

2016

Interagency Geriatric Annual Report

Interagency Geriatric Mental Health and
Chemical Dependence Planning Council



**Office of
Mental Health**

2016 Annual Report on Geriatric Mental Health and Chemical Dependence

This report has been submitted to the Governor and Legislature of New York State

I. Introduction

New York State Geriatric Mental Health Act took effect in April 2006. What was initially called the Interagency Geriatric Mental Health Planning Council held its first meeting in May 2006, and requests for proposals for the first round of geriatric service demonstration program grants were issued in November 2006.

Ten years and 48 demonstration grants later, the Interagency Geriatric Mental Health and Chemical Dependence Planning Council (the Council) continues to actively meet and discharge its responsibilities, a third round of service demonstration projects on health integration for older adults drew to a close, and a new fourth round on local partnership innovation for older adults was set to begin.

A special focus of this report is on the recently concluded third round of service demonstration program grants on the integration of physical and behavioral health care: (1) planning recommendations; (2) a summary of grantee experiences with project implementation, services integration, sustainability, and data collection and utilization; and (3) a data summary.

Also included are descriptions of the eight new grant projects to create local “triple partnerships” of mental health, substance use disorder, and aging services providers to innovatively address the unmet needs of older adults for these services.

II. Background

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

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

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.

Reference to the Geriatric Mental Health Act, its provisions, and the first three rounds of service demonstration program grants were included in an October 2016 publication from the Substance Abuse and Mental Health Services Administration entitled ***Developing or Enhancing Your State's Older Adult Behavioral Services***.

III. Council Membership

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

- The Commissioner of the New York State Office of 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 (OCFS);
- One member representing the Office of Temporary Disability Assistance (OTDA);
- 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. Council Collaboration

The Council and its members continued to collaborate with others in a number of important areas affecting the behavioral, physical, and psychosocial health needs of older adults in New York State. Council meetings in 2016 included presentations, agency updates, and reporting on work related to:

- The Alzheimer's Disease Caregiver Support Initiative;
- Certified Community Behavioral Health Clinic planning grants and demonstration programs;
- Focusing on women veterans during Women's History Month;
- Fully Integrated Duals Advantage plans;
- The Green House model of nursing home care and a visit to a local example of one;
- The Livable New York Legal Services Initiative;
- A Livable New York Resource Manual;
- Managed Long-Term Care services;
- The Nursing Home Transition and Diversion Medicaid Waiver Program;

- An Office of Community Living Feasibility Study;
- The Olmstead Housing Subsidy Program;
- A Project Extension for Community health Care Outcomes in Geriatric Mental Health;
- System Barriers or challenges to providing older adult services;
- Outreach efforts with Vietnam Veterans, the largest veterans' population in need; and
- World Elder Abuse Awareness Day

Council member agency staff from DOH, NYSOFA, OASAS, OCFS, OMH, and OPWDD also supported a number of statewide conferences and education and training initiatives related to older adults through assistance in planning programs, delivering presentations, and serving on expert panels, including these four conferences or trainings:

- **Substance Use Among the Aging Population: A System-Wide Response** – This one-day summit and conference was sponsored by the New York State Association of Alcoholism and Substance Abuse Providers and co-sponsored by OASAS and NYSOFA. It brought together more than 100 providers of substance use disorder prevention, treatment, and recovery services; behavioral health; and aging service agencies, organizations, and coalitions from across New York to create and expand a better informed and integrated network of providers who serve older adults dealing with or at risk of problems related to substance use.
- **Aging Concerns Unite Us Conference** – Sponsored by the Association of aging in New York, this annual two-day conference provided educational programming for local area agencies on aging and other leaders in the field, attracting more than 450 professionals from New York State who provide services for older adults and their caregivers. The 2016 conference included an expert panel discussion by staff from DOH, NYSOFA, OASAS, OMH, and OPWDD on New York Connects, a locally based No Wrong Door system established by NYSOFA in collaboration with DOH in 2006 that provides one stop access to information and assistance for individuals of all ages needing long-term services and supports
- **Adult Abuse Training Institute: Community Collaboration and How Partnerships Can Expand Your Toolkit** – The 2016 institute was presented by the Brookdale Center for Healthy Aging on behalf of OCFS and brought together more than 400 participants from a variety of public, non-profit, and private service providers. Goals of the training included building the networks, collaboration, skills, and knowledge of those working with vulnerable adults; promoting the exchange of information, innovative thinking, and best practices; and improving the provision of services to protect vulnerable adults. A Council member from the Mental Health Association of New York City and staff from NYSOFA, OASAS, OCFS, and OMH conducted a number of workshops at the institute, including a joint presentation on “Partnership Innovation for Older Adults,” a new round of geriatric service demonstration program grants.
- **New York Connects/No Wrong Door Regional Training** – To ensure continuous quality improvement, NYSOFA collaborated with the Association of Aging in New York to conduct nine one-day regional training sessions for area agency on aging and partner agency staff in fall 2016. The training focused on skills-based learning and program updates related to the significant expansion and enhancement of the New York Connects system as a result of the state's

participation in the Balancing Incentive Program, which provides enhanced federal funding to states that commit to rebalancing their system of long term services and supports from institutional to community-based care. In addition to NYSOFA, staff from DOH, OASAS, OMH, and OPWDD also presented at the sessions.

V. Round 3 Service Demonstration Project (2014-16)

The third round of geriatric service demonstration program grants made possible by the Geriatric Mental Health Act focused on health integration, as did most of the previous grants.

For a three-year grant period, OMH solicited proposals in 2013 to integrate physical and behavioral health care for older adults in either behavioral health care settings (Model 1) or physical health care settings (Model 2). Because previous rounds of geriatric health integration projects demonstrated that collaborative partnership models of integrated health care increased the probability of creating and sustaining effective programs, applicants were required to engage in at least one formal internal or external agency partnership in order to assure the on-site provision of integrated services.

A total of ten awards were made throughout the state for these service demonstration projects (*Integrated Health Care for Older Adults*), which were also expected to utilize Core Implementation teams, fast-track pre-implementation and program installation tasks, and be sustainable and fiscally viable without grant support by the conclusion of the grant period in December 2016.

Additional Information

The appendices attached to this report provide 14 pages of additional information about these grant projects.

- **See Appendix A** for updated descriptions of each of the Model 1 and Model 2 health integration programs.
- **See Appendix B** for a summary of grantee experiences on implementation, services integration, sustainability, and the collection and utilization of data.
- **See Appendix C** for a data summary

Planning Recommendations

Planning recommendations to address geriatric mental health and chemical dependence needs to continue 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 for the future. The planning recommendations identified as a result of the third round of projects are summarized below.

- **Successful Integration Requires Organizational Commitment** – Organizations who most successfully implemented integrated care viewed their grant projects as central to their vision and strategic plan, not as just another program option or addition to their menu of services. They exhibited the perseverance and stamina needed to meet the challenges of a rapidly changing health care environment.
- **No Mission No Margin, No Margin No Mission** – Connecting service delivery, cost, and outcomes was difficult for many of the grantees who were

unaccustomed to establishing costs for their services and tracking related patient outcomes. The recommendation for those seeking to integrate health care for older adults is to pay special attention to these areas in planning for sustainable integration, especially as they apply to arrangements for value-based payments.

- **Partnership Requires Shared Values, Shared Wins, and a Shared Commitment to Change** – While collaborative partnership models of integrated health care typically increase the probability of creating and sustaining effective programs, they involve a lot of coaching and ongoing practice. This entails strong organizational relationships, leadership commitment, mutual financial benefit, and ongoing attention to maintaining partnership relationships.
- **Be Prepared** – Despite some progress in the state regulatory environment during the three-year grant period, grantees who sought to integrate physical health care in behavioral health care settings (Model 1) continued to have a far more difficult time than those who sought to integrate behavioral health care in physical health care settings (Model 2). This was especially true for grantees seeking state approval to co-locate Article 28 primary care services in an Article 31 mental health clinic, which can be an expensive and time consuming process. Before examining options to establish a Model 1 health integration program, an organization needs to know (1) if the demand for physical health services is sufficient to sustain, at a minimum, a part-time primary care practice and (2) if it has the capacity to make required physical plant changes.
- **Consider Access to Workforce, Recruiting Strategies, and Salary Requirements** -- The grantees in this round of geriatric service demonstration projects struggled with recruiting an appropriate workforce – including licensed clinical social workers, psychiatric nurse practitioners, and primary care providers – for their programs. A plan for developing integrated health care needs to include consideration of salary packages, benefits, and assertive recruitment for hiring and retaining the right people.
- **Culture Change Requires Time** -- While the three-year grant period demonstrated considerable project improvement over time, many of the grantees ended up in a place different than they expected. For most, this was a positive development and spoke to their commitment not only to develop their project but also to completely change the way they do business in order to focus on the whole health and wellness of those they serve.

V. Round 4 Service Demonstration Projects (2017-21)

For the fourth round of service demonstration program grants, OMH solicited proposals in 2016 to create local “triple partnerships” of mental health, substance use disorder, and aging services providers to innovatively address the unmet needs of older adults for these services. The Request for Proposals was largely based on recommendations made by members of the Council in June 2015 for local partnerships, outreach support, off-site support, and technology to innovatively meet the unmet needs of older adults in New York State.

Local triple partnerships are to: (1) access behavioral health services for those in aging services programs who need them; (2) access aging services for those in behavioral health services programs who need them; (3) develop and utilize substantial mobile outreach and off-site services capacity to identify at-risk older adults in the community who are not connected to the service delivery system or who encounter difficulties

accessing needed services, assess their needs for services, and provide and/or access services to address unmet needs; and (4) utilize technological innovations such as telecare, telemedicine, telepsychiatry, and mobile technologies.

A total of eight awards were made for these new five-year service demonstration projects (*Partnership Innovation for Older Adults*), all of which are to receive operational support from OMH staff and programmatic and fiscal technical assistance from New York State's Geriatric Technical Assistance Center.

Project Descriptions

- **Central Nassau Guidance & Counseling Services'** triple partnership includes the Family & Children's Association and the Nassau County Office for the Aging, with each of the three agencies responsible for delivering a specific set of services county-wide. Their program, called the Link-Age Project, will utilize care co-ordination to assure the integration of needed services for an older adult population to be served that is expected to be 40 percent black and Hispanic. In addition to partnership provided services, the program will also connect older adults to a range of services delivered by more than 75 collaborative agencies.
- **Family Services of Westchester's** triple partnership intends to bring mobile outreach and off-site services, behavioral health services, and aging services – including telehealth interventions – to older adults in Westchester County with the goal of reducing the isolation and decline that can accompany untreated behavioral health and unaddressed aging issues. The partnership, which includes the Westchester County Department of Senior Programs and Services and the Lexington Center for Recovery, plans to operate their program as one unified program with a core implementation team comprised of members of each partner agency.
- **Flushing Hospital Medical Center** – for a population of older adults in the racially/ethnically diverse neighborhood of Flushing, New York, Flushing Hospital's triple partnership plans to increase access to behavioral health and aging services by employing collaborative strategies that utilize outreach and telemedicine technology to identify and engage at-risk individuals; one such strategy is a Mobile Health van staffed by a master's prepared clinician to provide mobile outreach and off-site services. Members of the partnership, which include Arms Acres and the New York City Department for the Aging, will directly provide or connect older adults with the services they need.
- **The Institute for Family Health's** triple partnership includes the Ulster County Office for the Aging and Step One Child & Family Guidance Center Addiction Services. The partnership's goal is to launch and sustain a mobile outreach, care navigation, and telehealth program that increases access for older adults who are not connected to the county's traditional behavioral health and aging services. Made more severe by widespread unemployment and limited public transportation, the population to be served has difficulty accessing critical medical care and social services in locales that are largely mountainous, primarily rural, and characterized by several small towns and villages.
- **Niagara County Department of Mental Health** – with the Niagara County Office for the Aging and NorthPointe Council as partners, the Niagara County Department of Mental Health's triple partnership intends to create a strong, connected network of behavioral health and aging services providers and leverage other existing supports to meet the needs of at-risk older adults in

Niagara County, helping them not only remain safe in the community but also flourish. The program will utilize community-based case management staff and a mobile Older Adult Clinical Specialist to ensure the ability to reach isolated individuals and those who are reluctant to reach out because of cultural beliefs or stigma.

- **Onondaga County Department of Adult & Long-Term Care Services** (which includes the county's Department for the Aging) and its partners, Liberty Resources and Syracuse Behavioral Health, formed a triple partnership to expand services for a diverse population of older adults. Their program, called the Senior Health and Resource Partnership Project, seeks to increase the integration of aging and behavioral health services while addressing natural and manufactured barriers to service accessibility such as limited English language proficiency, cultural mores, cognitive and physical impairments, poverty, perceived shame, and isolation.
- **Orange County Department of Mental Health's** triple partnership plans to create a service delivery infrastructure that will maximize linkages to existing community-based assessment, treatment, and supportive services by creating a geriatric team to educate providers on specialized engagement strategies and offer immediate treatment and linkages to care. The partnership, which includes Catholic Charities of Orange County and the Orange County Office for the Aging, will also help develop a tele-psychiatry network in the county and plans to replicate the Gatekeeper model to train the outreach team on cultural competence, suicide prevention, and screening for behavioral and primary care health needs.
- **Putnam Family & Community Services'** triple partnership includes the Putnam County Office for Senior Resources and the National Council on Alcoholism & Other Drug Dependencies/Putnam. The partnership intends to employ a licensed clinical social worker to assess, diagnose, and treat older adults; a care manager to identify and provide concrete services and address the social determinants of health; a recovery coach to identify and address substance use issues; and nursing and psychiatric time. The majority of the work will be done on site in the homes of the seniors or elsewhere in the community to support living in place.

VI. Service Demonstration Project Supports

- **Program & Policy Development Staff** -- OMH staff in the Division of Adult Services and Managed Care's Bureau of Program and Policy Development continued to provide ongoing program operational support for the geriatric service demonstration projects in 2016. Bureau staff had responsibilities for assigned projects that include on-site and off-site consultation and project oversight and worked closely with staff responsible for the operation of New York State's Geriatric Technical Assistance Center.
- **Geriatric Technical Assistance Center** – OMH established the Geriatric Technical Assistance Center in 2012 and contracted with the National Council for Behavioral Health to provide programmatic and fiscal technical assistance for the service demonstration program grants. The Center's work with the third round of health integration grantees in 2016 included:
 - Visiting all grant project sites on a routine and as-needed basis;

- Conducting individual project coaching calls every month to help implement work plans and meet overall grant goals;
- Troubleshooting implementation issues;
- Reinforcing principles of integration, sharing best practices from around the country, and facilitating a connection to clinical organizational, and fiscal resources based on individual and group project needs;
- Coaching grant projects on change processes;
- Hosting face-to-face Learning Community meetings in Albany every four months;
- Conducting group calls and skill development webinars to provide direct information and facilitate conversation among projects;
- Promoting the importance of data and generating bi-monthly project data dashboards; and
- Helping grant projects use data to drive practice improvement and demonstrate positive clinical outcomes.

VIII. Summary

The successful third round of service demonstration program grants on the integration of physical and behavioral health care for older adults ended in 2016, and new fourth round of grants to create local “triple partnerships” of mental health, substance abuse disorder, and aging services providers to innovatively address the unmet needs of older adults for these services began in 2017.

Ten years after the enactment of the Geriatric Mental Health Act, the Interagency Geriatric Mental Health and Chemical Dependence Planning Council actively continues its work, and the geriatric service demonstration program continues to identify lessons learned and innovative practices to assist planners and providers develop, implement, and assess the effectiveness of behavioral health and related services that meet the needs of older adults in New York State.

Appendix A: Project Description

Round 3 Demonstration Projects (2014-16)

Model 1 Projects: Integrated Care in Behavioral Health Care Settings

- **Catholic Charities Neighborhood Services** initially partnered with the Joseph Addabbo Family Health Center to provide integrated physical and mental health care for individuals living in Far Rockaway, Queens, for a target population of mostly older adults receiving services at its Rockaway Mental Health Services clinic and Rockaway Personalized Recovery Oriented Services program. The agency later negotiated a partnership agreement with Delmont Health Care, a local medical group, and was able to expand the on-site hours and availability of primary care staff and services, as well as opportunities to work more closely with behavioral health staff to provide better integrated services.
- For a population of new and existing older adults in its outpatient mental health clinic in Hicksville, New York, **Central Nassau Guidance and Counseling Services** initially partnered with Nassau Medical Associates – which was subsequently assimilated by Long Island Federally Qualified Health Center (LIFQHC) – 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 now integrating behavioral health treatment services with on-site primary care provided by a physician and supported by a medical assistant from LIFQHC. Other services include management of identified health problems, referral, and care coordination.
- **Equinox** and its partner, the Whitney M. Young, Jr. Community Health Center, planned to provide integrated health care primarily for older adults in Equinox’s outpatient mental health clinic and Personalized Recovery Oriented Services programs in Albany, New York. A part-time physician’s assistant from Whitney Young was to conduct physical exams, provide routine and emergent physical health care, and make referrals for more specialized care. However, unanticipated implementation issues identified during the first year of the grant could not be resolved and led to a decision to limit participation in the service demonstration program to first two years of the grant.
- For a target population of older adults with serious mental illness in Buffalo and Erie County, **Erie County Medical Center Corporation** 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.
- To introduce and integrate primary care in the agency’s Brownell Center for Behavioral Health – an outpatient mental health clinic in Syracuse, New York – **Liberty Resources** established its own Article 28 diagnostic and treatment center for Brownell Center patients and their families at the same location. Doing so increased the need to add primary care physicians and nurse practitioners to the interdisciplinary clinical integration team to keep pace with growing demand and patient complexity, adopt an electronic medical record better aligned with integrated services, and expand nurse practitioner training partnerships with LeMoyne College and Upstate Medical University.

Model 2 Projects: Integrated Care in Physical Health Care Settings

- **Citizen Advocates, Inc.**, North Star Behavioral Services has been 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 was for two licensed clinical social workers to provide on-site behavioral health services as part of an integrated care team. The agency was able to retain one qualified social worker, making the project operational at two of the five sites.
- **Jewish Board of Family and Children's Services** assumed responsibility for this health integration project (originally involving Federation Employment and Guidance Service and its partner, Maimonides Medical Center) in June 2015. The goals of the project with Maimonides remained 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. A grant-funded social worker subsequently retained by Maimonides continues to help integrate behavioral health with physical health care at Maimonides' Geriatric Outpatient Practice in Brooklyn.
- **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 at its rural health centers in Washington County located in Greenwich and Granville. The project is currently operational at the Greenwich site, where integration is improving direct access to care and communication among providers. The hospital received a significant amount of Delivery System Reform Incentive Payment (DSRIP) program monies in 2016 for capital projects to support enhancement of the Greenwich facility and facilitate the replication of its health integration model in Granville and two other regional locations.
- **Niagara Falls Memorial Medical Center**, in partnership with its Department of Psychiatry and The Dale Association, continues to improve clinical outcomes and quality of life for older adults by integrating physical and behavioral health care and senior services at one of the facility's primary care settings in Wheatfield, New York; notably, the project includes a part-time senior advocate, whose services are intended to address the psychosocial needs of older patients through linkages and other resources in the community. Hospital leadership is planning to expand their integrated care model to other outpatient primary care settings as part of the state's DSRIP program.
- Through an internal partnership, **Odyssey House** placed a 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 was older adults with substance use disorders or co-occurring mental health and substance use disorders who accessed primary care services at the center. Working as a member of the medical team, the social worker provided screening, assessment, and brief intervention services and served as a behavioral health care manager to ensure appropriate referrals for treatment.

Appendix B: Summary of Grantee Experience

Round 3 Service Demonstration Projects (2014-16)

Final Reflections

Model 1 Grantees Summary

1. Implementation: “Looking back on your experience during this demonstration project, how would you characterize the experience of implementing your program?”

Select Success

- From the outset, the key stakeholders in the project were committed to its success.
- Our clients were eager to be able to see a medical provider at a site they already visited every week, and the behavioral health staff on site was eager to refer their clients for the medical treatment they needed and often went without.
- Our successes rest upon the ability of our team to proactively respond to challenges during the start-up phase while continuing the momentum regardless of obstacles.

Select Challenges

- Creating the physical space for primary care to take place.
- Learning how to manage medical insurance and billing.
- Reliability Issues with patient medical transportation that can negatively affect a program’s no-show rate.
- Regulations related to the acquisition of licensure and their many levels of review that actually slowed down implementation.

Lessons Learned

- For the program to work, it was essential for all organizational partners to communicate and collaborate and have patient care as their number one priority.
- Huddles, team meetings, and case conferences all activated the interdisciplinary team structure. Without structured communication plans, the team approach is inevitably weakened.
- Understanding that you cannot always wait for perfect information or 100% success to move forward.
- Persistence is important, especially during the trying times of implementation, if you are to experience the rewards of seeing patients get better.

2. 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 health services?”

Select Success

- Adapting the electronic medical record (EMR) for physical health indicators was an ongoing challenge but worth it when successfully completed.
- The care, understanding, and expertise of our medical partners helped create a safe, professional environment to allow our patients to get the physical health care they needed.
- Positive health outcomes in depression management and a number of other behavioral and physical health areas.
- Establishing an interdisciplinary team model of treatment and consultation re-energized the team and began the process of bringing the various experts together, resulting in a less fragmented approach to care and consultation.

Select Challenges

- Finding the balance between the number and length of interdisciplinary team meetings, case conferences, and warm hand-offs and the need for providing as many billable hours of service as possible
- Without the ability to draw bloods and give vaccines, the biggest challenge was having patients follow through with getting their labs, x-rays, and referrals done, leaving doctors and patients both frustrated as it delayed patients from being seen on a timely basis.
- There has been a significant shift in our work culture which required a lot of lift, training, support, and patience with our behavioral health clinical team, who did not have previous expertise in the theory and practice of an integrated care delivery model.

Lessons Learned

- A new endeavor like our integrated care program requires a great deal of initiative and flexibility to succeed.
- It is important to integrate care management/health home staff into the provision of integrated care and include them in team meetings and case conferences.
- Having a robust team that has built solid, integrated relationships has been a game changer both in terms of clinic culture and treatment efficacy.

3. 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

- Our main success in sustainability is keeping the program open, eventually finding a partner that will allow us to see the most clients possible.
- With our new medical partners, the physician’s schedule was increased and a constant review is being done to increase the amount of patients that he sees within an hour. A new federal health integration grant we received will further assist us with sustainability.

- Building strategies around plans for increased capacity, patient engagement, and provider support is essential to stability. Real time data metrics to track customer satisfaction, no-show rates, utilization, and other trends to help identify areas to improve quality or adjust workflows provided a template for informed decision making related to growth, opportunity, and sustainability.

Select Challenges

- Attempting to pay for integrated services using OMH clinic regulations (Part 599) is difficult to sustain over the long term.
- The high no-show rate in this population has a negative impact on provider productivity. This, coupled with the complexity of care required, means that a careful balance has to be struck between over scheduling and managing productivity.
- The complexity of physical health challenges in this population cannot be overstated. When they come into integrated primary care after years of minimal to no health care, they have multiple needs for diagnosis and testing and intervention. Physical health providers need support in delivering stepped care – dealing with the most urgent first and moving down the line – rather than trying to do it all at once. Development of this skill is critical to maintaining the productivity required to be financially sustainable.

Lessons Learned

- The implementation of integrated care in our behavioral health setting was complex and challenging. Projects of this magnitude are for the fearless, not for those who are easily overwhelmed, fearful, risk averse, or faint of heart; they are, instead, for those who are committed to and passionate about improving overall health outcomes for complex patients within a very complicated system.
- The hours that primary care is provided need to fit the needs of patients. Late afternoon/evening hours are rarely workable for people dependent on transportation and handicap the ability of an integrated health program to maximize attendance and revenue possibilities.
- No-show rates can be decreased through careful care coordination with health home care managers and frequent reminder calls.
- The road to integration is long, so celebrate small wins.

4. Data Collection: “What have you learned through the data collection process?”

Select Successes

- We committed a great deal of time and energy to accomplish the task of building new data collection mechanisms. These automated mechanisms made the regular and time effective collection of data possible.
- Improvements and outcomes were monitored from baseline to reassessments to determine needed changes and improve our patients’ physical health outcomes.

Select Challenges

- At a number of points, the data demonstrated difficulties that the program was facing.
- Developing workflows inclusive of data entry was challenging, and it took time to learn how to productively use data to inform clinical care.

Lessons Learned

- Our program learned the importance of building data collection into the client workflow, which ensures that the reporting takes place and also occurs in a time efficient way.
- The data coaching and review of data was instrumental in the development and continued success of the program and key to becoming a data driven organization.
- Collecting, interpreting, and using data to inform patient care is well worth the effort.

“Final Reflections”

Model 2 Grantees Summary

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

Select Successes

- After a long effort searching for appropriate staff, we hired a social worker who has exceeded expectations and exemplifies the values of the project in nearly every way.
- The communication with partner organizations became a vehicle to other opportunities for collaboration and development of innovative service provision models.
- We experienced a change in staff culture across throughout our organization that affected care coordination, clinical, prevention, and case management staff regarding physical health care needs, how to address them, and how to collaborate with primary care physicians.

Select Challenges

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2. 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 health services?”

Select Successes

- The project prepared us to integrate physical and behavioral health within our own organization, and we are now better prepared for performance based services and value based payments.
- With the right behavioral health staff, the integration process was very successful, and the referral process between medical staff and the social worker has been seamless and effective.
- Patients have been very receptive to primary care provider referrals to the social worker via “warm handoffs.” Clinicians continue to refine workflows to accomplish this more routinely and improve communication among the care team in real time.
- We have seen a nice decline in body mass index scores, blood pressure, glucose levels, and the number of patients who smoke.
- Integration resulted in better access to a licensed clinician than patients in residential drug treatment would have had without the project. Also, having a licensed clinical social worker on site allowed the clinic psychiatrists to be more productive.

Select Challenges

- Integration requires shifting to a quality, outcome, and value based model, but we still live in a volume based payment world.
- Clinician turnover limited the ability to thoroughly test, evaluate, and identify best practices.
- Experienced project clinicians struggled to move beyond the traditional modes of intake/assessment and the accompanying rigorous documentation requirements.
- Some of the patients were uncomfortable with the screening tools in the beginning and were not so amenable to anything different. Eventually this became less of an issue as habits changed and patients were assured that screening was not something directed against them personally.

Lessons Learned

- Our clinician was amazing, steadfast, flexible, and used her outstanding relationship building skills to keep the project going “on the ground” at various sites.
- Key success factors included alignment of project goals with existing quality initiatives and leveraging like resources for improvement activities.
- Consideration of recruiting clinicians earlier in their careers versus more seasoned practitioners may be of benefit in a less-structured, non-traditional care setting.
- The need for continuous training and reinforcement of concepts.

3. 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

- We believe this project has had a profound impact on our organization’s expertise and capability to address often complex co-morbid physical and behavioral health needs.
- Our office is currently producing at a level where our social worker and consulting psychiatrist will be retained based on our behavioral health services.
- We are going to sustain integrated care in two health centers with high need, one of them located the farthest distance from and with the least access to behavioral health care.
- The project has opened-up other opportunities that will help us with sustaining this and other related projects.
- Continuation of program implementation and sustainability is more certain with available Delivery System Reform Incentive Payment Program funding.

Select Challenges

- The inability to bill Medicare in light of a licensed clinical social worker shortage was a challenge in the model we used for this project.
- Behavioral health clinic documentation requirements are considerable; for real integration to work, brief documentation and short visits that focus on direct interventions are preferred and rely less on extensive history taking and detailed documentation.
- Our office is currently producing at a level where our social worker and consulting psychiatrist will be retained based on our behavioral health services.
- We are going to sustain integrated care in two health centers with high need, one of them located the farthest distance from and with the least access to behavioral health care.
- The project has opened-up other opportunities that will help us with sustaining this and other related projects.
- Continuation of program implementation and sustainability is more certain with available Delivery System Reform Incentive Payment Program funding.

Lessons Learned

- Buy-in at all levels is key – front door to back door, top to bottom.
- Engagement of a financial champion to monitor progress and correct course as necessary is vital to long-term sustainability, particularly for projects of relatively short duration.

- We needed more information technology department involvement at the start of the project. Better use of data would have helped “sell” integration to the primary care practitioners.

4. Data Collection: “What have you learned through the data collection process?”

Select Successes

- Our success in data acquisition and reporting was largely due to establishing regular communication. Grant team meetings provided a forum to resolve issues regarding data collection.
- Our initial limited success around data prompted us to modify the flow of our behavioral health EMR and develop reports that kept our integration project moving.
- Data collection efforts related to the distribution, tracking, and collection of both behavioral and physical health screening data were extremely successful.
- The ability to collect, track, and successfully report data is an essential part of every organization. The data we obtained provides us with a quality indication of how our patients are progressing and where we should place our focus moving forward.

Select Challenges

- Our assessment data was captured in our partner’s EMR, but retrieving it was a problem.
- The single greatest challenge was the manual nature of the data collection necessitated by our not being able to build all of the screening tools into our EMR; it made the practice and execution of the tools very difficult.
- Our partner turned out to be not as committed or accountable as we were to collecting baseline and outcome evaluation data.
- Face-to-face rescreening was a challenge. We tried rescreening by phone, but that was a problem because so few patients answered calls or returned messages.

Lessons Learned

- When it comes to data, consistency is very important. You ideally want to know on day one exactly what you are collecting, how you want it labeled, and how you intend to collect it. This will save a lot of time in the long run.
- We learned the importance of building better partnerships around data collection with everyone involved; everyone needs to understand the “why” as well as the “how.”
- In retrospect, our project seriously underestimated the resources needed to manage project priorities, including the collection and analysis of data. Allocation of resources to support a data coordinator/analyst position would have been of great benefit and enabled more timely data collection and reporting, followed by more formal and routine feedback to clinicians and key stakeholders.
- In our setting, data suggested that the most frequently indicated clinical problem is anxiety and that family engagement and connection to community services appear to reduce symptoms.

Appendix C: Data Summary

Round 3 Services Demonstration Projects (2014-16)

Introductions

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 OMH’s Geriatric Technical Assistance Center, 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) for obesity, Fasting Blood Glucose (FBS) for diabetes, and self-reported Tobacco Use.

Screening Results

- Model 1 projects – which integrated 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. Model 2 projects – which integrated 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.
- Data collected from both model types were aggregated for this summary.
- A total of 3,493 individuals aged 55 or older were screened. A total of 4,893 screenings were conducted (many individuals were screened more than once). Of the 3,493 individuals age 55 or older who were screened, 88% of them (3,079) scored at risk for one or more of the seven health indicators.

For all projects, **Table 1** shows the number of individuals age 55 or older with baseline at-risk screening scores for each screen.

Table 1 – Number of individuals 55+ with At-Risk Screening Scores by Screen

PHQ-9	GAD-7	AUDIT-C	Blood Pressure	BMI	FBS	Tobacco Use
491	360	578	851	844	329	363

Interventions

In addition to program-provided care and treatment services in their own settings, both models of health integration projects provided three types of intervention to address at-risk health conditions:

- **Wellness and Prevention Counseling** in the areas of Healthy Eating and Nutrition, Physical Activity, Stress Management, Smoking Cessation, and Alcohol Use.

- Overall, 61% 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, 64% 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.
- **Ongoing Health Supports**, such as scheduling follow-up appointments with a therapist for an individual with depression or a return visit for blood pressure monitoring for an individual with high blood pressure.
 - Overall, 69% of individuals age 55 or older who scored at risk for one or more of the physical or behavioral health screens received ongoing health supports.
- **Referral to External Specialists**, such as a referral to a non-affiliated hypertension specialist or non-affiliated behavioral health therapist.
 - Overall, 23% of individuals age 55 or older who scored at risk for one or more of the physical or behavioral health screens received a referral to an external specialist.

Health Improvement

- The eight grantees that completed this round of geriatric health integration demonstration projects became skilled in developing efficient and effective workflows that incorporated the collection and use of data. Most of them reported a change in the way they delivered patient care based on the use of data.
- 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 following outcomes, 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 the health integration projects irrespective of model type.

Outcomes

- **PHQ-9** outcomes for individuals age 55 or older who were at-risk at their baseline screen. Of the 258 individuals who were at risk at baseline and had a valid follow-up screen, 61% were no longer at risk and 78% showed improvement.
- **GAD-7** outcomes for individuals age 55 or older who were at-risk at their baseline screen. Of the 181 individuals who were at risk at baseline and had a valid follow-up screen, 53% were no longer at risk and 74% showed improvement.
- **AUDIT-C** outcomes for individuals age 55 or older who were at risk at their baseline screen. Of the 258 individuals who were at risk at baseline and had a valid follow-up screen, 40% were no longer at risk and 60% showed improvement.
- **Blood Pressure** outcomes for individuals age 55 or older who were at risk at their baseline screen. Of the 240 individuals who were at risk at baseline and had a valid follow-up screen, 13% were no longer at risk and 82% showed improvement.
- **BMI** outcomes for individuals age 55 or older who were at risk at their baseline screen. Of the 403 individuals who were at risk at baseline and had a valid follow-up screen, 5 percent were no longer at risk and 47 percent showed improvement.
- **FBS** outcomes for individuals age 55 or older who were at risk at their baseline screen. Of the 86 individuals who were at risk at baseline and had a valid follow-up screen, 19 percent were no longer at risk and 49 percent showed improvement.

- **Tobacco Use** outcomes for individuals age 55 or older who were at risk at their baseline screen. Of the 183 individuals who were at risk at baseline and had a valid follow-up screen, 13 percent were no longer at risk and 15 percent showed improvement

Conclusions

Overall, outcome data from the third round of health integration projects demonstrated considerable improvement in health for the target population of older adults age 55 or older. Many individuals received a variety of program-provided care and treatment services, wellness and prevention counseling, ongoing health supports, and referral to external specialists that improved their health.

- As presented in the outcomes graphics, the percentages of individuals who showed improvement in screening scores related to depression (78%), anxiety (74%), alcohol misuse (60%), and blood pressure (82%) were high or very high.
- The percentages of individuals who showed improvement in screening scores related to obesity (47%) and diabetes (49%) were lower.
- The percentage of individuals who showed improvement in screening scores related to tobacco use (15%) was very low.

Worth noting was a very significant increase in the percentages of individuals who were no longer at risk (40%) or showed improvement (60%) in screening scores related to alcohol misuse when compared to the prior round of geriatric health integration grants; using the same AUDIT-C screening tool, the percentages of individuals no longer at risk (11%) or showed improvement (29%) were much lower at the end of that grant period.

The eight grantees that completed this round of geriatric health integration demonstration projects did so with considerable energy, creativity, and determination. The three-year grant period fell in the middle of major health care system transformations in New York State, the most successful grantees taking full advantage of the synergy between the grant and the Delivery System Reform Incentive Payment Program, as well as other opportunities, to extend their projects beyond initial plans. It is a credit to the work of these providers that two of them recently received Primary Care and Behavioral Health Integration grants from the Substance Abuse and Mental Health Services Administration that will help them continue to transform their health integration projects and their organizations.