model, the plan is for two licensed clinical social workers to provide on-site behavioral health services as part of an integrated care team. One social worker has been retained to date, making the project currently operational at three of the five sites.

- **Equinox – Model 1**

Equinox and the Whitney Young Community Health Center – a Federally Qualified Health Center – are collaborating to provide integrated health care primarily for older adults in Equinox's outpatient mental health clinic and PROS programs in Albany, New York. A full-time registered nurse completes health assessments and functions as health coordinator. A part-time physician's assistant from Whitney Young posted at the Equinox clinic conducts physical exams and provides routine and emergent physical health care services for recipients marginally linked or not linked to primary care providers, and makes referrals for more specialized care.

- **Erie County Medical Center Corporation – Model 1**

For a target population of older adults with serious mental illness in Buffalo and Erie County, Erie County Medical Center and its partner, the State University of New York at Buffalo's School of Medicine and Biomedical Sciences Department of Internal Medicine, planned to address unmet needs for primary care services in two of the hospital's mental health clinics. Physical health care was to be provided by an on-site primary care physician and a nurse.

However, changes at the hospital led to a series of implementation delays and a decision to limit participation in the service demonstration program to the first year of the grant.

- **FEGS/ Jewish Board of Family and Children's Services – Model 2**

Working closely with its partner, Maimonides Medical Center, FEGS partially embedded behavioral health services for older adults in two of Maimonides' outpatient primary care settings in Southwest Brooklyn before needing to transfer responsibility for the project to JBFCS because of financial difficulties. The goals of the health integration project with Maimonides remain the same, i.e., to identify and treat behavioral health disorders among older adults, implement a fully integrated care model, and reduce or stabilize the severity of chronic medical conditions exacerbated by behavioral disorders.

- **Glens Falls Hospital – Model 2**

Glens Falls Hospital's Behavioral Health Services is internally partnering with the hospital's Adirondack Medical Services to integrate behavioral health care for older adults in its rural health centers in Washington County located in Greenwich and Granville. The plan is to add a full-time psychiatric nurse practitioner, licensed clinical social worker, and medical technician to each health center. The project is currently operational at the Greenwich site. Integration is improving direct access to care and communication among providers, potentiating mutual support of shared goals, and assuring well coordinated care.

- **Liberty Resources – Model 1**

Liberty Resources is pursuing Article 28 licensure to introduce and integrate primary care in Liberty's Brownell Center for Behavioral Health, an outpatient mental health clinic in Syracuse, New York. The clinic augmented its staffing pattern with a nurse practitioner and mental health nurse to help provide and coordinate integrated care in the interim. Joining the project when Article 28 licensure is approved will be Syracuse Jewish Family Services, whose staff will conduct or coordinate PEARLS (the Program to Encourage Active Rewarding Lives) depression screens for older adults in the community.

- **Niagara Falls Memorial Medical Center – Model 2**

Niagara Falls Memorial, in partnership with its Department of Psychiatry and The Dale Association, is improving clinical outcomes and quality of life for older adults by integrating physical and behavioral health care and senior services at one of the hospital's primary care settings, the Summit Family Care Center in Wheatfield, New York. The project includes a part-time senior advocate, whose services are intended to address the psychosocial needs of older patients through linkages with housing, meal, caregiver, and other resources in the community.

- **Odyssey House – Model 2**

Through an internal partnership, Odyssey House has located a full-time social worker at its Article 28 diagnostic and treatment center in East Harlem to facilitate the integration of behavioral health care in a physical health care setting. The target population is older adults who access primary care services at the center and have substance use disorders or co-occurring mental health and substance use disorders. Working as a member of the medical

team, the social worker provides screening, assessment, and brief intervention services and serve as a behavioral health care manager to ensure appropriate referrals for treatment.

## **VII: SERVICE DEMONSTRATION PROJECT SUPPORTS**

### **Program & Policy Development Staff**

OMH staff in the Adult Community Care Group's Bureau of Program and Policy Development continue to provide ongoing program operational support for the geriatric service demonstration projects. Bureau staff have responsibilities for assigned projects that include on-site and off-site consultation and project oversight and work closely with staff responsible for the operation of New York State's Geriatric Technical Assistance Center.

### **Geriatric Technical Assistance Center**

OMH established a Geriatric Technical Assistance Center (GTAC) in 2011 and contracted with the National Council for Behavioral Health to provide programmatic and fiscal training and technical assistance for the service demonstration program grants. GTAC's work with the third round of health integration grantees in 2014 included:

- Introductory calls with the senior leadership of each grantee agency to discuss their organization's vision, commitment, and support of integrated services;
- In-person site visits to all projects;
- Monthly individual project coaching calls to help implement work plans and meet overall grant goals;
- Reinforcing principles of integration, sharing best practices from around the country, and disseminating clinical, organizational, and fiscal resources based on individual and group needs;
- Hosting face-to-face Learning Community meetings in Albany, webinars, and group calls to provide direct information and facilitate communication among grantees;
- Learning Community meeting topics on integration, finance, measurement, clinical care in the age of system reform, the crux of changing outcomes, aligning with new payors for integrated services, planning for sustainability, building internal support and alignment for integration efforts, what the data tells us, and documenting and analyzing work flow processes; and
- Webinar topics on using medications with the elderly, wellness programs for older adults with serious mental illness, and falls prevention at home and in the clinical workplace.

### **Health Integration Planning Guide**

Based on its training and technical assistance work in New York State, GTAC developed a geriatric health integration planning guide in March 2014 to assist providers plan and sustain health integration programs for older adults in either physical or behavioral health care settings. The guide, "Integrated Primary Care and Behavioral Health Services for Older Adults: Options for New York State Providers," is accessible at <http://www.nationalcouncildocs.net/wp-content/uploads/2013/08/Integration-Options-for-NYS-Providers-FINAL.pdf>.

## VIII: SUMMARY

New York State's planning to address the mental health and chemical dependence needs of older adults is taking full advantage of the geriatric service demonstration program and other state initiatives related to the changing landscape of health care to advance geriatric behavioral health.

The experiences of 40 geriatric health integration or outreach projects made possible by service demonstration program funding since 2007 – including the second round of health integration projects featured in this report – is informing the ability of providers to build effective and sustainable programs. The geriatric health integration planning guide developed by the Geriatric Technical Assistance Center is extending the Center's work beyond the service demonstration projects to others in New York State.

Collaborative planning in state initiatives affecting the physical and behavioral health needs of older adults in New York continues – notably in the FIDA Demonstration Program for those eligible for both Medicare and Medicaid, BIP to re-structure long-term services and supports, and Integrated Outpatient Services to further the integration of physical and behavioral health care in DOH, OASAS, and OMH outpatient clinics; but also in Health Homes for Medicaid enrollees with complex medical, behavioral, and long-term care needs, and in the Delivery System Reform Incentive Payment Program to reduce avoidable hospital use through delivery system reform.

**APPENDIX A: PROJECT DESCRIPTIONS**  
**SECOND ROUND OF HEALTH INTEGRATION PROJECTS (2011-2014)**

**Model 1 Projects: Integrated Care in Behavioral Health Care Settings**

- The **Association for Mental Health and Wellness (formerly Clubhouse of Suffolk)** partially implemented plans to operate an integrated health care program for adults age 55 or older with serious mental and/or substance use disorders. With an emphasis on coaching for the prevention and management of metabolic syndrome, peer wellness coach mentors were trained and engaged members in healthy lifestyle choices. The agency is looking to expand peer coaching while continuing efforts to co-locate a physical health care provider in its Personalized Recovery-Oriented Services programs.
- **Comunilife** established Mi Salud, a program of coordinated behavioral and physical health care management for Latino older adults – still in operation after the grant period – in an outpatient mental health clinic in the Bronx that serves primarily Latino adults, children, and families. A nurse practitioner was added to a designated clinical team that includes a bi-lingual psychiatrist and a number of part-time social workers and therapists to address behavioral, physical, and socio-economic needs of low income seniors with psychiatric disorders and chronic physical illness.
- **Coney Island Hospital** planned but was unable to staff an outpatient mental health clinic satellite it established at the Council Center for Senior Citizens in Brooklyn with a part-time social worker and nurse practitioner to integrate a variety of physical health services with behavioral health care for a multi-ethnic population of older adults that included Jewish-Americans, Russian, and Asian immigrants. The hospital withdrew from the service demonstration program before the end of the grant period.
- **Flushing Hospital Medical Center's** outpatient mental health clinic established an integrated health care program – still in operation after the grant period – that enabled their older adult patients to access primary care services at the clinic. An organizing principle to implement the program was a Metabolic Syndrome performance improvement initiative. An adult health nurse practitioner, who focused on preventive care and the interrelationship between a patient's medical and psychiatric illnesses, coordinated physical and mental health care.
- **Hudson Valley Mental Health** partnered with Hudson River HealthCare, an Article 28 health facility, to integrate physical health care into its outpatient mental health clinics. The agency began by implementing limited integrated care at its Dover Plains site, where a number of physical health care visits were provided by a nurse practitioner from Hudson River.
- **Institute for Community Living** co-located a part-time physician, nurse care manager, and peer wellness coach in its outpatient mental health clinic in Canarsie to provide on-site health assessment/monitoring and care management/coordination. The target population was elderly clients who do not have primary care providers, those who are not using primary care providers listed in their records, and those receiving treatment from multiple health providers without the benefit of care coordination. The program has continued to operate after the grant period.

- **Interborough Developmental and Consultation Center** implemented an integrated physical and behavioral health care program for the elderly – still in operation after the grant period – at its Flatbush outpatient mental health clinic. This site had high concentrations of older Russian immigrants seeking care. A nurse practitioner worked in collaboration with a physician to provide integrated care, which included physical exams, health wellness groups, complex care management, and integrated physical and behavioral health treatment plans.
- The **Mental Health Association of Nassau County**, in partnership with Nassau University Medical Center, co-located a physician at its behavioral health site in Hempstead to establish a health integration program – still in operation after the grant period – based on the expectation that the co-location of a primary care provider in this setting would allow it to function as a health home for their consumers. For mental health consumers age 55 or older, the goals were to improve overall health, promote recovery, foster independence, and reduce public expenditures.
- **Mercy Medical Center** renovated space at its outpatient behavioral health services site in Garden City to conduct physical examinations, added part-time physical health care staff, and reorganized procedures to integrate the delivery of care provided by both physical and behavioral health staff. The integration project – still in operation after the grant period – recently acquired the part-time services of physicians affiliated with the hospital to prepare for the transition of fee-for-service Medicaid behavioral health services to managed care.
- **Monsignor Carr Institute's** integration program – still in operation after the grant period and looking to expand – provided health screening and assessment, as needed physical examinations, health monitoring, follow-up, and care coordination services for clients age 55 or older at its outpatient mental health and chemical dependency clinics in Erie County. The agency hired a full-time medical assistant and contracted for a part-time nurse practitioner, who maintained regular hours at the two clinics and also consulted with mental health and chemical dependency staff on treatment options.
- **Montefiore Behavioral Health Center (formerly Sound View Throgs Neck Community Health Center)** provided primary health care screening, intervention, and treatment services tailored to individuals age 55 or older with serious mental health and substance use disorders at its outpatient mental health clinic in the Bronx. The integrated program – still in operation after the grant period and expanded – included the employment of primary care health professionals as well as referrals for highly complex cases to Montefiore Medical Center.
- **Service Program for Older People's** health integration program – the core components of which were still in operation after the grant period – utilized a psychiatric nurse practitioner to coordinate all medical services for SPOP's outpatient mental health clinic and homebound clients and expanded the hours of their psychiatrist to work in partnership with her. While the program served adults age 55 or older who came to the agency for behavioral health services, it especially focused on hard-to-reach groups of older adults, such as the frail homebound elderly and Spanish-speaking older adults.
- **Southeast Nassau Guidance Center** planned and initially implemented an integrated health care program operating within the model of a person-centered healthcare home in which a nurse practitioner and other specialty staff assessed and medically monitored adults

age 55 or older receiving treatment in its outpatient mental health clinic. When the program's nurse practitioner resigned, Southeast Nassau was unable to recruit a qualified replacement and withdrew from the service demonstration program before the end of the grant period.

- **Union Settlement Association** added a full-time nurse practitioner to the staff of its Johnson Counseling Center outpatient mental health clinic and its satellite senior centers in East Harlem to integrate health care for their clients age 55 or older. Working as part of a team with each client's therapist or social worker and primary psychiatrist, the nurse practitioner provided on-site physical health assessments, screening, monitoring, treatment, and referrals to partners and others for additional health services. The agency is looking to fill a key staffing position to continue the program.

### **Model 2 Projects: Integrated Care in Physical Health Care Settings**

- **Adirondack Medical Center** integrated behavioral health care services for adults age 55 or older into its primary health clinics in Essex and Franklin counties. A psychiatric nurse practitioner was co-located at the clinics to complete assessments and consult with care team members. The program – still in operation after the grant period and expanded – has enabled the medical home care team, which consists of primary care providers, care coordinator, nutritionist, doctor of pharmacy, psychiatrist, and health educator, address a larger range of patient issues.
- **Bassett Medical Center** integrated behavioral health care for the elderly into its primary care clinic in Cobleskill, which is also a satellite location of Bassett's outpatient mental health clinic in Cooperstown. Patients completed basic behavioral health screens that were scored by primary care nursing staff, who referred those with positive scores to an on-site LCSW; she then completed the assessment process, in collaboration with the primary care team, and provided behavioral health treatment services, including counseling.
- **Cayuga Counseling Services** provided behavioral health services to residents of two recently merged nursing homes in Cayuga County now operated by Loretto. A licensed psychiatric nurse practitioner provided medication consultation services, and two licensed therapists provided therapy for adults age 55 or older. Program goals included the alleviation of symptoms of depression, anxiety, and psychosis, and improving the quality of life of residents who live there. The program has continued to operate after the grant period through a contract with Loretto.
- **Family Services of Chemung County** added behavioral health assessment and treatment services to primary care at Arnot Medical Services' Eastside Family Medicine primary care office in Elmira. The office is also a satellite location of Family Services' outpatient mental health clinic. Designed to serve as a blueprint for integrated treatment in Chemung County, the program – still in operation after the grant period – emphasized the importance of illness prevention, early intervention, and relapse prevention.
- **Henry Street Settlement's** health integration program targeted low-income adults age 55 or older in New York City's Community District 3, including the Lower East Side and Chinatown. A LMSW from the agency's mental health clinic was stationed at its Article 28 medical health care facility to facilitate the integration of physical and behavioral health care and senior services. While not in operation after the grant period, the program has resulted

in closer collaboration, formal interdisciplinary planning, and “warm hand-offs” of patients between medical and behavioral health staff.

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

**APPENDIX B: SUMMARY OF GRANTEE EXPERIENCES  
SECOND ROUND OF HEALTH INTEGRATION PROJECTS (2011-2014)**

**“Final Reflections”  
Model 1 Grantees Summary**

**I. Implementation.** Looking back on your experience during this demonstration project, how would you characterize the experience of implementing your program?

Select Successes:

- Excitement from staff and patients about integration during grant process
- Held multidisciplinary staff meetings
- Integrated wellness/physical well-being brochures and reading material in waiting areas
- Built great rapport between the psychiatric nurse practitioner and patients; established “warm hand-offs” during admissions process and routine exams
- Provided routine “check-ups” and venipuncture services to clients

Select Challenges:

- Recruitment of staff during grant process
- Management changed hands numerous times, including staff positions, which put a strain on employee and patient rapport during the process
- Transitioning from a stand-alone clinic to a hospital-based clinic
- Recruitment of new patients in surrounding areas remained low despite outreach efforts
- Client reluctance to participate in health and wellness activities
- Data collection and implementation of results

Lessons Learned:

- Need adequate financial resources up front to start service integration
- Be flexible with changing healthcare systems and structures
- Important to track health monitoring accurately and capture the data accurately
- Making a thorough assessment of clients and their existing relationships with primary care physicians (if they had one).
- All staff need to share patient information and be open to the integration model

**II. Integration of Service Delivery/Treatment.** How would you characterize the process of integrating physical or behavioral health services into your program and the process of delivering integrated physical and behavioral health services?

Select Successes:

- Integration of health goals into established treatment plan had become the norm
- Collaboration among medical providers
- All mental health staff were advocates on behalf of their patients for better physical care and well-being; aided them in getting regular check-ups and lab work done

- Having an established electronic health record system for patient services and billable encounters

Select Challenges:

- Lack of a nurse practitioner proved to make a difference in level of care that patients received
- Client no-show rates were high
  - Limited availability of medical staff made it difficult for patients to schedule appointments
  - Client trust issues with those clients wishing to keep their medical and mental health providers separate
- Lack of EMRs which has led to insufficient data collection on patients

Lessons Learned:

- Continued availability of both health and mental health on-site is invaluable
- Constant communication and collaboration are needed between medical and mental health staff about consumers' health and wellness
- Intensive outreach and patient education is vital to the growth of all practices

**III. Sustainability.** Now that the project is nearing its end, how would you characterize the experience of working to ensure the sustainability of your program?

Select Successes:

- Have proper funds for adequate staff
- Budgetary funds were made available for both medical and mental health staff
- Strengthened relationship between both mental health and primary care providers
- Medically based activities had been identified that could be billed to a client's insurance provider and later reimbursed
- Preventative services were identified and implemented specifically for high-risk clients

Select Challenges:

- Inability to recruit a nurse practitioner
- Reimbursement for medical services provided by MD and RN provided by a mental health clinic was not sufficient
- Our sustainable model requires a very high volume and quick pace by our NPP, who is able to spend less time in consultation with staff
- Proper billing and coding methods needed to be identified at outset

Lessons Learned:

- Commitment is needed to continue to provide integrated health to all patients
- Important to keep in mind the status quo and anticipated changes
- Without having a multidisciplinary approach, sustainability will remain a fickle concept
- Difficult to sustain full services through insurance revenue

**“Final Reflections”  
Model 2 Grantees Summary**

**IV. Implementation.** Looking back on your experience during this demonstration project, how would you characterize the experience of implementing your program?

Select Successes:

- Communication and collaboration among behavioral health and primary care physician staff members was key
- Primary care staff not getting “bogged” down in behavioral health issues, more just general education on the broad spectrum on behavioral health disorders
- Having a primary nursing practitioner from the outset
- Getting over the resistance by staff to change the way the health care system had been running to a new integrated treatment system
- Patients who had participated in the program were receiving adequate care from both service providers and reported being better for it

Select Challenges:

- Time management and maintaining a workflow that could reasonable meet the needs of both physical and behavioral health providers
- Blending two service providers into one space created space constraints
- Sharing patient information among multidisciplinary staff needed to be more streamlined

Lessons Learned:

- Be flexible with new changes to existing health care structure
- Be aware of financial needs at outset of integration
- Define target population and help staff know who an appropriate referral is

**V. Integration of Service Delivery/Treatment.** How would you characterize the process of integrating physical or behavioral health services into your program and the process of delivering integrated physical and behavioral health services?

Select Successes:

- Having open and honest communication between all service providers
- Continued education for primary care staff on the complexity of mental health issues
- Implemented new records system to existing medical records system exclusively for behavioral health screens
- Active use of screening instruments for behavioral health issues

Select Challenges:

- Not all staff members were immediately open/accommodating to an integrated health system and required a lot of education and rapport building
- Even with current patient information in the EMR, It is critical but difficult to have a weekly “huddle”/team meeting with the interdisciplinary staff
- Budget crisis resulted in numerous staff cuts

Lessons Learned:

- Be open to change at all levels of management (micro and macro)
- Be flexible with billing and insurance providers
- Follow-up with patients has to be consistent
- May need to implement outreach efforts to bolster referrals for primary health care facility.
- Validating each other's respective field when integrating goes a long way
- Have patience

**VI. Sustainability.** Now that the project is nearing its end, how would you characterize the experience of working to ensure the sustainability of your program?

Select Successes:

- Relied on referrals and relationships made with other organizations if/when funding is an issue
- Increased patient flow and patient referrals
  - Having easy patient follow-up appointments and screening tools streamlines the process
- Established a billing plan that is easy to use for both the service provider and the patient

Select Challenges:

- Primary care providers are very busy, and this can make it difficult for them to adequately meet the mental health needs of their patients
- Our challenge is working with volume limitations in our patient load
- The billing and payment process is tedious and focused on cutting costs rather than in sync with treatment outcomes
- We spent a great deal of time exploring various ways of reimbursement, but there was no alternative to establishing a satellite mental health clinic

Lessons Learned:

- Continued collaboration and respect for one another on behalf of mental health providers and primary care providers
- Have patience and pay detailed attention to project management
- Cultivate relationships with external providers for both business development and for patient care
- Be flexible
- Think about sustainability from the outset
- Systemic, regulatory changes are needed in order to realize true integration

**APPENDIX C: DATA SUMMARY  
SECOND ROUND OF HEALTH INTEGRATION PROJECTS (2011-2014)**

**Introduction**

Once data protocols were established and implemented in 2013, data on individuals served were collected at time of initial screening, annual screening, and – for individuals with screening scores defined as “positive” or “at risk” – at three month follow-up intervals. This information, in non-individually identifiable form, was submitted on a monthly basis to GTAC, which created data reports that were shared with grantees and OMH.

**Screening Instruments**

- The three behavioral health screening tools used were the Patient Health Questionnaire (PHQ-9) for depression, the General Anxiety Disorder scale (GAD-7) for anxiety, and the Alcohol Use Disorders Test - Consumption (AUDIT-C) for alcohol misuse.
- The four physical health screens utilized were Blood Pressure, Body Mass Index (BMI), Fasting Blood Glucose (FBS), and self-reported Tobacco Use.

**Overall Screening Results**

- A total of 3,552 individuals were screened, and 69 percent of them (2,462) were age 55 or older. A total of 5,767 screenings were conducted (many individuals were screened more than once), and 69 percent of them were for those age 55 or older.
- Of the 2,462 individuals age 55 or older who were screened, 47 percent of them (1,161) scored at risk for one or more of the seven health indicators.

**Model 1 Projects Screening Results**

- Model 1 projects – integrating physical health into behavioral health care settings – were required to screen individuals with all four physical health screens and the PHQ-9 and AUDIT-C.
- A total of 1,539 individuals were screened in Model 1 projects, 738 of them age 55 or older. Table 1 shows the number of individuals age 55 or older with baseline at-risk screening scores in Model 1 projects.

**Table 1**

Number of Individuals 55+ with At-Risk Screening Scores in Model 1 Projects						
PHQ-9	GAD-7	AUDIT-C	Blood Pressure	BMI	FBS	Tobacco Use
288	129	31	423	460	99	146

## Model 2 Projects Screening Results

- Model 2 projects – integrating behavioral health into physical health care settings – were required to screen individuals with all three behavioral health screening tools, and if one or more of these screens yielded an at-risk score, the four physical health screens were additionally utilized.
- A total of 2,013 individuals were screened in Model 2 projects, 1,724 of them age 55 or older. Table 2 shows the number of individuals age 55 or older with baseline at-risk screening scores in Model 2 projects.

**Table 2**

Number of Individuals 55+ with At-Risk Screening Scores in Model 2 Projects						
PHQ-9	GAD-7	AUDIT-C	Blood Pressure	BMI	FBS	Tobacco Use
418	346	316	387	419	123	110

## Wellness and Prevention Counseling

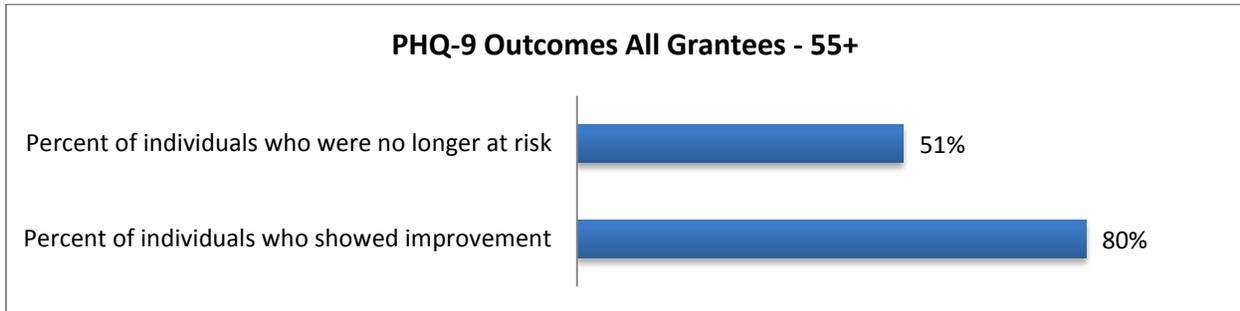
- In addition to program-provided care and treatment services and as needed referral to external providers of specialty care, both models of health integration projects offered five types of wellness and prevention counseling: Healthy Eating and Nutrition, Physical Activity, Stress Management, Smoking Cessation, and Alcohol Use.
- Overall, 78 percent of individuals age 55 or older who scored at risk for one or more of the behavioral health screens received at least one type of wellness and prevention counseling.
- Overall, 87 percent of individuals age 55 or older who scored at risk for one or more of the physical health screens received at least one type of wellness and prevention counseling.

## Health Improvement

- Health improvement was noted by measuring the change between an individual’s baseline at-risk screening scores and his or her most recent follow-up screening scores.
- In the figures that follow, improvement is shown as “no longer at risk” and as any positive change or “improvement” in screening scores, including the scores of those no longer at risk. The data are aggregate data for individuals age 55 or older collected from all of the health integration projects irrespective of model type.
- Figures showing FBS and Tobacco Use outcomes are not included because of the low number of individuals age 55 or older who had valid FBS and Tobacco Use follow-up screens.

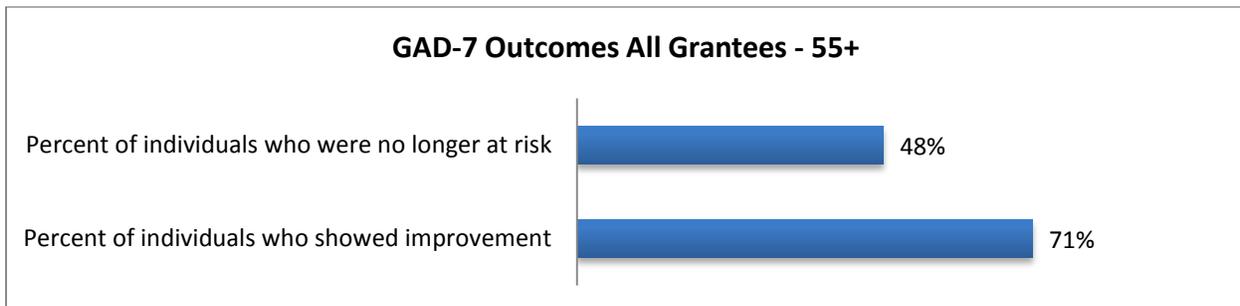
- Figure 1 shows PHQ-9 outcomes for individuals age 55 or older who were at risk at their baseline screen. Of the 84 individuals who were at risk at baseline and had a valid follow-up screen, 51 percent were no longer at risk and 80 percent showed improvement.

**Figure 1**



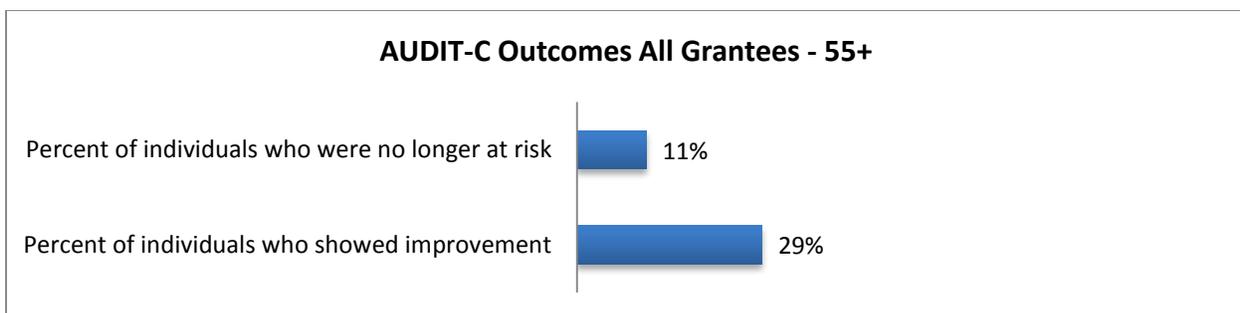
- Figure 2 shows GAD-7 outcomes for individuals age 55 or older who were at risk at their baseline screen. Of the 73 individuals who were at risk at baseline and had a valid follow-up screen, 48 percent were no longer at risk and 71 percent showed improvement.

**Figure 2**



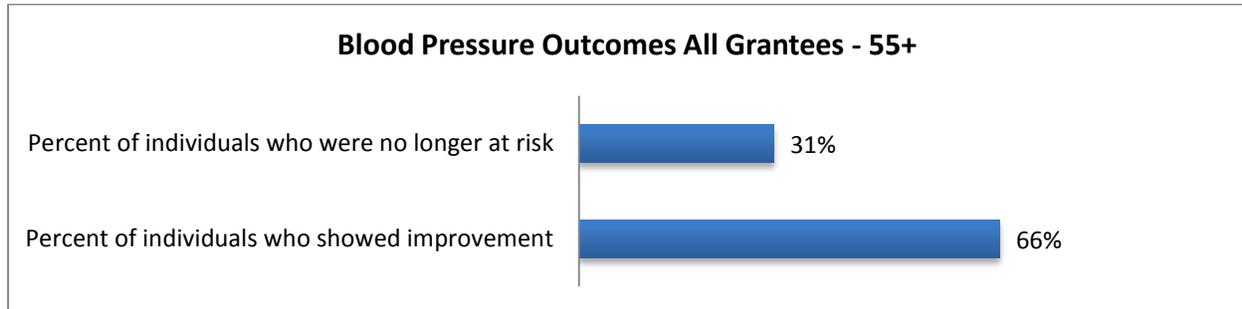
- Figure 3 shows AUDIT-C outcomes for individuals age 55 or older who were at risk at their baseline screen. Of the 83 individuals who were at risk at baseline and had a valid follow-up screen, 11 percent were no longer at risk and 29 percent showed improvement.

**Figure 3**



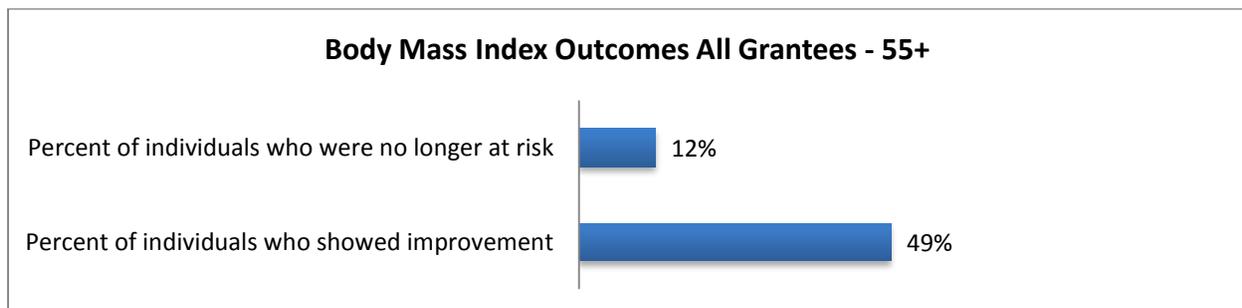
- Figure 4 shows Blood Pressure outcomes for individuals age 55 or older who were at risk at their baseline screen. Of the 147 individuals who were at risk at baseline and had a valid follow-up screen, 31 percent were no longer at risk and 66 percent showed improvement.

**Figure 4**



- Figure 5 shows BMI outcomes for individuals age 55 or older who were at risk at their baseline screen. Of the 176 individuals who were at risk at baseline and had a valid follow-up screen, 12 percent were no longer at risk and 49 percent showed improvement.

**Figure 5**



## Conclusions

Recipients of the second round of geriatric service demonstration program grants were largely successful in integrating health care for the elderly in behavioral and physical health care settings despite a host of challenges that included implementing integrated care in a short period of time, seeking approval to provide on-site services, learning the value of partnerships, hiring the right staff, and preparing for sustainability in a changing health care environment. Later than expected establishment of data protocols in 2013 resulted in limiting the amount of data collected, especially for first phase or group of five Model 1 projects, and the US Food and Drug Administration’s 2013 determination that glucose meters may not be used for screening slowed the collection of FBS data for an elderly population often resistant to blood draws.

Nevertheless, the health integration projects established effective screening and evaluation procedures, provided and/or referred out for needed services, engaged a large percentage of their patients in wellness and prevention counseling, and demonstrated positive outcomes.