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Q1 Please provide your contact information below.

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Q2 Please describe your company or organizations overall goals and mission.

The Bridge's mission is to change lives by offering help, hope, and opportunity to the most vulnerable New Yorkers. The agency has a successful 64-year track record of providing behavioral health services to adults with serious mental illness (SMI), substance use disorders (SUD), and histories of homelessness and justice involvement. The Bridge's highly-trained and skilled staff offer a comprehensive range of evidence-based services, including mental health and substance abuse treatment, vocational training and job placement, healthcare, education, Assertive Community Treatment, care coordination, and creative art therapies. All services are based on evidence-based practices, are person-centered and trauma-informed, and designed to support clients' recovery and independent living and recovery goals.

The Bridge's program offerings for clients with complex needs extend beyond its clinical practices. In response to the growing need for permanent housing solutions for adults with special needs in NYC, The Bridge began developing housing in 1979 and has created a continuum of housing including licensed supervised residences, licensed apartment treatment, and unlicensed permanent supportive housing in single site and scattered site apartments. The Bridge is known for its housing innovation - we provide housing with services for over 1,250 men and women with SMI, chronic health conditions, and/or SUD (50% of whom are formerly homeless). We operate 25 single-site buildings and over 500 scatter-site apartments in Manhattan, the Bronx, and Brooklyn offering 24/7 staff supervision, on-site case management, activities of daily living skills training, recreation and socialization opportunities, and crisis intervention. Our service model provides the supports necessary to help individuals become and remain stably housed in the community of their choice.

Q3 Please indicate which category your organization falls under.

Community Based Organization

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants

of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility, evidence based support for innovation, relevance to the Medicaid population and speed to market).

The Bridge's innovative program targeting its older adult population - AGES (Assessing, Guiding and Empowering Seniors) – is designed to meet the multilayered needs of older adults with serious behavioral health conditions and chronic medical conditions living in Bridge housing. The program uniquely pairs quality affordable housing with intensive individualized services to address the social determinants of health, and responds to the needs of its older residents by delivering culturally-sensitive specialized medical care, peer support, case management, and social work services where clients live and spend their time. A key feature of this intervention is using The Bridge's vast network of linkages to community-based organizations to support and encourage seniors' connections to all aspects of community life.

The Bridge was one of the first agencies to identify the need for integrated service delivery for older adults with special needs and has been resourceful in combining multiple competitive funding streams to fill a gap in the healthcare and supportive housing fields for this population. AGES uniquely comprises a multidisciplinary team of professionals who possess expertise in both the age-related and behavioral health care needs of older adults with complex conditions. The AGES team is comprised of a Director of Aging Services, a Registered Nurse, a Peer Specialist, a Case Manager/Benefits Coordinator, Masters' level social work interns, and a soon to-be-hired Spiritual Care Provider. The AGES team works collaboratively with The Bridge's Residential and Outpatient Clinical staff to activate existing partnerships with local service providers and engage older tenants in mainstream senior services, health and wellness activities, and other community-based resources. The goal is to assist seniors to maintain community tenure in supportive and affordable housing, improve their economic stability, address the social determinants of health, and achieve better health outcomes.

Potential ROI

According to a 2013 HUD report entitled Measuring the Costs and Savings of Aging in Place, between 2004 and 2007, average monthly costs associated with non-institutional long term care ($928) were significantly less than average monthly costs for institutional long term care ($5,243). Non-institutional long term care is an affordable alternative to nursing homes that provides older adults with the services and resources necessary to successfully age in place. The Bridge's Peter Beitchman House serves as an important and successful nursing home diversion program, and as a model that can be widely replicated. For a small fraction of the annual cost of nursing home care ($26,000 per person at Peter Beitchman House versus $133,000 in New York State nursing homes), the program provides an independent living environment with the on-site support services needed to maintain community tenure. Despite its proven success in improving community tenure for older adults, the funding Peter Beitchman House receives is not generally available to other agencies. The Bridge has been unable to secure the funding required to create another program like Peter Beitchman House. AGES provides the same supports throughout all Bridge single and scatter site programs, thus making it possible to adequately address the needs of older adults without acquiring the enhanced funding necessary to create another program. The yearly budget for the AGES program is $322,081, which translates to $1,917 per client for 168 clients in the program. If you also factor in the housing cost of $26,000 at Peter Beitchman House, it still costs less than any other higher level of care, including adult day care ($29,000 per client), assisted living ($48,000 per client), and nursing home care ($133,000 per client) in New York State.

AGES is in the midst of an overhaul of the electronic note-taking system, AWARDS, to create customized categories in preparation for value based payments. Currently, data is being collected manually as the program was not established to use electronic health records effectively. Once the new system has been implemented, documentation will be better integrated into the electronic record. Staff will have data on services provided and specific referrals made. This information will demonstrate the quality outcomes and cost effectiveness of the program. The Bridge will establish a pilot partnership with a health insurance company that already serves Bridge clients, to form a foundation for the program to grow and serve more older adults in need. This would sustain the program while shifting the reimbursement costs from private grant funds to Medicaid managed care companies, guaranteeing the long-term sustainability of needed services to vulnerable older adults.

The Bridge is also exploring HCBS as a viable fee-for-service reimbursement avenue for a subset of the clients served by AGES. Most AGES clients have dual insurance coverage (Medicare/Medicaid), making them ineligible for HCBS. However, for younger 50+ clients, this rehabilitation and recovery offering a MCO authorized plan of care based suite of services includes billable peer support services and habilitation.

Scalability

An Older Adults Needs Assessment Form was developed and is completed annually by primary case workers for every housing client over age 50. The assessment covers:

- Insurance coverage

- Enrollment in programs
- Functional assessment (ADLs/IADLs): based off of Section F of the UAS
- Enrollment in home care
- Physical Environment
- Common issues of concern (e.g., financial issues, isolation, food security, etc.)

In 2017, The Bridge developed a fillable form to make the collected data easier to handle. We also developed an online resource guide (http://thebridgeny.org/resource-guide-aging-services) that provides a list of community-based resources for older adults. In 2018, Bridge staff gave a presentation titled "Interdisciplinary Whole Person Care for Older Adults with Complex Needs" at the 4th Annual Silberman Conference on Aging: Highlighting Resilience in Aging Communities: Stories of Challenges and Strengths and have also participated in a Supportive Housing Network of New York panel titled "Serving Aging Tenants in Supportive Housing" in order to highlight the current disparities in aging services and explain how the Bridge's Aging Services program addresses these disparities.

Feasibility

The Bridge's innovative AGES program meets two criteria of feasibility: clinical and fiscal.

Clinically, the AGES program uses widely available, evidence-based interventions delivered by a coordinated, interdisciplinary team. The skills and staffing required to replicate this model are within reach of any number of agencies if funding is structured in ways that recognize and support the synergies that can be achieved. Until this point, this has only been made possible through a uniquely leveraged combination of funding, including city discretionary grants, private foundations, DSRIP funds, and HCBS billing.

The fiscal feasibility of the integrated AGES approach to services is demonstrated by its low relative cost and the positive outcomes it has achieved related to the Triple Aim of health care reform.

Feasibility and replicability of the AGES model as implemented by The Bridge is enhanced by the continuum of services the agency provides, including Residential, Mental Health, Substance Abuse and Community Support (ACT and Care Coordination). However, this range of services can also be brought to bear by a lead agency in collaboration with community partners. Within our model this is exemplified by our partnership with Ryan Health, which provides individuals with primary care services and coordinated referral to specialty care when needed. Ryan offers these services to clients who receive their mental health and substance abuse treatment at our clinical hub via an on-site clinic ("one-stop shopping") and to others at their sites around Manhattan and by way of their mobile health van.

Through our relationship with Hunter School of Social Work we have developed a model social work training curriculum for those interested in working with this expanding cohort of older adults. We work with Hunter to bring a minimum of two student interns into the field each academic year, thus reaching more aging clients, both at The Bridge and at other agencies. Student interns under staff supervision provide 30% of AGES interventions. The AGES team has presented at Hunter's last two annual conferences on aging.

Evidence-Based Support for Innovation

AGES is an outcomes-driven, community-based service model that integrates the siloed systems of medical, psychological and substance abuse care for older adults with complex needs. The program provides housing and linkages to community-based services that adapt to the changing needs of vulnerable adults as they age, enabling them to stay in their homes as long as possible. The growing population of aging adults in Bridge housing is evidence that the integration of behavioral and physical health care services, wellness programming, case management and supportive housing that The Bridge has pioneered assists clients to live longer and maintain community tenure. The AGES program utilizes motivational interviewing, harm reduction principles, and a trauma informed approach to care. Staff attend regular trainings to stay up to date on the newest and most effective approaches to aging services.

Clients with SMI are older than their chronological age but have access to fewer resources. Studies show accelerated brain aging in older adults with SMI. Only 9% of social workers identify geriatric as their field of practice, and only 2% of current APA members practice geropsychology. Geriatric programs that do exist often provide isolated services; they only serve clients who are over 65; the services are not whole-person centered; and they may exclude clients with SMI. Older adults who live alone, are low-income, and/or have a mobility, psychological, or cognitive impairment are at an increased risk for social isolation. Consequently, isolation negatively affects physical and mental health, and contributes to risk of dementia.

Data and client feedback suggest the AGES program has improved the lives of Bridge seniors in many key areas. According to data from the Older Adult Needs Assessments from 2015, 2016, and 2017, clients report improved chronic illness management, reduced isolation and food insecurity, improved prescription drug access, and reductions in drug and alcohol use. Bridge clients ages 50-59 experienced a reduction in hospitalizations from 2015 (244 hospitalizations) to 2017 (132 hospitalizations). Bridge clients ages 60+ also

experienced a reduction in hospitalizations – 175 in 2015 to 88 in 2017. In addition, from 2015 to 2017, there was a 10% increase in older clients (60+) experiencing no hospitalizations during the year (76% to 86%). Bridge staff are beginning to examine how fall prevention measures and education are impacting the frequency and severity of client falls.

Relevance to the Medicaid Population

Almost all of our clients are on Medicaid; The Bridge uniquely serves adults 50 and over. According to the U.S. Census, by 2030 there will be 772,000 adults with SMI living in New York State; by 2050 20% of the population will be ages 65+. The needs of these particularly vulnerable individuals often fall on a continuum between nursing home care, assisted living, and supportive housing. One of our most successful residential programs, Peter Beitchman House, is highly responsive to the indication that older adults with mental illness have rates of serious medical co-morbidities two to three times that of the general population, and life expectancy 20-25 years less than the general population; for people with major mental illness, the average life expectancy is 53. In order to address the complex needs of our growing cohort of older clients, while at the same time staying in tune with rapidly changing payment methodologies, we established a suite of services that achieve the Triple Aim for older adults: improve outcomes, improve experience of care for the individual, and reduce costs.

End of Life care planning helps staff to provide guidance for outside providers based on our clients' wishes, improve quality of life for aging residents while keeping unnecessary medical costs down, and ensure that appropriate care is provided to our clients at the end of life. Many of our clients do not have involved family members. Therefore, staff gently assist clients with completing health care proxies and living wills. The AGES team follows clients throughout the course of treatment, providing referrals to hospice, coordinating care, and advocating for client-centered treatment. When a client passes away, the AGES team provides counseling for affected clients and staff. The recent grant for a spiritual care provider, as part of the interdisciplinary team, will grow these vital services.

Speed to market

As we are already providing this integrated suite of services with demonstrated effectiveness they can be quickly brought to market if payment systems are arranged in a way that supports them. This means payment that rewards outcomes rather than one based on fee-for-service methodologies that pay based on time and volume.

We are in the process of preparing for changes in health care and payment structures and working to establish the model, with the hope that others will replicate the program.

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.

Yes (please specify when and the estimated number of people impacted):
Recognizing the importance of stable housing to the seniors we serve, we created the AGES program to connect older adults residing in Bridge housing (both scatter site apartments and single site buildings) with other key services that support their recovery and ability to live independently in the community of their choice. Since its inception in 2014, The Bridge has served well over 250 senior clients in the AGES program (enrollment in the program is based on a prioritized list of the most vulnerable clients). The services provided to these clients range widely from support during and after hospitalization, to advocating for benefits and assisting with applications for the Medicare Savings Program and supplemental needs trusts. The program works to reduce costly preventable hospitalizations and Emergency Room visits and increase the number of tenants attending senior centers and community services. It also provides health education and training for clients and staff, reduces preventable placements in higher levels of care through environmental modifications (grab bars and other improvements) and facilitates links to home care resources. These include: referrals to primary care and behavioral health services, home health aides, meal delivery services, transportation, community-based senior centers, legal services, and benefits counseling. The intended outcomes of AGES are to increase seniors' opportunities for: achieving housing stability in a safe, nonjudgmental, supportive environment; achieving stable recovery from psychiatric conditions and co-occurring substance use disorders, where applicable; improving life functioning and stability in terms of chronic medical conditions; and achieving greater economic stability and self-sufficiency. The Team performs comprehensive assessments on all Bridge residents ages 50+ to determine how to best address their community support and healthcare needs. This population often has limited access to quality affordable healthcare and health resources. In addition, long histories of institutionalization or homelessness often lead to periods of interrupted care, especially routine medical care. This approach assists seniors to stay in their homes longer and avoid costly, unnecessary hospital and institutional care. AGES also improves quality of life for these seniors by helping them stay connected to their treatment providers and the community, decrease time spent away from home in medical settings, increase social connectedness and understanding of the aging process, preserve the highest level of autonomy possible, and identify opportunities for personal growth and wellness. Most importantly, the program aims to minimize health disparities related to social and economic factors impacting older adults with serious mental illness.

Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Health and Health Care** , **Economic Stability**
Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.	**I consent to have my innovation shared**