Interagency Geriatric Mental Health and Substance Use Disorder Planning Council

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

2021 Annual Report

to the Governor and Legislature of New York State on Geriatric Mental Health and Substance Use Disorders

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TABLE OF CONTENTS

Introduction……………………………………………………………………….....................2

Geriatric Mental Health Act……………………………………………………………………….3

Council Membership………………………………………………………………………...........3

Council Collaboration…………………………………………………………………………….4

Education and Training……………………………………………………………………………5

OMH Transition and Aging in Place Initiatives……………………………………………...........7

OMH Programs Tailored for Older Adults……………………………………………………........ 8

Providing Support for Older New Yorkers…………………………………………………............8

Serving New Yorkers Who Served……………………………………………………………….13

OMH Suicide Prevention Initiative for Uniformed Personnel……………………………………14

Round 4 Geriatric Service Demonstration Grants…………………………………………….............15

Round 5 Geriatric Service Demonstration Grants…………………………………………………..22

Summary………………………………………………………………………………………...25

INTRODUCTION

As it has for many years, New York State continued to advance its efforts to meet the behavioral health and aging services needs of its older adult population in 2021 despite the negative impact of COVID-19 on the population as a whole, and on older adults in particular. The pandemic continued to highlight the disparities in access and gaps in services in many communities, with the most severe impact on the older adult population, individuals receiving mental health and/or or addiction services and supports, and communities of color.

Examples of work accomplished to address the geriatric behavioral health and other needs of older adults in New York in 2021 are noted in this report. They include but are not limited to:

- Aging in place initiatives to expand possibilities for those with serious mental illness to transition to or continue to live and age in place in the most integrated and least restrictive community settings possible;
- NYSOFA's launch of the only tool in the country that evaluates an individual's risks associated with COVID-19 based on their life situation and individual behavior and also provides real-time recommendations and resources to reduce those risks;
- NYSDVS partnerships with agencies to present widely attended programs on human rights issues, needs, and initiatives of veterans, service members, and military families;
- A service called "GoGo Grandparent" that enables trained older adults to provide door-to-door transportation for their peers;
- NYSOFA's 2020-21 expansion of nearly 4,000 "animatronic pets" to combat social isolation and depression among older adults;
- OMH and NYSOFA mentoring of SUNY Albany School of Social Welfare students in the Internships in Aging Project (IAP);
- Completion of a five-year *"Partnership Innovation for Older Adults* (PIOA)*"* geriatric service demonstration program grant of eight projects made possible by the Geriatric Mental Health Act; and
- The beginning of a five-year *"Partnership to Support Aging in Place in Communities Severely Impacted by COVID-19"* (PSAP) geriatric service demonstration program grant of six projects made possible by the Geriatric Mental Health Act.

GERIATRIC MENTAL HEALTH ACT

New York State enacted the Geriatric Mental Health Act in 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 first approved during the state's 2006-07 budget year, and the legislation called for service demonstration projects in areas such as community integration, improved quality of treatment in the community, integration of services, workforce development, family support, finance, specialized populations, information clearinghouse, and staff training.

Amendments to the Geriatric Mental Health Act in 2008 expanded the scope of the Council to

include chemical dependence and veterans. The amendments also changed the formal name of the Council to the Interagency Geriatric Mental Health and Chemical Dependence Planning Council (now the Interagency Mental Health and Substance Use Disorder Planning Council); increased membership from 15 to 19 members; added the Commissioner of Alcoholism and Substance Abuse Services (now the Office of Addiction Services and Supports) and the Director of the Division of Veterans' Affairs (now the Division of Veterans' Services) as co-chairs of the Council; added the Adjutant General as an ex-officio member of the Council; and changed requirements for Council recommendations and joint annual reports to address both geriatric mental health and chemical dependence needs.

In acknowledging the importance of aging in place, the law was amended in 2018 to foster and support collaboration between licensed or certified providers of home care services and mental health providers for the integration of health and mental health care as part of the geriatric service demonstration program.

In 2019, amendments to the statute changed the formal name of the Council to the Interagency Geriatric Mental Health and Substance Use Disorder Planning Council and noted that providers of substance use disorder and/or compulsive gambling services and providers of health and aging services were able to receive Office of Mental Health geriatric service demonstration program grants in areas such as community integration, improved quality of treatment in the community or in residential facilities, workforce programs, veterans as a specialized population, information clearinghouse, and staff training. There have been no changes to the Geriatric Mental Health Act since 2019.

COUNCIL MEMBERSHIP

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

- The Commissioner of the 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 the Office of Addiction Services and Supports (OASAS), Co-chair of the Council;
- The Director of the Division of Veterans' Services (DVS), Co-chair of the Council;
- One member representing the Office for People with Developmental Disabilities (OPWDD);
- The Adjutant General;
- 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 and Disability Assistance;
- Four members appointed by the Governor;

- Two members appointed by the Temporary President of the Senate; and
- Two members appointed by the Speaker of the Assembly.

COUNCIL COLLABORATION

The Council and its members continued to collaborate with others in a number of important areas affecting the behavioral, physical, and psychosocial health needs of older adults in New York State in 2021. OMH hosted meetings of the Interagency Geriatric Mental Health and Substance Use Disorder Planning Council on 1/26/21 and 10/19/21. Planning Council meetings held in 2021 were virtual and/or telephonic, and included reporting on work related to:

- An overview of the program model developed for the next (fifth) round of geriatric service demonstration program grants to start in 2022;
- An overview of data collected to date from the current (fourth) round of geriatric service demonstration program grants which will conclude at the end of the year;
- A report from OMH's contracted Geriatric Technical Assistance Center staff who work with the current service demonstration program grantees focusing on the four major components of technical assistance provided throughout the year: "Brag and Steal" peer learning sessions and Affinity Groups, Learning Collaboratives, Individual Coaching and Site Visits, and Group Coaching and Webinars focused on specific learning topics;
- OMH's aging-in-place demonstration project to provide immediate access to long-term services and supports in the community for individuals identified as long stay patients or those at risk of becoming long stay patients of OMH state operated residences;
- Continued OMH and OASAS telemental health regulatory flexibility around treatment and service planning to increase access to services during the COVID-19 public health emergency;
- An update from OASAS Associate Commissioner Pat Lincourt on a variety of topics such as the integration of addiction services and supports with primary or family physicians, progress made with Federally Qualified Health Centers, identification of data trends with older adults regarding disparities, criminal justice involvement, socio-economic factors, findings of focus groups with individuals with Adverse Childhood Experiences and aging, and a discussion of challenges related to opioid substance use disorders;
- A presentation by OMH Associate Commissioner Christopher W. Smith, PhD., on "Behavioral Health and COVID in Older Adults" in which he reviewed findings from a national perspective, a number of select NYS OMH findings from consumer and outpatient provider surveys and select OMH regulatory and program efforts to meet COVID-19 public health emergency challenges including telehealth expansion, Project HOPE, mobile vaccination, and COVID-19 service adaptations to the current round of geriatric service demonstration grants;
- NYSOFA Acting Director Greg Olsen updated the Council on a wide variety of topics related to the work of his agency since the advent of COVID-19 and cited reliance on the Agency's 59 Local Area Agencies on Aging (AAA) to provide services that included outreach, food, nutrition, basic supplies, and transportation for needed medical services like dialysis and cancer treatments. He also spoke of the importance of focusing on

isolation as a problem and that connecting older adults with people and things that matter to them is critical.

- Opening dialogue with NYS Department of Health (DOH) on the impacts of newly proposed regulations on individuals living with serious mental illness concerning the eligibility process for personal care services (PCS), consumer directed personal assistance program services (CDPAS), and managed long-term care (MLTC) plan enrollment.

EDUCATION AND TRAINING

- The Learning & Development Projects (LDP) initiative at the Brookdale Center for Healthy Aging presented the 2021 New York State Adult Abuse Training Institute (AATI) on behalf of OCFS. This year's institute in October, "It Happened? What's Next?" focused on taking stock of the impact of the COVID-19 pandemic and moving forward through "Navigating, Reconnecting, and Rethinking Solutions." AATI enabled over 700 professionals from diverse fields representing adult protective services, aging, criminal justice, domestic violence, veterans, public health, and mental health to participate in a live, streaming three-day virtual conference consisting of over 21 workshops.

  NYSOFA, OASAS, OCFS, OMH and OPWDD representatives served on the Institute's steering committee, and their affiliate program staff coordinated and/or facilitated workshops on topics such as "NYC HRA Adult Protective Services: Pivoting During a Pandemic", "Preventing Abuse and Exploitation in Individuals with Alzheimer's or Dementia", "Elder Financial Exploitation and Domestic Violence", "Living with Vision Loss: Accessing Services and Maintaining Independence", "Physical Aspects of Aging: What's Normal and What's Not", "Engaging with Native American Tribal Nations", "At the Intersection of Ageism and Racism – Promoting Equal Access to Justice in Our Courts", "Considering Cultural Competence and Advancing Equity in E-MDTs, "Article 17A Guardianships, the MOU between OCFS and OPWDD and Court Activism", "Substance Use Disorders and Older Adults", and "Self-Care Strategies for Frontline Workers".

- The ACL Annual Conference
  The Association for Community Living (ACL), a statewide membership organization of not-for-profit agencies that provide OMH housing and rehabilitation services, held its 42nd annual 4-day conference in November with the theme, Resiliency, Recovery and Reinvention. OMH, in collaboration with the CSH (Corporation for Supportive Housing) and two OMH housing providers in NYC, the Jewish Board and Goddard Riverside Community Center, presented "Aging in Place: Resources, Innovations, Models and Opportunities." The presenters discussed the aging population of NYS that is mirrored in the growing percentage of adults aged 50 and older living in OMH supportive housing; based on the most recent data available, approximately 67% of OMH supportive housing residents in NY were age 50 and older[1], more than 20 percentage points higher than the estimated percentage of supportive housing residents nationwide[2]. The session also reviewed the accelerated or premature aging process that impacts adults living with serious mental illness, including individuals who are or have a history of homelessness, coupled with health disparities experienced by Black, Indigenous, and People of Color

[1] NYS OMH Child and Adult Integrated Reporting System (CAIRS), residents of OMH supportive housing (Scattered and Single-Site) as of January 2, 2018

[2] As reported by the Corporation for Supportive Housing, 42nd Annual ACLAIMH Conference, November 2021

(BIPOC). Two OMH providers, Jewish Board of Children and Family Services and Goddard Riverside, shared their OMH supportive housing models for facilitating successful aging in place; one or both program designs included the following components:

- Aging in place-specific needs assessment of residents and staff and operationalizing a method for ongoing assessment;
- Review of data related to age, race, insurance coverage and benefits, co-occurring chronic physical health conditions and substance use;
- Focus on identifying most vulnerable older adults and continued mechanism for stratifying based on risk; and
- Developing a model and tools that can be shared and adapted as needed by other OMH supportive housing providers to foster resilient aging in place.

- OMH reviewed its initiatives related to aging in place, specifically highlighting the innovative models awarded grants for the fifth round of the geriatric service demonstration program, *Partnership to Support Aging in Place in Communities Severely Impacted by COVID-19*. OMH also provided education on accessing personal and home health care services based on insurance coverage; eligibility and enrollment processes for managed long-term care (MLTC) plans; using OMH's PSYCKES application to find information about Medicaid long term services and supports (LTSS) received by OMH housing residents; and services and supports available through the Area Agencies on Aging (AAA) and NYSOFA's NY Connects.

- Models of Transformative Collaboration Summit
  The Home Care and Association of NYS (HCANYS), in partnership with the Hospital Association of NYS (HANYS) and Iroquois Health Association (IHA), hosted the *Models of Transformative Collaboration* summit on December 2, 2021, virtually bringing together hospital administrators, home care providers, and representatives from DOH, OMH and NYSOFA to address opportunities for collaboration to improve care. The virtual summit was part of the *Statewide Hospital-Home Care Collaborative* co-led by HCANYS, HANYS, and IHA to promote a shared vision of cross-sector collaboration. OMH's presentation, *Advancing Collaboration to Transform Mental Health-Health Partnerships*, highlighted OMH's commitment to aging and long-term care, dating back to the 2005 enactment of the Geriatric Mental Health Act and continuing through the language amended in 2018 describing the goals of the geriatric service demonstration projects to include fostering collaboration specifically with article 36 home care providers. OMH reviewed progress in transitioning approximately 1,100 residents from adult homes to OMH community housing and lessons learned from OMH Long Term Care Demonstration Pilot Project that utilized a tight collaborative model to make living in the most integrated setting possible for individuals with serious mental illness and co-occurring physical health conditions. OMH also shared recommendations for policy, regulations and reimbursement systems that help maintain community tenure, including reimbursable onsite assessment by mental health and homecare providers prior to discharge, cross-system planning, and training throughout the continuum of care facilitated by technology and established rates for remote patient monitoring, and stronger integration with social determinants of health.

- Representatives from Office for Aging and the Association for Aging in NYS presented on opportunities to better connect health systems to the aging services network, highlighting a successful partnership between Essex County Office for Aging and the Elizabethtown Community Hospital. NYSOFA demonstrated its strategic focus on high risk, high-cost

customers with multiple chronic conditions. Data analysis of aging network services shows that these clients have a high percentage of individuals with numerous chronic conditions, including those with six or more chronic conditions representing approximately 50% of personal care recipients[3]. Health system-aging network collaborations offer the highly coordinated services needed to divert emergency room use, reduce social admissions, and increase patient satisfaction for populations with complex care needs.

OMH TRANSITION AND AGING IN PLACE INITIATIVES

- The OMH Long Term Care (LTC) Demonstration Pilot Project (DPP) leveraged cross-service system interdisciplinary teams of OMH housing, home health and community behavioral health providers to end the cycle of re-institutionalization experienced by individuals with co-occurring behavioral health and chronic physical health conditions, including diabetes, COPD, and heart disease. The OMH LTC DPP completed its pilot phase this Spring and has integrated discharge tools and a community long term care consultation request form based on lessons learned from the demonstration. Resources developed from the pilot project have been shared across State Operated settings, fostering successful transition of individuals with complex medical conditions to OMH supportive housing. Established inter-agency partnerships with certified home health agencies, including the Visiting Nursing Services of New York (VNS-NY), and behavioral health community providers, such as article 31 clinics, ACT, and Specialty Mental Health Care Management Agencies providing HH+, in collaboration with primary care physicians, have proven to be key components of success. Pre-discharge and post discharge planning tasks included identification of needed support services, social determinants of health inventory and coordination of care combined with ADL and IADL support and skill building as essential elements for smooth transition to community living.

- MSW Internships in Aging Project (IAP) Students Support OMH and NYSOFA Aging in Communities of Choice Initiatives. SUNY Albany Master's in Social Work (MSW) students with a special concentration in aging interned at OMH and NYSOFA working on policy and program implementation efforts designed to foster aging in communities based on individual choice and preferences. IAP interns from OMH and NYSOFA supported services and program development focused on helping older adults maintain tenure in their communities of choice during the pandemic, incorporating choice and self-direction of services, analyzing LGBTQ+ inclusivity in nursing homes and other retirement communities and reviewing incorporation of serious mental illness into functional assessment processes for Medicaid services.

OMH PROGRAMS TAILORED FOR OLDER ADULTS

Located in New York City, *Service Program for Older People, Inc. (SPOP)* and *Vibrant Emotional Health* (*Vibrant*) are examples of two OMH-licensed agencies that have tailored services to meet the needs of older adults.

SPOP's Personalized Recovery Oriented Services (PROS) program in Manhattan serves older adults 55 or older with severe and persistent mental illness with the goal of integrating treatment,

[3] As reported by Association for Aging in NYS, *Opportunity to Better Connect Hospitals/Health Systems to Aging Services Network*, *Models of Transformative Collaboration Summit*, December 2, 2021

support, and rehabilitation to improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education, and secure preferred housing. The program's four components of service include Community Rehabilitation and Support, Intensive Rehabilitation, Ongoing Rehabilitation and Support, and Clinical Treatment.

Vibrant Emotional Health's Older Adult Assertive Community Treatment (ACT) program serves older adults 50 years or older with serious mental health disorders and living in the Bronx who are referred to the program from the NYC Department of Health and Mental Hygiene. The program is designed and tailored to meet the unique needs of these individuals with an on-the-ground ACT team that is mobile, multi-disciplinary, and available 24/7 to work with them to facilitate their independence. Comprehensive treatment, rehabilitation, and support services are provided around the clock whenever and wherever program participants need the support most. Services include but are not limited to helping with family life and social relationships, housing support, school and work opportunities, health visits and education, medication support, money management, recovery treatment and relapse prevention, and the development of skills to cultivate independence and personal empowerment.

PROVIDING SUPPORT FOR OLDER NEW YORKERS

NYSOFA, whose mission is to help older New Yorkers be as independent as possible for as long as possible, is a good example of a state Council member agency with a record of accomplishments and goals addressing geriatric and behavioral health needs in 2021.

Pandemic Response

Older New Yorkers were severely impacted by the COVID-19 pandemic and made up the most fatalities. Programs and services provided in senior centers, social adult day programs and other congregate settings were closed but began to reopen in 2021 with limited capacity to ensure safety. The following were the types of programs and services that were most in demand when the stay-at-home recommendation was issued, and most of the aging services network is still operating under this framework while continuing to provide the services older adults need to remain safe in the community.

Pandemic Information, Education and Resources:

- NYSOFA was a source of ongoing, accurate information on the seriousness of the virus and the safety protocols for individuals and service deliverers. This continues to be a priority.
- NYSOFA launched the only tool in the country, the *New York CV19 CheckUp*, that evaluates an individual's risks associated with COVID-19 based on their life situation and individual behavior and provided real-time recommendations and resources to reduce those risks. https://newyork.cv19checkup.org/
- NYSOFA and the aging services network worked tirelessly to provide accurate information on the efficacy of the vaccines and booster shots and worked to get older adults appointments, transportation, document verification, etc., to get shots in arms. The network led the way in getting home-bound older adults in-home vaccinations and booster shots.

Primary Service Adaptations During Pandemic

In addition to the 20+ traditional services and supports offered in communities throughout New York, several immediate needs rose in priority, including:

- Home delivered meals – The aging network continues to meet high demand for meals. Because our network of over 800+ senior centers and congregate meals sites were closed in 2020 and partially open in 2021, all meals had to be either hand delivered to the home or through a "grab and go" program that was implemented statewide. We were able to use our federal and state flexibility to purchase emergency meals on behalf of the network which reduced cost, using the states purchasing power.
- Groceries and supply deliveries – Many older individuals staying at home needed groceries and other supplies delivered to their homes. The network of aging professionals worked with food outlets to expand their delivery services if they had them, worked with stores to establish a delivery service, or shopped and delivered groceries on behalf of an older adult to help them meet basic needs, avoid going out and slow the spread of the virus.
- Medication deliveries – The network of aging professionals worked with local pharmacies to either establish or expand their prescription delivery services so that older adults could access the medications they need. Where delivery service was not available, network staff delivered prescriptions directly to their customers.
- Transportation to critical services – The pandemic did not stop the need to get to medical appointments, and aging services staff stepped up to provide transportation.
- Combating social isolation – Isolation and depression among older adults was a public health problem prior to the pandemic and increased during the pandemic. The network of aging professionals developed phone trees, wellness checks and expanded the use of technology to connect individuals to their loved ones, as well as developing platforms to engage individuals in lifelong learning, including classes based on their interests, as well as teaching how to use common technology and devices to stay engaged and enhance friendships and connections.
- Identifying and addressing elder abuse and scams –The network of aging professionals expanded outreach and education to encourage the public to check in on their family, friends, and neighbors to keep them safe. In addition, many older adults continue to be targets of scams, capitalizing on their isolation and their assets. These came in many forms such as charity scams, relief check scams, or phone calls, emails, or texts from what appeared to be legitimate public and private companies and organizations to click on links that would install malware and other viruses on their devices to defraud them.

Flexibility

NYSOFA continues to operate under a federal major disaster declaration that allows for flexibility in funding to be able to meet locally determined needs, ideas, and innovations. These flexibilities recognized the local, regional, and state differences and allowed the network of aging professionals to be creative in how they meet a spiking service demand and allowed for innovation to meet those service demands, and other emerging needs generated by the public health emergency. These innovations, particularly around combating isolation, included expansions of our animatronic pet project, expansion of web-based connectivity platforms and user technology

literacy assessment and education, landline outreach for those unable to use technology-based platforms, pushing out OMH's Mental health helpline.

Other Innovations

- Home Share Replication

  NYSOFA continues to work with two communities to replicate the successful Vermont Home Share Program that links older individuals interested in sharing their home with an individual looking for a home. While many get into these arrangements for economic reasons, data clearly shows that both the older adult and the individual benefit from the reciprocal arrangement with such gains as increased socialization, task assistance and mutual support.

- GoGo Grandparent

  This service was launched to provide an additional transportation option throughout New York State. The service provides an opportunity for older adults to engage in the gig economy by becoming drivers for their peers. This model uses trained drivers who understand the issues older adults face to provide door-to-door transportation.

- TCare/CaringWire/ArchAngels Pilot

  NYSOFA is working with several innovative technology platforms that help caregivers reduce stress and link to community resources. These platforms help to assess a caregiver's stress intensity level, develop a care plan, and link to local support services that help them continue to provide care for their loved one in the community and avoid more costly and high intensity care in the clinical environment.

- FEMA Nutrition and Restaurant Project

  NYSOFA worked with DHSES and FEMA to successfully apply for emergency meal funding given the large increase in demand. NYSOFA will continue to work with the county Offices for the Aging to expand the restaurant program that allows federal and state funding to be used to purchase meals for older adults at restaurants, continuing to meet nationally recognized nutritional standards.

- Council on the Arts Pilot

  NYSOFA partnered with the NYS Council on the Arts and Lifetime Arts to bring professional artists into the homes of older adults via technology platform. Arts and culture are important to many people, and this program helped connect professional artists and older adults with an interest in the arts.

- Virtual Senior Center & Get Set Up

  NYSOFA worked with the Association on Aging in New York to launch two platforms that offer a variety of virtual classes and programs in the home. One platform is successfully being piloted in 10 counties and NYSOFA has purchased 50,000 classes on behalf of older adults. Combined, there are more than 13,000 older adults utilizing the platforms that offer more than 600 different classes.

- Technology Support – Tech assessment

  Given the expansion of technology, telehealth and programs and services being delivered using technology, NYSOFA added a technology screen to the comprehensive assessment

tool so that individuals who can afford, use, or be taught to use technology can be immediately linked to the variety of programs and services that are now offered electronically. Individuals who cannot or choose not to use technology can be served in a traditional way.

Age-Friendly Planning Grant Program

NYSOFA, in partnership with DOH, DOS, the Health Foundation of Western and Central New York, the New York Academy of Medicine, and AARP, funded planning grants awarded to 14 counties in 2019 to help communities across the state incorporate healthy, age-friendly community principles into all relevant policies, plans, ordinances, and programs.

In 2021, NYSOFA is working to expand the replication of Executive Order 190 to 5 more counties, to build features of livable communities into the county planning and procurement. Executive Order 190 requires all state agencies to incorporate age-friendly health objectives from New York State's Health Prevention Agenda and the American Association of Retired Persons (AARP)/World Health Organization (WHO) domains of livability into their planning, procurement, procedures, and policies.

Animatronic Pet Pilot to Combat Social Isolation

In 2019, New York State became the first state in the nation to test the use of animatronic pets with isolated community-based older adults. New York piloted 60 Joy for All Companion Pets (30 cats and 30 pups) with socially isolated older adults living at home in 12 counties across the state: Broome, Cattaraugus, Clinton, Essex, Franklin, Lewis, Livingston, Onondaga, Orleans, Schuyler, St Lawrence counties; and the City of New York. In partnership with the Alzheimer's Association of Northeastern New York, pilot participants were identified using a 6-item loneliness scale. Animatronic pets are often used to assist people with Alzheimer's disease and other dementias as a form of calming pet therapy, but data has shown that using pets to decrease social isolation is highly successful – 70% of the pilot participants reported a decrease or significant decrease in feelings of social isolation after one year.

In 2020-21, NYSOFA expanded on the original pilot and purchased and distributed almost 4,000 pets to isolated older adults. In addition to New York's project, many states followed New York's lead and replicated the program. One study from Alabama showed that engagement with the pets increased each month for a one-year period, clearly demonstrating that the bond with these pets and their use for comfort and connectivity increased over time. NYSOFA received a statewide award and recognition, voted on by our peers, by the New York State Technology Enterprise Corporation (NYSTEC) for Population Health Innovation Summit session on Targeting the Effects of Social Isolation.

Villages Technical Assistance Center

In 2019 NYSOFA and the Albany Guardian Society partnered to create the first-of-its-kind Villages Technical Assistance Center (VTAC) to support and expand the Village movement in New York State. The Village movement is based on the idea of "neighbors helping neighbors" to make it possible for older adults and those with physical and/or behavioral health challenges remain independent in their homes. Villages are membership-driven, grassroots, nonprofit organizations run by volunteers and/or paid staff that coordinate access to a variety of services. Residents, typically age 50 and older, form a non-profit membership organization to provide access to services that make it possible for them to age in place. Services usually include transportation, grocery shopping, meals, personal care, home health care, light home maintenance and repair, technology assistance, education, and social activities. With additional Villages in development, there are currently more than 19 of them in the state and 200 in the country. NYSOFA continued

its support for the VTAC in 2021 and is currently working with communities to finalize readiness reviews to help get their programs operational.

Online Training Academy

New York is the first state in the nation to offer validated, skills-based, online certificate programs and training for case managers and other practitioners serving older adults and persons with disabilities. The training is delivered in partnership with Boston University's Centerfor Aging and Disability Education and Research.

Changes in the fields of health and long-term care have rapidly evolved to address challenges faced by a growing number of older adults and others unable or needing assistance to perform basic activities needed to live independently. New models of health and mental health care delivery that shift the balance towards community-based services, stronger integration of LTSS with primary and acute care, and improved cooperation between aging and disability networks all signify the magnitude of the policy and service developments. Developing a qualified, adaptable, and sustainable workforce within the aging network to support and coordinate services to older adults and younger adults with disabilities is a critical public policy challenge.

Highlights of NYSOFA Goals for 2022

- Working with OMH and DOH on an aging and mental health anti-stigma campaign.
- Expanding the animatronic pets project.
- Developing training on how to create friendly visitor programs to combat isolation.
- Expanding technology platforms and options for increased connectivity and lifelong learning
- Significantly increasing behavioral health screenings through the state's expanded and enhanced "No Wrong Door" service access.
- Strengthening relationships between local area agencies on aging and behavioral health care providers to increase referrals for treatment.
- Recruitment and awareness campaign to increase capacity and rides through GoGo Grandparent, a ride hailing service for older adults.
- Linking caregivers to mental health services as the pandemic has had a significant impact on depression, anxiety, COVID-induced trauma, and suicidal thoughts.
- Engaging businesses to better understand and assist working caregivers by distributing the Caregivers Guide for Business and distributing surveys to better understand working caregivers, their experiences and support needs.

SERVING NEW YORKERS WHO SERVED

The New York State Division of Veterans' Services (DVS) advocates on behalf of New York's veterans and their families, as individuals and as a group, to ensure they receive benefits granted by law for service in the United States Uniformed Services. The DVS provides free benefits advising. Experienced and dedicated advisors – each a veteran – work in a network of field offices across the state and offer veterans and their families professional help to resolve social, medical, and economic matters. More than half of the state's veterans are older adults aged 65 or older.

Restoration of Honor Act

In 2019, the Restoration of Honor Act was signed into law in New York State. The Restoration of Honor Act authorizes DVS to restore access to State Veterans Benefits to veterans with an Other-Than-Honorable Discharge (OTH) or a General Under Honorable Conditions Discharge due to the following:

- Post-Traumatic Stress Disorder (PTSD)
- Traumatic Brain Injury (TBI)
- Military Sexual Trauma (MST)
- Sexual Orientation
- Gender Identity

In 2021, 31 Veterans have received a favorable Restoration of Honor decision from DVS. These recipients include Veterans who are survivors of military sexual trauma who were then wrongfully accused of misconduct by military leaders unwilling to discipline the perpetrators of the sexual abuse, Veterans who unjustly received less-than-honorable administrative discharges due to the military's biased policies and conduct toward Service Members who identified as members of the LGBTQIA community, and Veterans whose manifestations of mental health conditions caused or worsened in their service to our nation were ignored or misunderstood by their chain of command. These Veterans now have been able to receive State benefits from property tax exemptions to eligibility for skilled nursing care at State Veterans Homes and much, much more, along with the recognition that the State of New York properly recognizes the honorable nature of their military service.

In 2021, New York State enacted new legislation that further improves the ability of Veterans to receive favorable determinations under the Restoration of Honor Act. Before this legislation, a Veteran needed to obtain medical evidence from the United States Department of Veterans Affairs to show that their mental health condition was related to military service. As many Veterans were unable to access VA medical care due to their unjustly issued less-than-honorable discharges, this situation created a Catch-22 that prevented too many Veterans from gaining access to their New York State benefits. Now, with the Restoration of Honor Act amended to allow a medical diagnosis from any provider -- VA or non-VA -- to qualify, a greater number of Veterans will meet the eligibility criteria for a favorable Restoration of Honor Act decision.

New York State Veterans Human Rights Conferences

Throughout 2021, DVS partnered with several agencies and organizations to present widely attended programs focusing on the human rights issues, needs, and initiatives of Veterans, Service Members, and Military Families. Some of these programs which addressed the concerns of older Veterans included:

- "Services For Older New Yorkers Who Served," an online presentation by DVS to all of the leaders of New York State's Area Agencies on Aging. The program focused on connecting Veterans and Military Families with disability compensation, non-service-connected pension, VA healthcare, federal benefits for surviving spouses and children of Veterans, and navigating the VA's Comprehensive Assistance for Family Caregivers Program, as well as a segment focusing on military cultural competency.

- "Restoration Of Honor Act Conference," a nationally broadcast Continuing Legal

Education program presented by DVS, SAGEVets, and the New York State Bar Association. This was the nation's first-ever conference bringing together leaders from each of the five states that have enacted Restoration of Honor legislation. The program featured Restoration of Honor Act presentations from leaders in New York, Connecticut, Rhode Island, Colorado, and Illinois. Members of the online audience came from all five participating states, as well as Maine, Ohio, Florida, Washington, and Maryland.

New York State Division of Veterans' Services and New York State Office for the Aging Collaborations

At the invitation of New York State Office for the Aging (NYSOFA) leadership, DVS's learning team provided a 90-minute online training to the leaders of all of New York State's Area Agencies on Aging on November 18. The training focused on disability compensation, non-service-connected pension, VA healthcare, federal benefits for surviving spouses and children of Veterans, and navigating the VA's Comprehensive Assistance for Family Caregivers Program, as well as a segment focusing on military cultural competency. The training followed a process throughout the summer and early autumn in which DVS and NYS OFA worked together to amend their intake documents, adding screening tools to better identify Veterans and Military Families seeking services at their offices. The training was well-received and has already led to multiple referrals of older New Yorkers for services at DVS field offices throughout the state.

In this spirit of collaboration, on Veterans Day 2021, DVS dedicated New York State's first-ever Veterans Welcome Center kiosk. With informational screens provided by DVS, DOL, DHR, OFA, OMH, OGS, and SUNY, the Veterans Welcome Center kiosk provides Veterans and Military Families with quick and easy access to information about benefits, programs, and services available to them. Located at the Capital Region Welcome Center, this marks the first of several Veterans Welcome Center kiosks that DVS will place in high-traffic locations throughout New York State.

OMH SUICIDE PREVENTION INITIATIVE FOR UNIFORMED PERSONNEL

With continued concern over the rate of veteran suicides in many states and in the nation, New York State is looking for ways to improve tracking the problem and better ways to combat it.

In November 2021 OMH announced the launch of an initiative to strengthen suicide prevention efforts for uniformed personnel, including police and other law enforcement personnel, firefighters, emergency medical service members, corrections, and military veterans. The program – called the CARES UP Initiative and developed by OMH's Suicide Prevention Center of New York – is to utilize $1,000,000 in funding annually from OMH to offer suicide prevention and resiliency trainings, create targeted media awareness campaigns, and present grant opportunities to provide uniformed personnel departments across the state with funding to increase suicide prevention efforts and wellness programming.

The Center has focused on making an impact on wellness, resilience, and suicide prevention for veterans through partnership with the Expiration of Term of Service Sponsorship Program (ETS), which focuses on the first year of post-military life and is sometimes referred to as "the deadly gap" due to the high rates of homelessness, criminal justice involvement, alcohol and substance use, unemployment, and suicide among veterans during the potentially difficult transition period.

CARES UP is in the process of evaluating applications for proposals to provide three NYS veteran-serving organizations with 21 months of funding to develop the infrastructure necessary to implement the ETS program.

ROUND 4 GERIATRIC SERVICE DEMONSTRATION GRANTS

The fourth round of geriatric service demonstration program grants made possible by the Geriatric Mental Health Act concluded its fifth and final year of operation in December 2021. The *Partnership Innovation for Older Adults* comprised a total of eight awards for five-year projects to create local "triple partnerships" of mental health, substance use disorder, and aging services providers to innovatively address the unmet needs of older adults for such services. The value of the eight awards totaled $7.96 million over the five-year grant period.

Background

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

- Access behavioral health services to meet the needs of older adults in aging services programs who need them;
- Access home and community-based, non-medical, aging support services to meet the needs of older adults in behavioral health service programs who need them;
- Identify at-risk older adults in the community who are not connected to the service delivery system and those who encounter difficulties accessing needed services. Mobile Outreach and Off-site services are to be used to assess unmet needs for behavioral health and aging services – as well as unmet needs related to areas such as physical health, cognition, social isolation, self-neglect, abuse, housing, financial resources/benefits, and legal issues – and see that needed services are provided; and
- Utilize one or more technological innovations to better serve the target population and innovatively address the unmet needs of the target population.

Grant 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," is designed to identify the need for services and utilizes care coordination to connect older adults to a range of supports delivered by more than 75 collaborative agencies in Nassau County.

CoveCare Center's triple partnership project, called "Senior Partnership Services," includes the Putnam County Office for Senior Resources and the National Council on Alcoholism & Other Drug Dependencies/Putnam. Providing care management, behavioral health treatment, and recovery

coaching for older adults, most services are delivered on-site in the homes of seniors or elsewhere in the community to support aging in place.

The goal of *Family Services of Westchester's* triple partnership, which includes the Westchester County Department of Senior Programs and Services and the Lexington Center for Recovery, is to reduce the isolation and decline that can accompany untreated behavioral health and unaddressed aging issues. Their program provides mobile outreach and behavioral health services and utilizes a model telehealth intervention program.

Flushing Hospital Medical Center's partnership, which includes the New York City Department for the Aging, provides culturally and linguistically competent behavioral health and aging services for a population of older adults in a community-based senior center in Flushing, New York. The population consists of Chinese speaking older adults; some of them are high functioning, but many others are lower functioning and have unmet behavioral health needs that put their independence, tenure, or survival in the community at risk.

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. Their program utilizes mobile outreach to engage older adults who are not connected with the county's traditional behavioral health and aging services and provides care navigation and behavioral health and aging services to older adults to increase access to services and reduce barriers to engagement in services.

Called the "Niagara Partnership for Healthy Aging," the *Niagara County Department of Mental Health's* triple partnership includes the Niagara County Office for the Aging and Northpointe Council. Its focus is on creating a strong, connected network of behavioral health and aging services providers and leveraging other existing supports to meet the needs of at-risk older adults in Niagara County, helping them not only remain safe in the community but also flourish.

The *Onondaga County Department of Adult & Long-Term Care Services* and its partners, Liberty Resources, Aurora of Central New York, and Helio Health are expanding services for a diverse population of older adults. Called the "Senior Health and Resource Partnership (SHARP) Project," the program seeks to increase the integration of aging and behavioral health services while addressing barriers to accessibility such as limited English language proficiency, cultural mores, poverty, cognitive and physical impairments, perceived shame, and isolation.

The *Orange County Department of Mental Health's* triple partnership includes Catholic Charities of Orange County and the Orange County Office for the Aging. Their program, called the "Welcome Orange Geriatric Initiative (WOGI)," offers older adults behavioral health assessment and treatment services and linkages to existing aging and other community-based services. Plans for telepsychiatry services are underway to better engage individuals who have difficulty accessing place-based services and treatment.

Grant Project Wrap-Up

OMH and its Geriatric Technical Assistance Center (GTAC) partner from the National Council for Mental Wellbeing held a concluding virtual Learning Collaborative meeting with all the grantees in December 2021 to discuss grantee presentations on four topics: (1) program model and changes, (2) program impacts on individuals served and the community, (3) adaptations to

changing climates such as those necessitated by COVID-19, and (4) lessons learned over the five years of the grant funding period. What follows is a sample of each grantee's presentation:

Central Nassau Guidance & Counseling Services' Triple Partnership (Link-Age)

- The initial grant focused on intensive case management for clients – we pivoted when we realized most client referrals had severe and pervasive mental health and/or substance challenges such as hoarding disorders, trauma-based, homelessness, elder abuse and neglect, personality disorders, and paranoia.
- We developed community relationships and a reputation for being the go-to program for older adults who are falling through the cracks.
- We have exceeded our 5-year goal of connecting with 350 older adults to improve overall quality of life and reduce behavioral health concerns.
- During COVID-19 we were able to swiftly shift from a home-based program to a hybrid model of tele-health and in-person visitations on a case-by-case basis. Some clients needed the in-person visits to be able utilize services, and we were one of the few programs continuing in-person visits during the height of the pandemic. This really strengthened our community partnerships and collaboration.
- We increased technology education as supports and services transitioned to virtual planforms during the pandemic.
- Lessons learned included: (1) how to adapt the program and remain flexible to meet the changing needs of the population we are serving and the changing environment, (2) the value of collaboration – not only within the community but also within our partnerships, (3) the value of continuing education and staff training and support – especially when the cases are vast in need and have a high risk of burnout for dedicated staff, and (4) the significance of tracking services and data to reflect the cost analysis of the program and build your own value proposition.

Cove Care Center's Triple Partnership

- Cove Care Center employed Social Workers, a Care Manager, and a Registered Nurse in our partnership. The Putnam Prevention Council employed a Recovery Coach, and the Office of Senior Resources allowed us to have a dedicated Care Manager who was the liaison between our agencies.
- We provided mobile and on-site mental health and substance use counseling and Recovery Coach connection. Those connected also benefited from our RN providing medication packing, psychoeducation, wound care, and doctor consultations.
- We assisted clients get connected to Medicare, Medicaid, SNAP, HEAP, senior housing, and recovery programs. Many of them are homebound, so access to mobile and telehealth services made a huge impact in working toward wellness. Our partnership is a go-to source for APS, DCMH, and OSR whenever someone is identified as needing assistance in the community.
- We were able to use telehealth platforms to connect with clients throughout the COVID-19 pandemic and were still mobile during the height of the pandemic bringing food and toiletries to those in need. For those who needed in-person mobile services, we had

appropriate PPE for both staff and clients, weather permitting, met with people outside.

- Regarding lessons learned, we reimagined our original idea of the use of technology and adapted to more flexible means, such as Amazon Alexa, Fitbits, teaching the use of Zoom, and medication packing machines. Collaborations were already established in our small community, but we learned that they could be even stronger, more creative and more fluid. We learned that this is a desperately needed service and without which people struggle.

Family Services of Westchester's Triple Partnership

- The goals of Westchester County's triple partnership were to reduce the isolation and decline that can accompany untreated behavioral health and aging issues in older adults and to help older adults maintain their dignity while enhancing their quality of life and helping them to live independently in the community for as long as possible.

- Our partnership successfully outreached and provided services for more than 185 older adults and caregivers.

- Outreach and presentations were provided for 223,000+ individuals and groups in the community. A wide variety of modalities were used, including emails, face-to-face presentations, Westchester Department of Senior Programs and Services newsletters and list serves, telephone calls, and the Family Services of Westchester and DSPS Care Prep websites.

- Adapting to the fluid changes that resulted from COVID-19, we engaged in ongoing communication to how COVID significantly affected the global and local Westchester communities, clients, and themselves; problem solving ways to modify the program, monitoring for the effectiveness of changes needed to alter their approaches; and pivoting to increase remote access so that service delivery was never interrupted; and discovering new and creative ways to fully implement the program.

- Our partnership engaged in a successful collaboration that allowed us to share resources, fully implement the program, and make small and major modifications as needed. We learned how to integrate the three major service systems in the service of older adults and how to successfully utilize peers in the process of providing services. Underlying it all was genuine respect for one another in the partnership and belief in the mission and overall goals of the program.

Flushing Hospital Medical Center's Partnership

- The Flushing Hospital partnership model was designed as an embedded mental health services program in a setting operated by the New York City Department for the Aging largely serving the Chinese-speaking community. Naming the program "Successful Aging for Increased Longevity" (SAIL) helped in the development of materials, curriculum, and outreach initiatives.

- We followed a manualized curriculum to guide participants through a series of health-related topics each week and utilized Fitbits to promote health, self-efficacy, and social support skills. Program impacts included integrating physical and mental health in engaging ways, such as using technology to track health goals, classes, and movement. New York City's Department for the Aging is collecting and summarizing the Fitbit health

data.

- Contact with a Psychiatric Nurse Practitioner enabled our participants to access and receive direct care for medical concerns, a connection that also helped break language and cultural barriers and ease anxiety. The development of four short educational videos produced in English, Spanish, Cantonese, and Mandarin showed what a counseling session looks like and helped de-stigmatize mental health services.

- The partnership program continued through the COVID crisis through virtual support groups, tele-mental health via WeChat, Zoom, telephone, and later (when the Older Adult Centers opened again) in person. New engagement activities were established at another Center in Flushing.

- Lessons learned included: (1) Components of the program required in-person attention to be successful, (2) education and engagement were critical to the program's impact, (3) the manualized aspect of the program was useful in reaching the Chinese community in this setting, where the response to teaching and in-classroom learning helped participants more openly discuss mental health issues, and (4) the program will continue at the Flushing Hospital Mental Health Clinic.

The Institute for Family Health's Partnership

- For what became a partnership between the Institute for Family Health and the Ulster County Office for the Aging, the goal was to provide mental health and care navigation services to older adults in Ulster County, the key components of which included outreach, community education, the use of technology for warm hand-offs, and collaboration with community partners. Outreach was conducted with police departments, senior apartment complexes, and emergency response services. We made warm hand-offs using Skype to introduce members of the partnership and schedule appointments and developed a Resource Guide.

- Our model was to purchase and customize tablets for use by selected older adults to give them easy access to services, with the hope that tablets could prove to be a "warm" touch to the isolated older adults being treated by the Institute for Family Health. Group sessions could also be managed through video platforms. But when offered phone contact or tablet access, most older adults preferred the phone.

- Realizing the lack of trust or knowledge in technology, our Office for the Aging was able to expand its Cyber Senior Program in the county. This was accomplished by developing computer procurement programs with people willing to help train "super users" in senior housing and senior centers to get more older adults connected by video/live programs and resources, so they feel more comfortable reaching out for help.

- Among the lessons learned were that (1) Ulster County's connectivity is not ideal and that many rural areas have little or no broadband access, (2) There is only one cable company, and it is inflexible and not geared to serve low-income people, and (3) older adults must have wi-fi availability to use the tablets and are still wary of technology.

Niagara County Department of Mental Health's Triple Partnership

- Our Niagara "Partnership for Healthy Aging" (PHA) program included the Niagara County Department of Mental Health, the Niagara County Office for the Aging, and the Northpointe

Council up until the last three months of the grant when we went from three agencies to two. We have worked hard to assure that there has been no interruption or changes to the delivery of services that we provide.

- We have provided case management and counseling services to clients of Niagara County for the past four to five years. The Partnership for Health Aging program has expanded referral sources, including sources out of the county that have become aware of the program and its benefits.
- Due to the limited internet capability in many areas, the PHA program adapted during COVID by conducting phone call sessions. Case management has had fewer face-to-face contacts with clients but has been able to achieve the same objectives. The PHA program has also overcome limited resources during COVID. New York Connects has been helpful filling the gaps and obtaining additional resources.
- The PHA has learned to adapt to staffing changes and departures and to constantly re-evaluate program objectives. We have developed a good network of providers who serve those we serve, the 55+ population of Niagara County.

Onondaga County Department of Adult & Long-Term Care Services' Triple Partnership

- Actually a Quadruple Partnership, Onondaga County's "Senior Health and Resource Partnership (SHARP) Project" included the Onondaga County Department of Adult & Long-Term Care Services, Liberty Resources, Helio Health, and Aurora of Central New York.
- Our core services: (1) Person-Centered Care Management; (2) Aging services including Meals-on-Wheels, Home Care, Transportation, Housing Assistance, and more through the Onondaga County of Adult and Long-Term Care Services; (3) a full range of Behavioral Health services through two partnership providers, Liberty Resources and Helio Health; (4) Home Visits and Telehealth; and (5) Sensory Loss services, Assistive Equipment, and Peer Support through Aurora of Central New York.
- We used a "No Wrong Door" approach to accessing services and built a solid foundation for collaboration between service systems from the beginning. Notable program impacts included a significant reduction in the severity of depression scores as measured by the PHQ-9, increased use of adaptive equipment, and the delivery of destigmatized mental health services among seniors. In working with older adults between 55 and 59 years old, we served many individuals who may not have otherwise been age-eligible for needed services.
- In responding to the challenges of COVID-19 in our partnership, we temporarily paused in-person home visits but increased telehealth services. We also responded to an increase in demand to meet basic needs for food, medicine, and toiletries and effectively communicated with all our partners to insure no gaps in services.
- Lessons learned: we found that (1) many older adults in our community struggle with mental health and sensory loss, (2) seniors might not otherwise have had easy access to needed services without a partnership approach to their care, (3) regular communication with partners was key to success, and (4) always be patient throughout the growth process.

Orange County Department of Mental Health's Triple Partnership

- Called the "Welcome Orange Geriatric Initiative" (WOGI), Orange County's Department of

Mental Health's triple partnership included Catholic Charities of Orange County and the Orange County Office for the Aging.

- Changes to our model: shifting from a satellite-based model to a community-based model, allowed us to cover the entire county, not just part of it. We use a Gatekeeper model for intakes and referrals. Other changes involved turning to a more virtual model for many services during COVID-19 and establishing connections with our county's 24-hour call center when it was initiated in 2019.

- Positive program impacts included in-home services allowing for greater communication and coordination with families and other providers; closer relationships established with referral sources such as hospitals; clients reporting feeling heard and supported and having a greater sense of confidence and empowerment; and improvement in depression and anxiety scores.

- Program adaptations: over time we became creative in resuming in-person contacts while maintaining safety per changing COVID-19 guidance. We were able to increase the scope of group engagement and work with families according to their comfort level.

- The lessons learned: (1) There is a depth of resources and creativity in the county that can be used strategically for client benefit, (2) Sometimes where we land is better than what we had originally planned, (3) It works better when we first identify an individual's needs and try to meet them rather than trying fit the individual into an existing model or program, and (4) Working to coordinate budgets and strategies in advance is helpful.

Grant Evaluation

OMH staff in the Office for Population Health and Evaluation continued to collect and review data reported by each of the geriatric service demonstration projects to inform and support their efforts and to conduct implementation and outcomes evaluations of their work. The *Partnership Innovation for Older Adults* (PIOA) Mid-Grant Evaluation Report" was completed in December 2019 and showed the many ways the project has been effective in both providing and improving services to the older adult population. With the conclusion of the grant in 2021, a final report is to be developed, completed, and released in 2022.

Grant Project Support

OMH staff in the Division of Adult Services' Bureau of Program and Policy Development continued to provide ongoing program operational support for the grant projects in 2021. With responsibilities for assigned projects that include on-site and off-site consultation and project oversight, they also approved contract work plans, monitored contract deliverables, reviewed requests for program and/or budget changes, worked with OMH field office staff, facilitated communication with others at the agency, served as grant project advocates, and helped troubleshoot and problem solve with and on behalf of the grantees.

OMH staff also worked closely with contract staff responsible for the operation of New York State's Geriatric Technical Assistance Center (GTAC), established by OMH in 2012 to provide programmatic and fiscal training and technical assistance for the geriatric service demonstration program. Staffed by the National Council for Mental Wellbeing, GTAC's work with the *Partnership Innovation for Older Adults* projects in 2021 included:

- A Motivational Interviewing Affinity Series on organizational and client change;

- A day-long virtual Learning Collaborative in February with presentations on "Leveraging

Your Value Proposition," "Recognizing Risky Substance Use and SUD in the 55 and Older Population," and "Finding Your Way as You Lead Sustainability in Recovery";

- A day-long virtual Learning Collaborative in September with a presentation from the E-4 Benjamin Rush Center of Excellence on "Safe-Home and Narcan Use," "Post-Grant Review Trends", "Telehealth Utilization", and a presentation from NYSOFA Acting Director Greg Olsen;
- Virtual grantee site visits in May on (1) finance data verification and budgets, and (2) a sustainability action plan template and discussion of financial domains;
- Virtual grantee site visits in November on (1) a review of post-grant action plans, and (2) a review of post-grant questionnaires;
- Group collaboration sessions on "Brag and Steal" peer learning sessions in February, May, June, August, and October; Project newsletters in September through December; and
- Coaching calls in March and July focused on data reviews, grant wrap-up planning, program sustainability and post-grant transition action plans, non-financial domains identified by each team, OMH data collection, success stories and lessons learned.

ROUND 5 GERIATRIC SERVICE DEMONSTRATION GRANTS

In April 2021 the Office of Mental Health issued a Request for Proposals to invite eligible applicants to submit proposals for developing a *Partnership to Support Aging in Place in Communities Severely Impacted by COVID-19* program. The program was required to support older adults aged 55 and older age in place in either OMH supportive housing or other community located housing where older adults reside. The program model required the development of formal partnerships between the primary applicant – identified as an NYS OMH licensed provider – and both an NYS OASAS provider and a NYSOFA local Area Agency on Aging (AAA). The RFP could be used to expand or enhance existing programs or develop a new program that met all of the program requirements. Both types of proposals were evaluated using the same criteria. OMH awarded six grants of up to $300,000 a year for a five-year grant cycle to begin January 1, 2022.

Background

Program requirements included, but were not limited to:

- Analysis of community need and the identification of community-based resources and assets to better serve culturally diverse and historically underserved populations, with a focus on older adults with behavioral health needs;
- Community outreach, education, and engagement activities to promote identification and referral of at-risk individuals and linkage to grant project services;
- Assessment of an at-risk individual's behavioral health, physical health, environmental and social needs through a person-centered, trauma-informed, recovery-oriented, and culturally attuned perspective to support aging in place;
- Provision of mobile and community-based services to increase access to behavioral health, physical health, and other social support services to improve health outcomes and reduce risk of premature institutionalization;

- Intensive care coordination to include linkage to Area Agencies on Aging services, community-based organizations, health care providers, Health home case management services, and Home Health Care provider agencies as needed;

- The use of peer services provided by individuals with lived experience such as OMH Certified Peer Specialist (CPS), OASAS Certified Recovery Peer Advocates (CRPA), Community Health Workers and community-based organization volunteers to improve outreach and engagement, reduce social isolation and the effects of stigma, and assist with system navigation;

- The use of technology to increase outreach and improve access and participation in care. Examples of technology may include a variety of telehealth and telecare options, mobile technologies, and audio, visual and "smart" technologies, access to Virtual Senior Centers, access to personal health portal, electronic health monitoring devices and other technological innovations; and

- The use of program budgeted funding to provide wraparound funds to support aging in place as needed. Examples may include, but are not limited to, home modifications to improve safety and security, payments for home care services not eligible under current coverage, improving access to technology (equipment, WI/fi/internet access, technology literacy training).

This fifth round of geriatric service demonstration program grants, made possible by the Geriatric Mental Health Act, was announced in a press release from Governor Kathy Hochul on December 3, 2021, with the Governor saying that "As the COVID-19 pandemic continues to impact communities across New York, we must do everything in our power to protect the most vulnerable among us. This financial support will help older New Yorkers in communities that have been especially hard-hit by the pandemic, and the funding will ensure that they have the assistance and support to live independently and with dignity." OMH Commissioner Dr. Ann Sullivan, OASAS Commissioner Dr. Chinazo Cunningham, NYSOFA Acting Director Greg Olsen, and Division of Veterans' Services Executive Deputy Director Joel Evans expressed additional statements of support.

Grant Project Descriptions

Central Nassau Guidance & Counseling Services is partnering with the Family & Children's Association and the Nassau County Office for the Aging in what they call their "Link-Age Project." Their goals are to integrate mobile outreach and service delivery among their agencies; identify and engage older adults; identify the specific needs of each older adult encountered; use technology to help older adults and their families/caretakers overcome common barriers to access care and services; and utilize wrap-around funding and peer supports to address unmet needs. Mobile mental health and co-occurring disorders treatment and mobile targeted outreach to isolated seniors figure largely in their plans.

Jamaica Hospital Medical Center is partnering with Flushing Hospital Medical Center and the New York City Department for the Aging in the "Jamaica Partnership to Support Aging in Place." Project goals are to effect decreases in untreated mental health and substance use disorders among at-risk individuals; decreases in episodic care in the Emergency Department; decreases in maladaptive behaviors that contribute to poor mental health; increased engagement; and

decreased unmet needs stemming from cultural and language barriers. The partnership expects to serve 360 individuals during the grant period, with Flushing providing substance use disorders treatment and telemedicine addiction support services and the Department for the Aging training medical staff on non-medical aging support and connecting medical center staff with aging services providers.

Ohel, in partnership with LSA Recovery, Inc. and the New York City Department for the Aging (DFTA), will provide wrap-around mental health services and connect older adults with a full array of services so that they can successfully age in place. They plan to implement a "hub and spoke" model where their multi-disciplinary team will conduct outreach, engagement, and field-based screening throughout the Rockaways, maintaining on-site presence within NYCDFTA-designated NORCS, Older Adults Centers, and NYCHA housing ("spokes') leading to linkage with OHEL mental health clinics and LSA substance use disorder clinics ("hubs") for additional assessment/treatment, as well as connection to NYCDFTA services and supportive technologies.

Orange County Department of Mental Health, Catholic Charities of Orange and Sullivan Counties, and the Orange County Office for the Aging partner to support aging in place through the "Enhanced WELCOME Orange Geriatric Initiative (E-WOGI)" and includes the Making use of the "Gatekeeper" model, the enhanced project aims to serve those who have been traditionally underserved by increasing stabilization in the community and reducing avoidable emergency department, hospital, and nursing home admissions; supporting older adults to improve their wellbeing and functioning so that can age-in-place; and improving the use of technology to better serve the target population by creating an infrastructure to match individuals with services and supports based on their unique assessed needs.

Samuel Field YM&YWHA is partnering with Rego Park Counseling and the New York City Department for the Aging to identify and engage older adults in screenings in their home communities and connect them with services. Mobile outreach and off-site services are the dual focal points of the program and include assessment of behavioral health, physical health, and aging services needs as well as unmet needs in other areas. An individualized plan of care is to be created for each client, and interim care and care coordination is to be provided until all identified services are in place. Counseling, including individual or family psychotherapy and psychiatric care, is to be provided through Samuel Field and Rego Park counseling services.

Service Program for Older People (SPOP), is partnering with the Metropolitan Center for Mental Health and the New York City Department for the Aging, will support aging-in-place and reduce premature institutionalization of older adults by providing integrated services related to overall health – psychological well-being, medical care, and treatment for substance use disorders – while also addressing concrete needs through case management services, home health care, socialization opportunities, meals, minor home modifications, and connections to community-based programs. The program expects to serve 240 adults each year, a total 2,700 over the grant period, and to provide additional education and outreach to 300 individuals each year through its two partnerships, one of which brings extensive outpatient substance use treatment experience to the table and the other concrete services to support aging-in-place.

SUMMARY

As noted in this document, planning and addressing the needs of older adults in New York State for behavioral health and related services is taking full advantage of (1) the provisions of the

Geriatric Mental Health Act; (2) the planning and collaborative efforts of the Interagency Geriatric Mental Health and Substance Use Disorder Planning Council and its members; (3) New York State agency initiatives supporting aging in place; (4) the provision of core behavioral health services, support, and aging services for older New Yorkers; (5) help for older adult veterans and service members and their families to obtain the state and federal benefits they earned as a result of military service; (6) lessons learned from the *“Partnership Innovation for Older Adults”* geriatric service demonstration program grants to create local partnerships of mental health, substance use disorder, and aging services providers to address unmet needs; and (7) lessons yet to be learned from the new *“Partnership to Support Aging in Place in Communities Severely Impacted by COVID-19”* geriatric service demonstration program grants.