New York State Geriatric Mental Health Needs – On May 20, 2009, in response to a legislative charge by the NYS legislature, the Center for Practice Innovations assembled topic-area experts to participate in a planning day to study, evaluate and report on the service needs of older adults with serious mental illness. Representatives from each of 10 demonstration sites described some of the work currently underway at their sites. The purpose of the meeting was to identify policy recommendations in collaboration with the experts and demonstration sites to take back to the geriatric council and then send to the legislature. Recommendations included having sites document what interventions have been implemented (as opposed to planned), provide information about the number of clients participating in these interventions, and providing information to OMH to document the interventions and provide a repository of resources from and for the demonstration sites. Invited experts included: Stephen J. Bartels, MD, Martha Bruce, MD, PhD, Fred Blow, PhD, Michael Friedman, LMSW, Devangere Devanand, MD, Yeates Conwell, MD, Barnett Meyers, MD, Kim Williams, LMSW. To see a summary of the meeting, please see below.
Geriatric Mental Health Planning Day  
Meeting Summary  
New York State Psychiatric Institute  
New York, NY  
May 20, 2009  
Draft of 10/7/09

Attendees

OMH:
Robert Myers, Ph.D.
Don Zalucki
Steve Huz, Ph.D.
Jeff Gleba, M.S., C.R.C.
Laura Grillo
James Spencer, M.D.

New York State Psychiatry Institute: New York, NY  
May 20, 2009

Columbia University:  
Devangere Devanand, M.D.
Susan M. Essock, Ph.D.

Columbia University:  
Stephen J. Bartels, M.D.

Cornell University:  
Martha Bruce M.D., Ph.D.
Barnett Meyers M.D.

University of Rochester Medical Center:  
Ben Chapman, Ph.D.
Deborah King, Ph.D.

University of Rochester:  
Yeates Conwell, M.D.

Flushing Hospital Medical Center:  
Ira Frankel, Ph.D.

Mental Health Association of New York City:  
Michael Friedman, L.M.S.W.
Kim Williams, L.M.S.W.

Grantee Agencies:
Weill Cornell  
NY Presbyterian Hospital  
Ron Adelman, M.D.
Risa Breckman, L.C.S.W.

Village Care:  
Charles Anflick, L.M.S.W.

University of Rochester Medical Center:  
Marilyn Lam, M.F.T.

Greene County Mental Health Center:  
Peter Konrad, L.C.S.W.
Sue Rosenberg, L.C.S.W.

St. Vincent’s Hospital:  
Marge Leffler, L.C.S.W.
Pam McGurgan-Marinelli, L.M.H.C.

Metropolitan Hospital Center:  
Richard Siegel, L.C.S.W.

Relevance to New York State Office of Mental Health (OMH)

Robert Myers, Ph.D., stated that the objective of this session is to construct long-term plans and make policy recommendations for geriatric mental health in New York State. The mental health system in the state is very large—a $5.5 billion system—and 7 percent of the people OMH serves are over 65. However, very few programs focus on the elderly population, and the state must change this focus.
The Geriatric Mental Health Act, passed in 2006, included a provision for a planning council, which has helped provide stimulating ideas for demonstration projects as well as a long-term plan. Nine demonstration projects were funded, and another in Greene County decided to participate without funding.

Dr. Myers began the day by describing the primary goal for the day: That participants, the invited experts, and staff representing the Geriatric mental health demonstration projects identify policy recommendations for the Interagency Geriatric Planning Council and, ultimately, the New York State legislature.

**Experiences at Demonstration Sites**

Stephen Bartels facilitated a discussion of experiences at the demonstration sites. Speakers from the sites made the following observations:

- Problems of culture arise—both medical and mental health culture, Office of Aging culture, culture of the home, and culture of caregivers.
- Programs should create settings that focus on the whole person.
- Programs should integrate innovative screening.
- Pragmatic, brief screens seem to make the most sense.
- A systems redesign should incorporate daily screening into the system in a way that is seamless and without question.
- Finally, providers need to offer a service; participants discussed a number of products, including direct case management, problem-solving therapy, and similar interventions.

**Future Considerations**

Some of the points made at this meeting can guide the OMH in certain directions:

- Providers should share data with each other to improve quality of care and foster innovation. OMH has developed a quantitative data system and asked the demonstration programs to submit data.
- Some genuine research needs exist, and filling research gaps should be part of the recommendation to Interagency Geriatric Planning Council and the legislature.
- Older patients are complex. Focusing only on depression loses context and misses pieces that are not assessed for. Emerging research on bundling interventions focuses on a number of different problem areas; bundling interventions shows promise by addressing more than one issue simultaneously.
- OMH should create a repository for resources with information about promising practices from the demonstration sites. Examples would be how to start and implement a gatekeeper program and specific screening and assessment tools. This would allow other counties or areas outside of the demonstration projects to start their own programs.
In the long-term, behavioral health must be more integrated into physical health. Ideally, clinicians treating physical or mental problems in the future will have easy access to the other component.

Dr. Myers noted that programs should plan how to generate revenue once the grant dollars are used up.

The invited experts made the following policy recommendations:
1. OMH needs to understand how the interventions were actually implemented.
2. OMH staff should reach out to sites to ensure that they are quantifying their work in ways that will allow OMH to document what interventions were used, how many individuals were screened, results of screening, percentage of those who screened positive who entered services, etc.
3. OMH should develop a repository with:
   - Implementation recommendations
   - Screening, assessment, and follow-up tools
   - An outline of how to integrate a physical health care setting or create a gatekeeper program
4. A protocol related to stepped care should provide simultaneous best practices and cost-effectiveness.
5. Directives should create linkages across different systems of care; e.g., physical health, mental health, chemical dependency, etc.
6. Another directive could create a statewide integrative system, with recommendations on how to accomplish this and key players who should be at the table. The directive can highlight the cost-effectiveness of such a system and show how Greene County has made a countywide system work without any funding.
7. Identify what it takes to sustain a program and how this could be aided by the revision of Medicare or Medicaid rules (i.e., a no-cost solution).
8. Develop better screening tools for alcohol use among older adults screened in the demonstration projects.

Next Steps for OMH
1. OMH staff will contact sites to ensure that they are quantifying their work to date in ways that will allow OMH to know what the interventions were, how many individuals were screened, results of screening, percentage of those who screened positive who entered services, etc.
2. Continue the conversation surrounding the long-term plan and sustainability of demonstration projects with other agencies and discuss the best way to integrate mental health care of older adults and all ages into the Department of Health, Office for the Aging, and Office of Alcoholism and Substance Abuse Services.