Empire State Integrates To Face the

The proportion of people who are age 65 and older will double from 7 to 14 percent of the world's total population by 2040, according to a U.S. Census Bureau study. The over-65 population worldwide will grow to 1.3 billion. Global aging is changing the social and economic nature of the planet and presenting difficult challenges. The fact that, by 2020, for the first time in human history, there will be more people aged 65 and older than children under five in the world underlines the extent of this change.

Ten years ago, New York State realized that, like much of the country and the world, it had a geriatric problem. The number of older adults was expected to increase 50 percent by the year 2030, and, correspondingly, the number of older adults with mental illness was anticipated to grow from 480,000 to 740,000. Recognizing that the state was going to be hit with this elder boom — and that behavioral health and primary care providers would need to adjust their practices accordingly — in 2005 New York passed the Geriatric Mental Health Act, which established the authority and funding for demonstration programs that would integrate physical and behavioral health care for older adults.

Since that time, over three dozen programs have received seed funding to provide integrated health services for older adults. New York has not prescribed a single model for delivery of care. The state has supported bidirectional integration — both behavioral health clinicians in primary care offices and physical health-focused practitioners in behavioral health settings. Specifically, the demonstration programs are testing out varied implementation models, including:

- Taking advantage of the full scope of practice of a psychiatric nurse practitioner in a mental health clinic to do an initial psychiatric and physical assessment at intake (as seen at Service Program for Older People).
- Engaging an licensed clinical social worker to work with primary care providers to screen and assess for behavioral health disorders, and then provide onsite triage, comprehensive assessments, and treatment as needed (as at Bassett Medical Center's Cobleskill Health Center).
- Using peers as wellness coaches to work with clients on developing and carrying out personal wellness plans and to facilitate connections to different health services (as with Clubhouse of Suffolk).

The National Council for Behavioral Health has been front and center in working with the demonstration programs for the past two years. The New York State's Office of Mental Health engaged us to run the Geriatric Technical Assistance Center and help grantees develop an integration model for their organizations that works for their target population. Through individual and group coaching, in-person learning community meetings, monitoring of clinical and process measures, and resource development, our charge as the Geriatric Technical Assistance Center is to help organizations to create a program that is sustainable and will continue beyond their grant period.

LESSONS LEARNED

In many respects, the lessons learned while developing integrated care models for an older adult population are the same as with any integrated health practice:

- It takes individual and collective leadership across the organization.

Elder Boom

Geriatric Mental Health Act integrated care demonstration program participants share success stories

Services Program for Older People (New York, New York)

"Ms. D., age 80, has been a clinic client for two years. She is overweight, depressed, and often complained to her therapist that she felt chronically tired and listless until mid-afternoon. When the Psychiatric Nurse Practitioner evaluated her, she learned that Ms. D. had not seen a medical doctor for six years – and that she had stopped taking the thyroid and blood pressure medications she had been prescribed. The nurse practitioner began to monitor her blood pressure on a weekly basis, and suspected that her fatigue was a symptom of hypothyroidism. She gently encouraged Ms. D to improve her diet, lose weight, and visit a doctor. Ms. D. is now back on her medications, has lost weight, and feels significantly better – so much so that she now feels she needs to see her therapist only twice a month, rather than every week."

Report from Bassett Medical Center (Cobleskill, New York)

"We have been looking for an initiative which would allow us to bring mental health care to our primary care sites located throughout the region. This is a way of operationalizing our vision of psychiatry as primary patient care. The opportunity to integrate with medical primary care salutes this enterprise."

Report from Clubhouse of Suffolk (Ronkonkoma, New York)

"This program gave us the opportunity to increase our use of peers. We have now elevated our use of peers and our expectations for peers and staff working in multidisciplinary teams. The program has also elevated awareness among both staff and members regarding physical health and the potential for change. Clinically we have seen improvements including lower rates of hospitalization (physical and psychiatric) for members participating in the program."

- The most successful initiatives have been those where groups took on the mantra, "Integration everywhere!" and did not consider their integration initiative to be a discrete project, segregated from the rest of their services.
- True integration is about more than clinical services alone; it requires health behavior change, and both clinicians and clients alike struggle to embrace that.
- Like politics, all healthcare is local; what service array you develop depends on your client mix, what other healthcare providers serve your community, and state and insurer regulations.
- Sustainability — fiscal and organizational — requires "not giving up."

What stands apart when developing programs that serve predominantly older adults, however, is the need for organizations to get comfortable with Medicare. Provider enrollment, covered services, regulations, and internal billing systems all need to be aligned. This has been a particular challenge for behavioral health clinics that have long relied on fee-for-service Medicaid as the primary, and often only, payer.

There are also clinical and care coordination considerations special to serving an older adult population. The concern of polypharmacy is higher among older adults; at the Service Program for Older People in New York City, "the [psychiatric nurse practitioner] works to avert drug interactions by reviewing drug protocols, dosages, and schedules. Most clients have multiple prescriptions (including psychotropic medications), and the NPP is alert to contraindications and dosage levels." Some grantees have incorporated home- and other community-based visits into their service array, in recognition that particularly frail individuals may not be able to consistently make it into the clinic. One program is in the midst of changing its primary service location to a site that is less chaotic so that it is more accessible to their elderly clients.

An early phase of these programs, all of which were primary care sites adding behavioral health capacity, showed a high rate of improvement in anxiety and depression among the older adults who were identified and received treatment. Data is just starting to come in from the current demonstration programs, and it is too early to comment on outcomes with any appreciable certainty. Anecdotally, however, sites have already begun to see an impact on indicators ranging from smoking and anxiety to obesity and hospitalization rates. There is a lot of promise in the models being tried in New York, hopefully just in time to address the elder boom.

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