INNOVATIVE HOSPITAL – HOME CARE – MENTAL HEALTH COLLABORATION MODELS: A PRIMER

Statewide Hospital-Home Care Collaborative for COVID-19 and Beyond

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EXECUTIVE SUMMARY

Hospitals and home care providers have long collaborated to tackle major problems in the healthcare system. The Home Care Association of New York State Education and Research (HCA E&R), Healthcare Association of New York State (HANYS) and Iroquois Healthcare Association (IHA) invited partner organizations, the New York State Office of Mental Health (OMH), and housing providers to share collaborative models and lessons learned to provide a foundation for hospital, home health and mental health collaboration. These models can be used as a roadmap for meeting the growing demand for mental health services.

THE MENTAL HEALTH LANDSCAPE

The COVID-19 pandemic exacerbated New York state's mental health crisis. Mental illness can cause or worsen other medical conditions, and vice versa. Mental health concerns span the age and disability spectrum, potentially affecting everyone. Mental illness is a powerful influence on our overall quality of life and can result in a diminished capacity for coping with the demands of everyday life.

The ongoing COVID-19 pandemic has increased the demand for mental healthcare services at a very challenging time. As older adults choose to age in place, hospital emergency departments continue to be overloaded and the healthcare sector faces personnel shortages in almost every area. Healthcare providers must work together to meet the healthcare needs of our communities.

COLLABORATION

Collaboration between hospital, home health and mental health services is essential to meet New Yorkers' healthcare needs. Approaching patient care from a team-based perspective and engaging with the patient to work toward a shared goal can improve cost-effectiveness[1], patient care and outcomes, patient and job satisfaction[2], reduce medical errors[3] and lead to a better quality of life for patients and caregivers.[4] Collaboration also supports the Triple Aim of improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of healthcare.

This primer highlights hospital, home care and mental health collaboration models and efforts, including OMH initiatives that foster interdisciplinary collaboration, and OMH supportive housing provider programs that help people with behavioral health needs who are entering the community or aging in place, to be successful in the most integrated setting.

[1]David E. Goodrich, et al., "Mental Health Collaborative Care and Its Role in Primary Care Settings," *Current Psychology*, PubMed Central, August 2013, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3759986.
[2]Cynthia D. Smith, et al., "Implementing Optimal Team-Based Care to Reduce Clinician Burnout," National Academy of Medicine, September 2018, https://nam.edu/implementing-optimal-team-based-care-to-reduce-clinician-burnout.
[3]Tori DeAngelis, "Preventing medical errors," American Psychological Association, September 2016, Vol. 47, No. 8, page 48, https://www.apa.org/monitor/2016/09/preventing-errors.
[4]Mohammad Zoladl, et al., "Applying Collaborative Care Model on Intensive Caregiver Burden and Resilient Family Caregivers of Patients with Mental Disorders: A Randomized Controlled Trial," *Iranian Journal of Heath Psychology*, PubMed Central, January 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7193235.

EXECUTIVE SUMMARY CONTINUED

STRENGTHS AND BARRIERS OF HOSPITAL, HOME CARE AND MENTAL HEALTH COLLABORATION

Collaboration should be individualized and tailored to meet specific needs or parameters, but many essential best practice components and barriers are universal. Good communication, clear expectations, team engagement and flexibility can be the difference between a successful collaboration and failure. Time commitment, lack of trust, knowledge gaps, organizational silos and financial or regulatory constraints can be barriers to collaboration. Many barriers to collaboration begin with communication, which is often the best method for mitigating these barriers.

> **THE KEY IS TO CREATE A MULTIDISCIPLINARY WORK GROUP WHERE MEMBERS CAN SUPPORT, ENGAGE AND ASSIST EACH OTHER IN CREATING AND MEETING PROJECT GOALS.**

Hospital, home care and mental health providers bring unique strengths to work together to serve community members. Each has knowledge of community supports and services and has existing partnerships with community organizations. Providers in the hospital are knowledgeable about patient safety and stability and discharge planning. Home care providers have a familiarity with the home, hospital and community settings and care needs of people in those settings. Mental healthcare providers have extensive skills related to medication management, behavioral health interventions and skill building. Regulations, personnel shortages, training needs and inflexibility in billing pose barriers to these important partnerships.

NEXT STEPS

The collaborative models in this primer provide an important catalyst for all stakeholders to begin or continue collaboration efforts. The models have affirmed that hospital, home care and mental health collaboration are multilevel and multifaceted. The commitment to adequate funding, investment in current and future mental healthcare efforts and mobilization of the consumer as an active participant in their care must all be essential parts of the solution to meet society's mental health needs.

INTRODUCTION

ABOUT THE STATEWIDE HOSPITAL- HOME CARE COLLABORATIVE

Hospitals and home care providers have long collaborated to tackle major failure points encountered in the healthcare system. To continue these efforts, HCA E&R, HANYS and IHA developed a Statewide Hospital-Home Care Collaborative under a grant from the Mother Cabrini Health Foundation.

This collaborative aims to improve hospital-home care synchronization for pre-acute hospital care and post-hospital care, recovery and long-term support. As part of this effort, HCA E&R, HANYS and IHA hosted a series of webinars featuring prototypes of hospital and home care collaboration that can be emulated by other providers statewide — working together, across settings. An online library of resources and tools further assists hospital-home care collaborative development.

HCA, HANYS and IHA thank the New York State Office for Mental Health for its support of the Statewide Hospital-Home Care Collaborative and for sharing materials from its presentations. These presentations provided real-world examples of collaboration between behavioral health[5], home care and OMH supportive housing providers designed to keep adults with complex conditions in the community of choice as they age.

HOME CARE ASSOCIATION OF NEW YORK STATE

"Hospital-Home Care-Mental/Behavioral Health Provider Collaboratives bring together these key partners for integrating services, care management and health and social supports. Teamed together and coordinated, these partners are essential to the overall health, preventive, primary and community living goals for individuals with co-occurring physical-mental health service needs. Individuals with these co-occurring needs represent some of the most complex, and high-risk within the healthcare system, and often falling into the gaps between sectors, disparate coverages, procedures, and jurisdictional entities. Our thanks to the hospital, home care and mental health providers, the NYS Office of Mental Health and the Mother Cabrini Foundation for the joint support in creating this roadmap of models and pathways through the *Statewide Hospital-Home Care Collaborative.* We are committed to further working with and supporting the state's providers, officials and constituencies toward these transformative models." -- Al Cardillo, HCA President and CEO

HEALTHCARE ASSOCIATION OF NEW YORK STATE

"Mental and physical health are inextricably connected. It is time to re-evaluate and invest in healthcare delivery models that are designed to serve New Yorkers with co-occurring conditions as the expectation, not the exception," said Bea Grause, RN, JD, president, HANYS. "Increased collaboration between care providers across the continuum will help pave the way to addressing longstanding barriers to care for individuals with behavioral health needs."

IROQUOIS HEALTHCARE ASSOCIATION

According to Gary Fitzgerald. President and CEO of IHA, "Now more than ever is the time to coalesce statewide policies to ensure the integration of physical and mental health. The pandemic has exacerbated the demand for mental health services among all populations and highlighted the need for providers and practitioners to solve problems in a collaborative manner."

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[5] Behavioral health is the collective term for mental health and substance use providers or services.

THE COMPLEXITY OF HOSPITAL AND HOME CARE

Whether individuals with complex care needs live in the community, are discharged from the hospital into the home or are choosing to age in place, they all have one thing in common: they would benefit from home care services.

As the older adult population continues to grow,[6] more older adults prefer to stay in their homes to age in place.[7] For many, staying in a familiar environment is ideal, as moving into a new and unfamiliar location such as an assisted living or nursing home setting can be an uncomfortable and potentially distressing adjustment.[8] Staying in the home reduces worry and stress, and gives reassurance to the individual and their family that they are in a comfortable and familiar environment.[9]

> **MENTAL HEALTHCARE NEEDS MUST ALSO BE CONSIDERED WHEN MAKING PLANS TO AGE IN PLACE OR RETURN TO THE COMMUNITY POST-HOSPITAL DISCHARGE. MENTAL AND PHYSICAL HEALTH GO TOGETHER, AND THESE NEEDS SHOULD BE ADDRESSED AS SUCH.**

Over time, older adults can face health and mobility challenges that threaten their independence and ability to successfully stay in the home.[10] To ensure an individual can remain as independent as possible in the home, steps must be taken to accommodate their needs, including finding the right home care services.

Care providers in the hospital are responsible for synchronizing complex care management for pre-acute hospital care, post-acute recovery and long-term support. The hospital care team assists with patient care and stabilization and helps to ensure needs are met when the patient transitions out of hospital care and into a new setting.

Home care services can help mitigate the care load during times of extreme need or emergency such as the COVID-19 pandemic surges, when many hospital systems are overloaded with patients while understaffed. Patients can be discharged from the hospital into their homes with the appropriate home care services to meet their needs, which also opens beds in the hospital for more acute cases. When post-acute medical care needs are not met in the home, the patient will likely return to the hospital to receive needed services — and use scarce resources.

[6]National Institutes of Health, "World's older population grows dramatically," March 2016, https://www.nih.gov/news-events/news-releases/worlds-older-population-grows-dramatically.
[7]AARP, "AARP Survey Shows 8 in 10 Older Adults Want to Age in Their Homes, While the Number and Needs of Households Headed by Older Adults Grow Dramatically," April 2021, https://press.aarp.org/2021-11-18-AARP-Survey-Shows-8-in-10-Older-Adults-Want-to-Age-in-Their-Homes-While-Number-and-Needs-of-Households-Headed-Older-Adults-Grow-Dramatically.
[8]Darlene Oakley, "The Psychological Impact of Moving to Assisted Living and Residential Care," *EmpowHer*, August 2011, https://www.empowher.com/caregiving/content/psychological-impact-moving-assisted-living-and-residential-care.
[9]Mandy Kloppers, "5 Vital Psychological Benefits of Home Care Services," Thoughts on Life and Love, https://thoughtsonlifeandlove.com/5-vital-psychological-benefits-of-home-care-services.
[10]National Institute on Aging, "Maintaining mobility and preventing disability are key to living independently as we age," November 2020, https://www.nia.nih.gov/news/maintaining-mobility-and-preventing-disability-are-key-living-independently-we-age.

THE MENTAL HEALTH LANDSCAPE

New York state is experiencing a mental health crisis that has been greatly exacerbated by the COVID-19 pandemic. Across the state, communities struggle to access mental health services and care facilities. When people cannot access timely mental health services, their conditions deteriorate, often leading to avoidable crises requiring hospitalization.[12] Individuals living with mental illnesses are at a much higher risk of other medical conditions, while those living with other medical conditions often experience psychological distress placing them at a higher risk of mental illness.

CURRENTLY, ONE IN FIVE NEW YORKERS HAS SYMPTOMS OF A MENTAL HEALTH DISORDER.

Mental health services with other medical care results in the delivery of safe, effective, efficient, equitable and timely patient-centered care. Pre-acute home care helps prevent avoidable hospitalizations, while post-acute home care helps in the recovery process.

Together, these efforts ensure that patients do not end up admitted or readmitted to the hospital unnecessarily, so that hospitals can dedicate resources where they are most needed for emergency, critical, surgical, trauma and/or other specialty care.

THE SPECTRUM OF MENTAL HEALTH CONCERNS

Mental health includes our emotional, psychological and social well-being, and spans the age and disability spectrum, affecting people of any race, religion, age or income. Mental illnesses are medical conditions that often result in a diminished capacity for coping with the demands of everyday life. It can affect every aspect of life and have a powerful influence on our overall quality of life. Young people and older adults are especially vulnerable, but due to stigma, many do not reach out for help. Also, due to persistent structural barriers to care, many may not know that resources are available and/or how to access them.

Individuals with serious mental illness often have co-occurring chronic health conditions and long-term care needs due to accelerated aging and cognitive impacts. Some individuals may also have a co-occurring substance use disorder and require assistance managing symptoms of addiction or substance use.[13] Assessments and early intervention are imperative to identifying mental and behavioral health concerns and needed resources.

THE IMPACT OF COVID-19 ON MENTAL HEALTH

The COVID-19 pandemic placed enormous stress on the healthcare system, necessitating strong partnerships across all settings. The impact of the COVID-19 pandemic on mental health cannot be overstated. The ongoing COVID-19 pandemic has simultaneously resulted in a surge in mental healthcare needs and historic workforce shortages, with unknown long-term consequences. Reports show amplified psychological distress, symptoms of depression, anxiety and post-traumatic stress, and increases in suicidal thoughts and behaviors. There have been dramatic increases in ED visits for mental health emergencies.

To address the mental health consequences of the COVID-19 pandemic, the World Health Organization recommends applying a "whole society" approach to promote and care for mental health through social and financial protection and communicating widely about COVID-19 to counter misinformation. The key aspect is to ensure widespread availability of mental health and psychosocial support, including scaling up access to self-help and supportive community initiatives.

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[11]New York State Department of Health, Priority Area: Mental Health/Substance Abuse - Mental Health, https://www.health.ny.gov/prevention/prevention_agenda/mental_health_and_substance_abuse/mental_health.htm.
[12]Madeline Hodgman-Korth, "What Happens If You Don't Treat Mental Health Disorders?" Desert Hope Treatment Center, October 2022, https://deserthopetreatment.com/co-occurring-disorders/going-untreated
[13]National Institutes of Health, "Substance Use and Co-Occurring Mental Disorders," https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health

HEALTHY AGING

Seventy-seven percent of older adults have two or more chronic conditions, and the rate of depressive symptoms increases with age. Men aged 85 years or older have a suicide rate of 45.23 per 100,000, compared to an overall rate of 11.01 per 100,000 for all ages. The need for coordinated, high-quality health and wellness care and other public services for older adults will only continue to rise.

PEOPLE OVER AGE 65 WILL REPRESENT 21% OF NEW YORK STATE'S POPULATION BY 2030.

In 2017, AARP designated New York state as the first Age-Friendly State. Former Gov. Cuomo's 2018 state of the state address included a commitment to have 50% of New York health systems become age-friendly within five years. Age-Friendly Health Systems is a model that uses the Institute for Healthcare Improvement's set of four evidence-based elements to organize the care of older adults. These elements are known as the "4Ms": What Matters, Medication, Mentation and Mobility. The 4Ms are essential components of high-quality care for older adults, and when implemented together, result in significant improvements. Age-Friendly facilities see improved patient experience scores and quality outcomes for readmissions, ED utilization and length of stay. At this writing, there are 217 Age-Friendly facilities in New York.

In recognition of the growing need for a coordinated and strategic approach to aging, Gov. Hochul's fiscal year 2023 budget calls for the creation of a Master Plan for Aging. A Master Plan for Aging is a deliberate process and plan to support older adults by integrating the work of the public and private sectors to create communities that promote several goals. These include healthy living, access to care, civic engagement, volunteering, work, and access to open space and walkable communities that promote physical exercise while reducing reliance on motor vehicles.

HOME CARE AND HOSPITAL STRENGTHS IN PARTNERSHIPS WITH MENTAL HEALTHCARE PROVIDERS

Home care and hospital providers have a unique array of knowledge and skills with which to collaborate successfully with mental healthcare providers. With experience working with individuals with mental health needs, care management and service navigation, these professionals can help meet care needs and avoid emergencies or unnecessary institutionalization. Hospital providers are an integral part of the mental health care continuum and have a knowledge of community resources to help with the care transition including transportation services, assistance with durable medical equipment, home modifications, access to food and receiving necessary medications upon discharge.

Familiar with the home and community setting, and the growing sector of consumer-preferred care, home care providers are able to support aging in place.

Home care providers have an existing and engaged partnership with managed care, hospitals, physicians and other community service support providers. Home care and hospital providers have the knowledge and ability to work with community mental health providers and primary care to provide the additional health component needed for a holistic plan of care for individuals in the community.

BARRIERS TO HOSPITAL – HOME CARE – MENTAL HEALTH COLLABORATION

- Regulatory silos: incompatibility with or lack of alignment for collaboration and/or service and population need;
- personnel shortages and training needs specific to certain populations;
- unique barriers to the provision of hospice care in some mental health residential settings, where a terminal condition conflicts with the eligibility threshold for care and requires patient transfers to alternate settings; and
- finance: inflexible billing, reimbursement silos and lack of financing in key areas of need.

COLLABORATION IS KEY

Collaboration and innovation are necessary to meet New Yorkers' healthcare needs. *Interprofessional collaboration is the practice of approaching patient care from a team-based perspective and requires all care team members to engage with the patient and each other to work together toward a shared goal.*[14]

Hospitals are often the first point of contact for physical and mental health emergencies. While in the hospital, the patient receives care from a multidisciplinary team of health professionals working together to meet complex needs. Communication and teamwork skills are essential for all healthcare disciplines to deliver safe, effective and timely care and reduce the likelihood of negative outcomes and excess resource utilization.

> Interdisciplinary collaboration can benefit all elements of healthcare delivery by:
>
> - improving efficiency and effectiveness;[15]
> - improving patient care and outcomes;[16]
> - preventing and reducing medical errors;[17]
> - increasing patient satisfaction;[18]
> - starting treatment faster;[16]
> - improving staff relationships and job satisfaction;[19] and
> - reducing inefficiencies and healthcare costs.[17]

Complex care management plans, especially for those with intensive behavioral needs, can be challenging for patients and caregivers to integrate into routine day-to-day activities post-discharge. Caregivers and families are tasked with the responsibility of caring for their chronically ill loved ones, typically with limited knowledge or education concerning the needs, disease process or available treatments and supports. Collaborative care from professionals can help reduce the caregiving burden and lead to a better quality of life.

REALIZING THE GOALS OF THE OLMSTEAD DECISION OR MOST INTEGRATED SETTING

The New York State Office for Mental Health identified the following priority populations, that often overlap, and whose needs must be met to achieve the aims of the *Olmstead v. L.C.* decision:

- individuals trying to age in place in the community, often in OMH supportive housing, the most independent level of OMH housing that is fully integrated into the community; and
- individuals transitioning out of acute care (hospitals, EDs) and institutional settings (state psychiatric centers and residences, adult homes) who require collaborative behavioral health, physical health and long-term care services to maintain tenure in the community.

Authorized by the Geriatric Mental Health Act enacted in 2005 to develop planning for the mental health needs of older adults in New York State, OMH collaborates with state agencies to oversee the Geriatric Service Demonstrations, now in its fifth round of grants, and in partnership with the Home Care Association and The Interagency Geriatric Mental Health and Substance Use Disorder Planning Council, the Geriatric Mental Health Act language was amended to include collaboration between licensed or certified providers of home care services and mental health providers to support aging in place.

OMH's collaborative work across services systems and feedback received by behavioral health providers supporting adults age 55+ with complex conditions shows that, while people living with severe mental illness have long-term care services as part of their Medicaid package, access to these services is often a challenge due to the complicated eligibility pathways and service navigation. OMH will continue to work with state agencies and community providers on initiatives that foster these needed collaborations and maximize service accessibility — critical components of policy needed to achieve the aims of *Olmstead.*

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[14]Johnson & Johnson, "The Importance of Interprofessional Collaboration in Healthcare," January 2016, https://nursing.jnj.com/getting-real-nursing-today/the-importance-of-interprofessional-collaboration-in-healthcare.

[15]Will O'Connor, MD,"5 Benefits of Interprofessional Collaboration in Healthcare,"TigerConnect, November 2019, https://tigerconnect.com/blog/5-benefits-of-interprofessional-collaboration-in-healthcare.

[16]David E. Goodrich, et al., "Mental Health Collaborative Care and Its Role in Primary Care Settings," *Current Psychiatry Reports*, PubMed Central, August 2013, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3759986.

[17]Tori DeAngelis, "Preventing medical errors," American Psychological Association, September 2016, https://www.apa.org/monitor/2016/09/preventing-errors.

[18]Kristen K. Will, et al. "Team-Based Care and Patient Satisfaction in the Hospital Setting: A Systematic Review," *Journal of Patient Centered Research and Reviews*, PubMed Central, April 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6676761.

[19]Cynthia D. Smith, et al., "Implementing Optimal Team-Based Care to Reduce Clinician Burnout," National Academy of Medicine, September 2018, https://nam.edu/implementing-optimal-team-based-care-to-reduce-clinician-burnout.

MODELS OF COLLABORATION

The collaborative care model is an evidence-based approach to integrating different healthcare services and can be implemented in many different settings. The following models can be duplicated and adjusted to meet the needs of the provider and service population. The strengths and challenges presented should be considered when making decisions about other collaborative efforts.

The following are examples of:
- hospital, home care and mental health collaboration efforts;
- OMH initiatives that begin with providers that foster interdisciplinary and inter-service system collaborations; and
- OMH supportive housing programs that use analysis and extensive knowledge of resident needs and community resources to support aging in the most integrated setting possible.

Jürgen Unützer, MD, et al., The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes,medicaid.gov, May 2013, https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-irc-collaborative-5-13.pdf.

COLLABORATION OF CARE FOR PATIENTS WITH MENTAL ILLNESS ACROSS THE HEALTH SYSTEM[23]

Summary and Goals: The purpose of this project is to move patients with mental illness seamlessly across care settings and to act as a bridge between services. Program goals are to save costs, decrease preventable readmissions and improve patient outcomes.

Responsibilities: *Hospital providers:* Responsible for moving patients where they can be treated in acute psychiatric inpatient care, coordinating a safe discharge plan and speaking with the patient prior to discharge to prepare them for what to expect in the transition.

Home care providers: Responsible for assisting in coordinating care for necessary follow-up or service continuation, including help with telehealth services and provision of certified home health agency services.

Behavioral health providers: Responsible for an initial screening, providing therapy and education, assessing medication effectiveness and compliance, assessing mood and behavior changes, and assisting with the coordination of other certified home health agency services as needed.

PROGRAM OVERVIEW

The focus of this collaboration is to facilitate interdisciplinary partnership across the care continuum to move patients with mental illness seamlessly across acute care, outpatient care and home care settings. This program acts as a bridge between services and a tool for patients and families, providing education on the nature of their illness and available treatments. Participants have thinking disorders, mood disorders and are treated with psychotropic medication regimens and group or one-on-one cognitive behavioral therapy. Assessments and supportive treatments are used, with a focus on emotions, biology and behaviors and how they impact overall health, including mind, body, spirit and mental health. Program leads worked to create an externship/internship/practicum experience; more than 100 students have enrolled. Students provide group and one-on-one therapy.

CARE IN THE OUTPATIENT ENVIRONMENT: TELEHEALTH

During the pandemic, participants with substance use disorders could not attend in-person groups. To address this gap, telehealth was used for psychiatric therapy for individuals and groups. During the pandemic, a grant was obtained from the Office of Addiction Supports and Services (OASAS) for telehealth devices and software. The grant directly increased access to behavioral health services by 30% and reduced canceled appointments.

CARE IN THE ACUTE CARE ENVIRONMENT: CENTRAL INTAKE

The behavioral health central intake services combine crisis team liaisons with inpatient services and social workers. Central intake was originally designed to streamline transferring patients to acute psychiatric inpatient facilities. Before centralized intake services, social workers placed patients wherever they could, even out of system, which led to breaks in care. The priority is to decant the EDs, increase safety and continuity of care for psychiatric patients and prevent financial loss. The inpatient service teams work closely with the outpatient facilities staff to coordinate care and facilitate a warm handoff. Staff speak with patients prior to discharge to inform them of what to expect in the outpatient environment.

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[23] Adapted from: Lawrence Ferber, et al., "Collaboration of Care for Patients with Mental Illness Across the Health System," *Statewide Hospital Home-Care Collaboration Summit*, live streaming event, April 2022, https://hca-nys.org/statewide-hospital-home-care-collaborative.

COLLABORATION OF CARE FOR PATIENTS WITH MENTAL ILLNESS ACROSS THE HEALTH SYSTEM

CARE AT HOME: THE BEHAVIORAL HEALTH PROGRAM

Patients of all ages (18+) come to this program from a variety of settings. Most patients have mood disorders, thinking disorders and are treated with psychotropic medication regimens. When a patient enters the program, they are screened with the Patient Health Questionnaire-2 to pinpoint underlying depression and other behavioral needs.

Once admitted for inpatient services, they follow a cognitive behavioral therapy framework with group and one-on-one therapy using motivational interviewing strategies. Education is provided for patients and families on the illness, treatments and services available. When stabilized psychiatrically, the patient is moved to an outpatient facility with assistance coordinating care for necessary follow-up or continuation.

The behavioral health nurse facilitates:
- assessment of medications and compliance;
- evaluation of medication effectiveness;
- assessment of mood, affect, suicidality and behavior changes;
- communication between physician, outpatient services and the patient; and
- coordination of other certified home health agency (CHHA) services as needed.

STRENGTHS

This collaboration decreased readmissions within the first 30 days post-discharge from the acute or rehabilitation setting, reduced costs associated with aggressive interventions within the community and expanded access due to telehealth/virtual services.

CHALLENGES

COVID-19 disrupted physician visits and day treatment programs. While substance use increased, there were no support groups to attend. Telehealth services expanded access, but at the same time, some individuals who lacked equipment or did not know how to use the telehealth service were unable to participate. Stigma continues to be a common barrier to finding and receiving mental health services. These factors hindered the benefits of the program:
- some primary care physicians are hesitant to order certain medications;
- large waiting lists for appointments with psychiatrists;
- lack of available outpatient resources;
- lack of home visiting psychiatrists in the patients' service areas;
- shortage of psychiatric physicians; and
- homebound counseling might not be available based on coverage.

NEXT STEPS

To address these challenges, additions in personnel, services, equipment and grants are required, including:
- addition of psychiatric nurse practitioners who are able to order psychiatric medications;
- addition of telemedicine equipment for more users; and
- apply for grants to assist patients with the cost of home care visits.

OMH LONG-TERM CARE DEMONSTRATION PILOT PROJECT[24]

Summary and Goals: The LTC DPP allows care providers to collaborate across systems and work closely together to assist transitioning individuals with serious mental illness into supportive housing. Goals are to identify and clarify needed supports, gaps or limits in services available, community-based resources and billing of long-term care services.

Responsibilities: *Hospital providers:* Responsible for a review of physical health needs, building a schedule for the first week in the community, maximizing entitlements and an initial pre-discharge assessment to determine needs.

Home care providers: Responsible for participation in discharge planning, evaluation of home care, long-term care supports, managed long-term care plan enrollments, education, provision of CHHA services and a joint onsite interview with the patient to review needs and resources once in the home.

Behavioral health providers: Responsible for provision of transition services, skill building, creating a medication management plan that includes supports for independence in self-administration of medication, acquiring durable medical equipment, a service assessment, coordinating with the PCP, and evaluation and provision of home and long-term care services and supports including personal care services as needed.

PROGRAM OVERVIEW

This is a collaborative model of shared responsibility that enables psychiatric centers, CHHAs, OMH supportive housing and care providers across service systems to work closely together. These tight collaborations between providers allow individuals living with serious mental illness and co-occurring chronic physical health conditions to successfully transition from OMH state-operated residences to OMH supportive housing and maintain tenure in independent, community-integrated settings.

PROJECT GOALS WERE TO IDENTIFY AND CLARIFY:

- the support needs of individuals living with SMI who require immediate access to skilled home health services and are transitioning to OMH supportive housing, an independent setting that is fully integrated with the community;
- gaps or limitations in services available, including accessibility;
- community-based resources and model enhancements needed to support successful transition and maintenance in the community; and
- billing of long-term care services through fee-for-services Medicaid and transitioning to appropriate insurance coverage to support ongoing behavioral, physical and long-term care needs.

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[24] Adapted from: Robert Myers, "Advancing Collaboration to Transform Mental Health-Health Partnerships," *Models of Transformative Collaboration Summit*. December 2022, https://www.accelevents.com/e/collabsummit.

OMH LONG-TERM CARE DEMONSTRATION PILOT PROJECT

THE RESPONSIBILITIES OF:

THE BEHAVIORAL HEALTH PROVIDERS

- Identify residents of a state-operated congregate residence or transitional living residence who were ready for discharge, needed immediate access to skilled home health services and could safely be maintained in the community with these supports.
- Schedule and participate in onsite joint interviews with the residents and the CHHA.
- Arrange for resident visits to preview supportive housing apartments available in the community.
- Identify and coordinate with a community-based primary care physician for each resident for post-discharge care, including home care oversight.
- Participate in discharge and transition care planning.
- Provide transition support services, skill building for community living, OMH supportive housing apartment, care management and reactivation of Supplemental Security Income/Social Security Disability Insurance, supplemental nutrition and assistance program, Medicaid and other benefits.
- Coordinate with the CHHA, primary care physician and community-based behavioral health service providers.

THE CHHAS

- Conduct onsite preliminary joint interview with residents and the OMH supportive housing provider.
- Assess CHHA services and develop individualized care plans for skilled home health services, including coordination with home health aide and personal care services when applicable.
- Participate in discharge and transition care planning with BH providers.
- Provide CHHA services in OMH supportive housing, including education and transition support for the management of chronic conditions such as diabetes, and independent medication management.
- Communicate with community primary care physician and behavioral healthcare providers, specifically OMH supportive housing providers.
- Evaluate home care and long-term care services and supports and manage long-term care plan enrollment options post-CHHA episode of care.
- Report on fee-for-service Medicaid billing for CHHA services delivered and needed documentation from the primary care physician to support billing.

OMH LONG-TERM CARE DEMONSTRATION PILOT PROJECT

STRENGTHS

This model, through careful selection of providers and sharing project goals, fosters close collaboration between home care and OMH supportive housing providers before and after discharge. Ongoing coordination among multi-service system providers enables the team to identify and address service system gaps and individualized care plan needs common to individuals with co-occurring physical and behavioral health conditions who are transitioning to integrated community settings.

LESSONS LEARNED:

PRE-DISCHARGE PREPARATION ACTIVITIES

- *Review physical health needs* and how to best meet them in the community, including mobility aides, accessibility of OMH supportive housing apartments and the surrounding community, options to simplify the medication regime and personal emergency response systems.
- *Review independent community functioning needs* and provide skill building on mobile phone access and operation, shopping, heating/cooking foods, and budgeting; use peers and residential staff to offer day trips and practice navigating in the community.
- *Maximize entitlements* (Medicaid, SSI, SSDI, Medicare, etc.) by reviewing the status of Medicaid and SSI/SSDI to initiate an appropriate process for the most expedient reactivation of benefits post discharge and begin Medicare application (if applicable) prior to discharge.
- *Build schedule* for the first week in the community, coordinate visits with all providers and review with individuals transitioning to an independent, community setting. Discuss connecting individuals with peers, club houses and other social supports in the community.

LESSONS LEARNED: CRITICAL ELEMENTS FOR SMOOTH TRANSITIONS

PRE-DISCHARGE	POST-DISCHARGE
An assessment or home care interview is necessary for the individual to transition home and avoid unnecessary readmission. Assessments should include: • skilled nursing and personal care needs; • social determinants of health inventory; • medication management regimen; • housing plan; • designated community providers: PCP, mental health, substance use supports, pharmacy, aging services; and • a comprehensive discharge plan, with a schedule of provider visits in the first two weeks post-discharge, shared with applicable parties.	Immediate provision of critical home care services and a comprehensive assessment in the new living environment is needed. The assessment should be supplemented with supportive mental health professionals who assist with: • scheduling visits; • communicating home care needs; • activities of daily living (ADL) and instrumental ADL supports; • skill building; • psychiatric and physical health medications; • creating a medication management plan; and • acquiring durable medical equipment.

OMH LONG-TERM CARE DEMONSTRATION PILOT PROJECT

LESSONS LEARNED:

CRITICAL ELEMENTS FOR MAINTAINING THE ABILITY TO LIVE IN THE COMMUNITY

Policy changes, regulations and reimbursement systems that facilitate:

- partnership and collaboration between mental health and home care providers, supported through reimbursable onsite assessment by interdisciplinary team prior to discharge;
- interdisciplinary and cross-system planning throughout the continuum of care, facilitated by technology, established rates for remote patient monitoring, virtual case conferences and cross-team education; and
- greater ongoing integration with social determinants of health (housing, food, basic supplies, mobile phone/internet access).

LESSONS LEARNED:

WHAT WOULD BE HELPFUL IN THE FUTURE

Organization and use of new resources and already existing systems, including:

- development of an online joint resource library to share best practices, pertinent policies and guidance on long-term care services and OMH housing programs;
- virtual live video education sessions and case reviews led by interdisciplinary panels of experts for home care and OMH housing providers;
- educational presentations and primers on home care and OMH housing; and
- new enhancements in the Psychiatric Services and Clinical Knowledge Enhancement System that allow OMH housing providers to view home care provider agencies serving residents (including residents of OMH supportive housing programs), type of services received and managed care enrollment status.

THE GERIATRIC MENTAL HEALTH SERVICE DEMONSTRATIONS[25]
ROUND 5: PARTNERSHIP TO SUPPORT AGING IN PLACE IN COMMUNITIES SEVERELY IMPACTED BY COVID-19

Summary and Goals: This project is focused on improving access service integration in underserved communities impacted by COVID-19. Goals are to support adults aging in place, increase technology use and meet their social and health needs.

Responsibilities: *Hospital providers:* When involved with care, responsible for referring and engaging in discharge coordination.

Home care providers: When involved with care, responsible for providing services to support aging in place.

Behavioral health providers: Responsible for assessing behavioral and physical health, providing or linking to services, as well as social and environmental needs, and using peer providers to increase outreach, reduce stigma and improve access to care.

PROGRAM OVERVIEW

The Geriatric Mental Health Act of 2006 was authorized under Section 7.41 in the Mental Hygiene Law and established the Interagency Geriatric Mental Health and Substance Use Disorder Planning Council co-chaired by the Commissioner of OMH, the Director of the Office for Aging (OFA), the Commissioner of the Office for Addiction Services and Supports (OASAS) and the Director of the Division of Veterans' Services (DVS).

The 2006-2007 New York state budget first approved funding for the Geriatric Service Demonstration Program, to support projects focused on community and services integration, improved treatment quality, family support, specialized populations, information clearinghouse and staff training.

The fifth round of demonstration service projects, *Partnership to Support Aging in Place in Communities Severely Impacted by COVID-19*, began in January 2022, and awarded six grants of up to $300,000 annually for the five-year cycle. Each grantee establishes a local triple partnership between OMH, OASAS and OFA providers to develop a program model that supports aging in place for older adults with mental health and/or substance use needs, aging and social determinant of health needs.

GRANT REQUIREMENTS

Formal partnerships between OMH and OASAS licensed providers, and the OFA area agency on aging to reduce service silos and support access to services.

Increase outreach to older adults not connected to the system of care through mobile and community-based services.

Intensive care coordination among partnership providers, community-based organizations, healthcare providers and home health providers to support aging in place.

Home modifications to improve safety and security, and to improve access to technology to support those aging in place.

Use peer providers to increase outreach, reduce stigma and improve access and participation in care.

PROJECT GOALS

Support adults aged 55 and older, whose independence and community tenure are at risk due to the impacts of aging on physical health, mental health or substance use needs.

Support individuals aging in place in their communities with an emphasis on reaching individuals in culturally diverse and historically underserved communities and improving access to behavioral health, substance use and aging services.

Assess their behavioral and physical health, and their environmental and social needs through a person-centered, recovery oriented and trauma-informed focus.

Increase the use of technology to expand outreach and improve access and participation in care through telehealth, virtual senior centers, electronic health monitoring and more.

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[25]Adapted from: "Aging in Place Models: Innovations in Supportive Housing," *42nd Annual ACLAIMH Conference: Resiliency-Recovery-Reinvention,* November 2021, The Sagamore, Bolton Landing, NY.

OMH SUPPORTIVE HOUSING PROVIDERS AND ACCESS TO COMMUNITY-BASED LONG-TERM CARE SERVICES AND AGING SUPPORTS

OMH supportive housing programs offer case management and skill-building services that are designed to assist residents in accessing community services and maintaining community tenure. These individuals often require ongoing access to community-based long-term care (LTC) and aging-related services. This need is ongoing but, particularly evident when individuals are establishing services after discharge from a more supervised setting, or when returning from a hospital, emergency room or short-term rehabilitation stay at a nursing home. Communication and collaboration between the medical/long-term care system and OMH supportive housing providers is critical for residents to access the services that facilitate successful aging in place.

The following section includes OMH housing providers offering programs and models made possible through:
- collaboration with physical and behavioral health community providers; and
- ongoing review of and application to funding and grant opportunities.

HEALTHY AGING - AN AGING IN PLACE NEEDS ASSESSMENT, THE JEWISH BOARD[26]

Summary and Goals: The Jewish Board serves and supports residents in agency supportive housing programs in meeting social and medical needs while aging in place. The goals are to work with residents to determine their needs and assist with connecting them with needed services.

Responsibilities: *Hospital providers:* Responsible for an initial assessment of needs prior to discharge (if applicable).

Home care providers: Responsible for assisting with home care and healthcare needs.

Behavioral health providers: Responsible for coordination with health home teams and other care coordinators.

Housing providers: Responsible for understanding resources and opportunities for residents and supporting collaboration with care agencies.

PROGRAM OVERVIEW

The Jewish Board's 42 Adult Residential Supportive Housing Programs serve 1,200 residents living in scatter-site apartments or congregate settings. The number of adults aging in place in supportive housing continues to increase, and the need for services and supports to maintain independence in the community continues to increase as well.

THE HEALTHY AGING PROGRAM AIMS TO:

- identify individual resident needs for adults age 60 or older who are aging in place;
- increase the number of services and supports for residents who need them;
- help residents navigate and access supports;
- motivate residents to accept supports;
- meet residents aging in place needs to maintain community tenure; and
- provide education and support for residential staff to expand their expertise on aging and related issues.

The Jewish Board received funding to pilot the Healthy Aging Project in three sites at Community Residence /Single Room Occupancy (CR/SRO) residences. All residents live with serious mental illness and receive support in maintaining linkages to medical care, behavioral health treatment, and home care services.

The Program Director, Social Worker, and residential staff work together to reach the project goals. The Social Worker will work with home care and behavioral health providers as needed to meet individual resident needs. They will also work to make connections with the residents and encourage their participation in interventions. Individuals with SMI may feel some uncertainty with inviting new people into their home, so the Social Worker aims to build a relationship with the resident to ease worries. Supportive housing staff also help to bridge the connection with any new providers entering the home to ease uncertainty.

The three elements of the organizational assessment for aging in place include the:
- internal assessment;
- environmental scan; and
- program model and training.

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[26]Adapted from: "Aging in Place Models: Innovations in Supportive Housing," *42nd Annual ACLAIMH Conference: Resiliency-Recovery-Reinvention,* November 2021, The Sagamore, Bolton Landing, NY.

HEALTHY AGING - AN AGING IN PLACE NEEDS ASSESSMENT, THE JEWISH BOARD[26]

INTERNAL ASSESSMENT AND OUTCOMES

The internal assessment determines where the greatest needs are. Outcomes include ages and age distribution within housing type, and within the individual programs. Age data need to be continuously assessed. The next step is further analysis of senior residents' chronic medical conditions and health and wellness needs through an assessment done in-home by the on-site Social Worker. The Social Worker will be on-site on a regular basis to conduct the assessment to find and fill the gaps.

BENEFITS OF DATA ANALYSIS: IDENTIFIED & NEED TO STRENGTHEN
- internal systems for gathering data to further inform aging in place model development;
- coordination with health home teams and care coordinators;
- linkages to benefits — critical to aging in place success; and
- housing teams' understanding of resources and opportunities (Medicare, MLTC, behavioral health home- and community-based services/Community Oriented Recovery and Empowerment program and Department for the Aging/social services).

FOCUS GROUPS

The focus groups provided resident and staff feedback to create the healthy aging program. Residents responded that they want to stay in their homes and the community and stay as active as possible. Staff feedback highlighted the need for staff trained with geriatric expertise and skills, and more resources. Both staff and residents believe aging residents with behavioral needs benefit from aging in place, and that supportive collaboration from the agency Real Estate Department is beneficial to program success. The Real Estate Department of the supportive housing provider coordinates and communicates with landlords of the private housing units leased for scatter-site housing programs. The focus groups identified a need for collaboration with the Real Estate Department and other facilities.

HEALTHY AGING - AN AGING IN PLACE NEEDS ASSESSMENT, THE JEWISH BOARD[26]

INTERNAL DOCUMENTS

Internal documents assessed include:
- clinical risk management;
- policy and procedure review;
- internal accommodations and environmental safety;
- apartment walkthrough using aging-in-place lens;
- building renovations; and
- scatter-site apartments floor access information (number of apartments with elevator/ first floor access).

ENVIRONMENTAL SCAN OUTCOMES

Consider partnering with the Program for All Inclusive Care for the Elderly and/or embedding an aging services program in their division of Adult Residential Division for all supportive housing provider residents.

PLANNING FOR PROGRAM MODEL AND STAFF TRAINING

Program model: Use experience in developing the Adult Residential Division-wide specialized service programs, piloting programs with the most need and training direct service staff on geriatrics, benefits and local resources to meet the current aging needs of senior residents.

LESSONS LEARNED AND NEXT STEPS

There is benefit in learning from others and becoming familiar with resources that are already available. There are a lot of resources out there, and it is beneficial to not have to reinvent the wheel and start from scratch. It is important to partner with other programs to enhance aging-related service needs, and to make connections to work together.

The staff needed for the program are in place, and they are working on building rapport and creating relationships with the residents. The Social Worker is running Healthy Aging groups to engage residents and make connections with them. The next step is to design and refine the assessment to best capture resident needs. Then, assessments will begin, and residents will be connected to needed services.

GODDARD RIVERSIDE'S CLINICAL INTEGRATION PROJECT[27]

Summary and Goals: Goddard Riverside serves and supports residents in meeting social and medical needs while aging in place. Goals are to provide safe and stable housing while creating a community among onsite and external health and mental health providers and to track and monitor services and outcomes.

Responsibilities: *Hospital providers:* Responsible for coordinating with housing sites for placement upon discharge and coordinating follow-up.

Home care providers: Responsible for an assessment of the home to determine necessary assistance and later evaluate the effectiveness of supports.

Behavioral health providers: Responsible for supporting aging in place by connecting the individual with health and mental health services, money management, medication monitoring and support groups.

Housing providers: Responsible for building supports into housing sites and seeking funding to help enhance nursing, psychiatric and care management at the sites.

GODDARD RIVERSIDE

Goddard Riverside Community Center is a community-based, not-for-profit in New York City with more than 30 programs covering early childhood, older adults, college access, homelessness and mental health. The provider serves more than 20,000 people per year with a social justice framework, focusing on investing in people and strengthening communities. Goddard Riverside has four permanent supportive housing sites in the Upper West Side of Manhattan, serving 339 tenants and one 74-bed transitional safe haven in Queens. Tenants are formerly homeless adults, many with mental illness and other comorbidities. 80% of the tenants are over the age of 55 and are aging in place.

SUPPORTIVE SERVICES

The adults aging in place require a range of supportive services. A number of services have been built into the sites to support tenants including primary care, nursing, medication monitoring, case management, mental health services, money management, recreational groups, substance use groups, meals programs and entitlement assistance. Staff identified the need to collect and assess data on tenants' vulnerability to chronic illness and overall wellness to best serve their needs and better engage with them in these areas. This is especially important for older adult populations since their needs are typically more immediate and complex. The assessments, goals and objectives of this project were self-created, but the program was designed to be replicated regardless of funding or location.

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[27]Adapted from: "Aging in Place Models: Innovations in Supportive Housing," *42nd Annual ACLAIMH Conference: Resiliency-Recovery-Reinvention,* November 2021, The Sagamore, Bolton Landing, NY.

GODDARD RIVERSIDE'S CLINICAL INTEGRATION PROJECT

PROGRAM OVERVIEW

Goddard Riverside sought funding and received grants from the Mother Cabrini Health Foundation, Fox Lane & Leslie R. Samuels Foundation, Van Ameringen Foundation and Noble Trust to enhance nursing, psychiatric and care management. The care management team consists of a case manager, registered nurse, nurse practitioner, psychotherapists, and primary care physician. The program is overseen by a specially created position that works across the four sites; the clinical manager.

A major focus was on the needs of older adults. As part of the goal to track outcomes, they identified the 75 most vulnerable tenants through an assessment (48 questions) to determine baseline wellness in mental health, physical health, hospital/emergency room use and substance use. After the most vulnerable 75 tenants were identified, a monthly assessment was created and later a re-assessment was conducted to compare to the baseline. The assessment is a necessary first step to determining resident needs and gaps in services. The case manager completes a wellness assessment, while the client also completes their own wellness assessment. The monthly assessment, completed by the case manager, covers mental health, substance use, physical health and hospital/ ER usage. Those results are used in conjunction to determine needs and interventions and identify who is linked or not linked with services.

32% of the population are active substance users. Goddard Riverside linked with the Bowman Center and harm reduction specialists to provide clients with onsite alcoholics anonymous and narcotics anonymous meetings and other supportive services. Staff at the supportive housing locations have the ability to connect residents to inpatient and outpatient services and can coordinate enrollment in long term care treatments.

ACHIEVEMENTS

- 100% of tenants age 55 and older were assessed for health and mental health needs;
- 90% of older adults have remained in their homes;
- 6% reduction in tenants without a PCP (in six months);
- created a reliable and routine way to track missed medical and psychiatric appointments; and
- developing partnerships to provide enhanced harm reduction.

GODDARD RIVERSIDE'S CLINICAL INTEGRATION PROJECT

CHALLENGES

The primary challenge faced by the project has been staff turnover both among clinical staff and program management. Three of the four residences saw turnover in program directorship including the Associate Deputy Executive Director. As a result of the COVID-19 pandemic and the incredible demands on the healthcare system, especially nursing professions, we have also experienced turnover in on-site primary care staff, which can be disruptive to residents.

CONTINUE TO ASSESS, LEARN, COLLABORATE AND EXPAND

ASSESSMENT

Assessments will continue monthly and data will be used to inform supervision with staff and identify service needs, high-risk cases and best practices.

SHARING WHAT WE HAVE LEARNED

A forthcoming white paper will be shared widely so other organizations can learn how to best assist their older adults in more dynamic ways.

EXPANSION AND COLLABORATION

Goddard Riverside will integrate this model into its expanded supportive housing portfolio that includes two new safe haven transitional residences and a fifth supportive housing residence in the Upper West Side. The Corporation of Supportive Housing is informed of this project and there is collaboration with consultants from Action Housing, who are creating a similar project. In May 2023, project staff will present at the Corporation for Supportive Housing (CSH) Supportive Housing Summit in Philadelphia in May 2023.

STAFF TRAININGS

Staff will continue to brush up on their trainings and re-train to be sure they are aware of the most important and most current practice information.

THE BRIDGE'S AGING SERVICES PROGRAM – MAGIC FRAMEWORK FOR AGING IN PLACE[28]

Summary and Goals: The Aging Services program is a practice-based approach that uses engagement, assessment, and monitoring protocols to connect older adults living in supportive housing with appropriate community-based services to ensure older adults with mental illness can age successfully within supportive housing.

Responsibilities: *Hospital providers:* Responsible for hospital discharge plans, making appropriate community-based referrals, and other assessments as needed

Home care providers: Responsible for assessing the individual and enrolling them in appropriate home care services.

Behavioral health providers: Responsible for making appropriate referrals to medical providers, socialization programs, and assisting with benefits and entitlements as needed, in addition to providing in-home counseling and nursing care.

Housing providers: Responsible for providing housing and a range of contacts and services appropriate for residents.

THE BRIDGE

OMH supportive housing programs focus on the needs of unhoused and housing insecure single adults (55+) who are diagnosed with behavioral health disabilities. The goal is to provide comprehensive assistance to ensure the ability to age successfully within supportive housing. The Bridge's mission is to change lives by offering help, hope and opportunity to the most vulnerable in our community, by offering a comprehensive range of evidence-based rehabilitative services, including mental health, substance use treatment, housing, vocational training and job placement, healthcare, education, and creative arts therapies. The Bridge serves more than 4,000 New Yorkers each year in the Bronx, Brooklyn, and Manhattan through more than 40 programs that are uniquely designed to meet individual needs.

Within the residential department, about half of The Bridge's 1,400 units are occupied by older adults. The Aging Services team was created to identify older adults and to address gaps in the mental health system by offering individualized care to older adults with behavioral health and physical health conditions living in supportive housing.

THE BRIDGE'S AGING SERVICES PROGRAM

PROGRAM OVERVIEW

The Aging Services model is a comprehensive, practice-based approach that uses enhanced engagement, assessment and monitoring protocols to promote well-being while minimizing costs. The program identifies older adults and connects them to community resources, while also providing in-home support. The team includes two nurses, an assistant director who is also a benefits and entitlements specialist, occupational therapist, peer specialist, and social work interns, and is led by a licensed clinical social worker. The multidisciplinary Aging Services team fills gaps in needed services so individuals can continue to age within OMH supportive housing program.

The goal is for older adults to maintain community tenure by increasing independence and self-sufficiency in the community while improving their quality of life. The Aging Services team visits can supplement hospital visits, case manager assistance, and the team assists clients in keeping their appointments, following up with medical recommendations, and receiving in home support. This is a roll-on, roll-off model, where participants and staff can step in and out as needed The Aging Services team uses the patient health questionnaire (PHQ-9) and the Modified Simple Screening Instrument for Substance Abuse (MSSI-SA) to assess for depression and substance use, in addition to specific assessments to address any needs and barriers to aging in place.

PROGRAM GOALS

- To age with dignity.
- To maintain community tenure
- to reduce unnecessary hospital admissions.
- To improve connections in the community.
- To meet physical health and behavioral health needs.

STRENGTHS

It has been beneficial to align the needs of the population with the program goals. Many problems and needs exist but narrowing it down to focus on a few using the MAGIC framework helps to streamline services. Involving social work interns in the Aging Services program helps to develop the workforce through this opportunity to get hands-on experience. The students assist with home visits and meeting the behavioral health needs of clients and shows them there are different options available to them in their chosen field.

CHALLENGES

General residential staff provide a range of contacts and services, although many of them are not trained in older adult services and are often not aware of available programs or how to best advocate for older adults. The Aging Services team fills this need. Gaps in data and reporting create challenges, and the Aging Services team is working to address these gaps by using multiple assessments and sources for data. The program is not sustainable without the proper staffing and funding. Insurance issues, referral issues, and stigma all pose a barrier for meeting client needs.

LESSONS LEARNED

It is important to differentiate goals, needs, and responsibilities. Identifying which staff are responsible for which piece of the intervention plan helps with collaboration and meeting each client's needs. Creating systems to identify and fill gaps assists with streamlining the provision of services. Focusing on a few metrics and narrowing it down to manageable and reachable goals help meet needs while keeping delivery simple.

THE BRIDGE'S AGING SERVICES PROGRAM

MAGIC FRAMEWORK: FIVE IDENTIFIED BARRIERS TO AGING IN PLACE

The MAGIC framework helps to identify and categorize client needs into categories to help determine necessary interventions. The MAGIC framework can help pinpoint needs and is a starting place for intervention. To be a part of the Aging Services program, the Bridge tenant needs to be 55 years old or older and meet one or more of the MAGIC criteria outlined below.

NEED/IDENTIFIED BARRIER	INTERVENTION
Medical needs not being met: two or more medical hospitalizations in the past 12 months, terminal illness and any impending discharge. Identification of needs done by nurse.	Conduct nursing assessment and facilitate access to community-based outpatient services, provide psychoeducation around diagnoses and medications, short-term wound care, etc.
ADL/IADL: Significant change in functionality in ADL and IADL. Identification in changes done by case manager.	Ensure clients are referred to home care and/or receive an increase in hours. Assist with any relevant benefit and entitlement issues necessary for enrollment.
Gait disturbance: Two or more falls in the last 12 months. Identified by occupational therapist.	Occupational therapists use screening, assessment, prevention and intervention strategies.
Increased isolation: marked change in interactions with natural supports and increased time spent in residence. Identified by the social worker.	In-home counseling and referral to socialization and outpatient mental health programs.
Cognitive Impairment: (Possible) significant decreases in recall, concentration and decision-making. Identified by the case manager or social worker.	The Montreal Cognitive Assessment is used as a baseline evaluation tool to assess cognitive function. Referrals to specialty medical providers as needed.

Once referred to the Aging Services program, staff perform one or more of the relevant standardized and evidenced-based MAGIC assessments. Depending on the outcome of the assessments, clients are either enrolled into the program or referred to a more appropriate intervention. Enrollees receive a personalized care plan that integrates both physical and mental health support around each client's individualized goals.

PROGRAM UPDATES

Currently the program is using data collected to enrich the work and expand initiatives. For the past 4 years, 100% of tenants ages 50 and older have completed The Bridge's annual Older Adult Needs Assessment (OANA). Data collected is used for both program development and sustainability purposes.

The aging services team leads an annual advance directive training for residential staff to be able to assist their clients. The Aging Services team has partnered with Professor Karen Fortuna at Dartmouth to improve data collection and better serve older adults diagnosed with SMI.

AVENUES FOR COLLABORATION

HOSPITAL – HOME CARE – PHYSICIAN COLLABORATION PROGRAM

Public Health Law Section 2805-x, New York's Hospital-Home Care-Physician Collaboration Law, was enacted as part of Chapter 57 of the Laws of 2015 to facilitate innovation in hospital, home care agency and physician collaboration to meet community needs. It provides a framework of initiatives to improve patient care access and management, patient health outcomes, cost-effectiveness in the use of healthcare services and community population health.

INITIATIVES CAN INCLUDE:

1. **HOSPITAL-HOME CARE-PHYSICIAN INTEGRATION** effectively transitions patients to post-acute care at home, coordinates follow-up care, addresses issues to avoid readmission, creates clinical pathways for specified conditions, guides progress and outcome goals, applies telehealth/telemedicine services, facilitates physician house calls to homebound patients and uses models for prevention avoidable hospital readmissions and emergency room visits. This integration also includes health home development, new models for collaborative care and care management and bundled payment demonstrations for the hospital to post-acute care for specialized conditions

2. **RECRUITMENT, TRAINING AND RETENTION OF STAFF IN HIGH-NEED AREAS,** including outreach and public education about the need and value of health occupations, salary and benefit enhancement, career ladder development, training, continuing education and cross-training to maximize staff flexibility. This includes training hospital nurses in home care, dual certified nurse aide/home health aide certification and dual personal care aide/ home health aide certification. Home care staff and the long-term care provider community also need access to interdisciplinary, expert-led training to enhance care of individuals with co-occurring physical and mental/behavioral health needs.

3. **HOSPITAL-HOME CARE-PHYSICIAN COLLABORATIVES** for the care and management of special needs, high-risk and high-cost patients, including best practices and training and education of direct care practitioners and service employees

AVENUES FOR COLLABORATION

TELEHEALTH

Telehealth is a powerful tool to support cross-sector collaboration and has the potential to fill a significant care need. Across the state, many people are unable to receive the mental healthcare they need due to mental health provider shortages in the area, the inability to travel or a lack of culturally appropriate practitioners. Telehealth is transforming the healthcare system by decreasing barriers and increasing access to services. Telehealth is an easy and effective way to receive needed mental health services on the computer, cellphone or tablet.

Telehealth is being used more widely as a result of the COVID-19 pandemic for both physical and mental health needs. Through the pandemic, telehealth allowed more individuals to attend virtual groups and one-on-one therapy appointments. Although in-person office visits are sometimes necessary, telehealth offers solutions to many healthcare problems and needs. Online therapy, counseling and medication management can all be successfully completed via virtual telehealth visits. Telehealth includes digital innovations such as patient portals, wearable technology, remote monitoring and mobile applications.

TYPES OF TELEHEALTH

LIVE VIDEO-SYNCHRONOUS

A substitute for in-person visits for consultative, diagnostic or treatment services. It provides a real-time, two-way interaction between the patient and healthcare delivery team.

REMOTE PATIENT MONITORING-ASYNCHRONOUS

Electronic collection of both personal health and medical data from the patient to provider to use for care and patient support. This service allows the provider to track a patient's data for later review.

MOBILE HEALTH

Mobile communications via phones, tablets or computers for patient engagement, education and public health programs to promote healthy behavior.

ADVOCACY

Hospital, home care and behavioral healthcare associations can advocate on behalf of their members to promote, develop and expand collaborative efforts. Providers can advocate within their agency to promote and increase opportunities for collaboration.

POTENTIAL OPPORTUNITIES INCLUDE:

- Approach the governor's office and legislature for budget support.
- Leverage the benefit of mental health and home health collaboration in state and federal reform models, including value-based payment, accountable care and advanced primary care.
- Propose policy and budget initiatives that lead to better management and care and invest in such funding to achieve better outcomes and lower costs.
- Hospitals and the state and regional healthcare associations should work with DOH, OMH, OASAS and other stakeholders to support the hospital-to-community discharge planning process, aligned to the needs and optimum care potential of the population.
- The associations, OMH, OASAS and DOH should collaborate to promote and encourage provider level engagement and partnership.

HOW TO COLLABORATE [29,30]

Step 1: Identify the goal and vision

- Identify the goal.
- Map the vision.
- Identify individual strengths.
- Identify personnel and knowledge gaps.
- Review past collaborative efforts and models; reflect on lessons learned.
- Identify immediate barriers.
- Set realistic priorities.

Step 2: Stakeholder mapping and plan development

- Select engagement strategies and mechanisms.
- Identify needed stakeholders.
- Establish clear, realistic expectations.
- Clarify goals.
- Review team roles.
- Develop a plan.
- Consider available or needed resources.
- Consider a timeline.

Step 3: Preparation and Logistics

- Focus on long-term goals.
- Determine logistics.
- Use collaboration tools to strengthen engagement strategies and assist in information sharing.
- Become familiar with team member roles and capacities.
- Describe how to overcome barriers.
- Layout a timeline and responsibilities.

Step 4: Engagement and Review

- Ensure equitable stakeholder contribution.
- Mitigate any tension.
- Encourage open-mindedness and innovation.
- Build consensus.
- Review the engagement process and pinpoint the most effective approach.
- Review task delegation.

Step 5: Action Plan

- Identify opportunities for feedback.
- Revisit goals.
- Plan for follow-up activities.
- Determine if the group is on the right track to meeting goals.
- Reflect on group participation and chosen engagement strategies.
- Adjust as needed.

[29]Adapted from: Alison Taylor, et al., "Five-Step Approach to Stakeholder Engagement," BSR, April 2019, https://www.bsr.org/en/our-insights/report-view/stakeholder-engagement-five-step-approach-toolkit.
[30]Adapted from: Sandeep Kashyap, "8 Steps to Collaboration to Work in a Collaborative Environment," Proofhub, https://www.proofhub.com/articles/collaborative-working-environment.

COLLABORATION CHALLENGES [29,30]

LACK OF TRUST

Mistrust can result in miscommunication or conflict, potentially affecting the success of the project. Discuss any conflicts or concerns to create a trusting environment.

COMMUNICATION GAPS

If team members don't feel like they can communicate openly, they are less likely to be involved, affecting the success of the project. Create opportunities for open discussion where all members feel comfortable expressing their thoughts and opinions.

LIMITATIONS & LACK OF COMMITMENT

Partners might be engaged at first, and then begin to pull back involvement, or commitment might be uncertain from the start. Set out clear expectations early on and be open about organizational or individual limits. Schedule check-ins to revisit expectations and limitations.

ORGANIZATIONAL SILOS

Organizational silos make information sharing difficult and can obstruct communication. Create a standard operating procedure defining what protocols to follow.

FINANCIAL & REGULATORY CONSTRAINTS

Financial resources and regulatory constraints can limit collaboration. Ensure the group understands the parameters of the constraints. If necessary, members can try to introduce policy or regulatory changes to assist in achieving the group's goals. Seek financial support if possible.

MAINTENANCE

Maintenance of data tracking, information collecting, training, and invoicing can be difficult. Identify point people to be responsible and set regular deadlines.

ESSENTIAL COMPONENTS OF COLLABORATION [29,30]

Accept that members will show different levels of engagement and progress, and some will need more support. Reorganize, re-strategize, and plan accordingly. Be open and flexible and find a balance in structure with reporting requirements and timelines. Avoid "that's not how we do it here" attitudes because when demands become too restrictive and dictatorial, it can remove individual freedom and diminish the quality of the collaboration.

STAFF AND TEAM ENGAGEMENT

To avoid miscommunications and future conflict, lay out roles, responsibilities, engagement, and communication expectations at the start. Use open communication to resolve conflict. Priorities among partners might change, and communication during this time is a must to avoid delays and duplication. Use shared workspaces to make communication easier.

COMMUNICATION

Keeping it simple can improve chances of success. Ensure topics and goals of the collaboration are focused and be realistic about what can be achieved. If the goal is unreachable and progress cannot be seen, the team can lose motivation.

SIMPLICITY

Collaborating takes time and effort to build working relationships. Some might be unable to dedicate time to improving these relationships. Getting organized into a shared workspace to seamlessly share data, resources, and support will help with this transition and time constraints.

TIME & ORGANIZATION, SHARED WORKSPACES

NEXT STEPS

The collaboration models outlined in this primer provide a foundation for accelerated, collaborative work and next steps. The models affirm that home care, hospital and mental health collaboration can be multilevel and multifaceted. Solutions must address the wide array of factors impacting a patient's ability to access mental health services in the home and community setting in the immediate, near and long-term future. All stakeholders must work together toward this goal.

Among the immediate next steps, HCA E&R, HANYS and IHA produced this primer of outstanding models and takeaways to share widely across the health continuum, the educational system, business community, with local, state and national leaders and the public. This primer provides an important catalyst for all stakeholders to begin or continue collaboration efforts. HCA, HANYS, IHA and OMH continue to partner to expand the current and future abilities, practices, benefits and opportunities for collaboration of mental health and home health services.

Ultimately, the commitment to adequate funding of mental healthcare; investment in the current and future mental healthcare efforts, including worker education and training; investment in and mobilization of the consumer as the key partner in healthcare; and innovations in technology, patterns of delivery and regulation, must all be essential parts of the solution to society's mental health needs.

The contributions of the models, participants and especially the support of the Mother Cabrini Health Foundation under the *Statewide Hospital-Home Care Collaborative*, is gratefully appreciated.

For more information on these models, contact Taylor Perre, tperre@hcanys.org.

LEARN MORE

OMH CONSUMER GROUPS

The Office of Advocacy and Peer Support Services (OAPSS): https://omh.ny.gov/omhweb/consumer_affairs

Consumers and Families: https://omh.ny.gov/omhweb/bootstrap/consumers-families.html

Geriatric Mental Health: https://omh.ny.gov/omhweb/geriatric

OMH PUBLICATIONS AND RESOURCES

Find a Mental Health Program: https://my.omh.ny.gov/bi/pd/saw.dll?PortalPages

The Office of Advocacy and Peer Support Services (OAPSS) Resources:
https://omh.ny.gov/omhweb/consumer_affairs/resources/advocacy.html

Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES):
https://omh.ny.gov/omhweb/psyckes_medicaid

OMH Publications (ny.gov)
General Mental Health Information and Resources: https://omh.ny.gov/omhweb/resources/publications

HCA COLLABORATION RESOURCES

Hospital-Home Care Collaboration:
https://hca-nys.org/statewide-hospital-home-care-collaborative

988 Suicide and Crisis Lifeline- Information, Data, and Toolkit
988 Suicide & Crisis Lifeline | SAMHSA

OMH/ HCA/ Finger Lakes Geriatric Education Center at the University of Rochester Mental Health Education 3-Part Series
An Introduction to Mental Health and Accessing Services, Understanding Health and Mental Health, & Improving Communication and Addressing Crisis
Home Care Association 2022-2023 Training Videos & Didactic Materials | Powered by Box

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