10. Mobile Triage – The purpose of this service is to serve high risk seniors in the 55 years and above age range that are at risk of progressing to higher levels of care and who may require emergency services.

    - Nurse practitioner (0.5 FTE) $48,000
    - Case manager (1 FTE) $60,000
    - Peer specialist (1FTE)$49,000
    - Psychiatry time (4 hours/week) $18,928
    - Total Personnel $175,928
    - Total Operating $21,111
    - Total Budget $197,039'

    This plan would provide for 100 individual consumers, 25% may be Medicaid and generate fees up to $97,950. The revised total budget would be $99,089.

11. Specialized Case Management Services - Seniors in treatment for Axis I disorders have a multiplicity of co-morbid medical issues as well as difficulties with housing, food, prescription medications and other barriers to optimal functioning. A complete and thorough continuum should include care management services. Informed decision making by the senior regarding these issues results in an ability to have a prolonged "aging in place". This service to seniors and their caretakers also reduces the need for utilization of more acute services as a preventative approach to these issues results in earlier interventions and earlier appropriate provision of a treatment protocol. Provision of this service would require 9 case managers at an estimated $60,000 per person. Total personnel costs for these services would be $540,000. As Medicare does not reimburse for case management services no revenue could be generated from these services. Fees are not included and may lower this cost. This provides one case manager per CSB to develop a senior service.

12. Education/Support - The focus of this service is work-force development. As we design and implement our Geriatric Center of Excellence it would be our plan to be a center of academic research seeking advancement in the treatment of seniors for Axis I disorders. We will develop and maintain relationships with colleges and universities in the region for training of interns and research into issues regarding the health of this ever growing segment of our population. These efforts hopefully will assist geriatric mental health providers across the region and indeed in the state in improving our delivery of services. In our first year we would retain a Licensed Clinician to provide supervision and direction to the interns providing clinical services to our patients and those involved in research and educational presentations. The costs for such an effort would be $160,000 and includes:

    - Licensed Clinician (1 FTE)
    - Educational Conference/Symposium
    - Specialty Mental Health training for CNAs - Joint venture with an academic institution

Department of Mental Health, Mental Retardation and Substance Abuse Services support to HPR Region V would provide financial assistance to create a comprehensive continuum of care for senior citizens across the Region. This continuum of care includes services from the least restrictive to residential care. The continuum is designed to meet the patient's needs to allow aging in place and reduce the need for institutional care at the Hancock Center and other residential settings. We are appreciative of this opportunity to present this comprehensive plan, and are ready to provide additional data at the appropriate time.

Services Menu - Summary[6]

System of Care – Eliminating Gaps				
Adjuncts and Supports	**Outpatient**	**Day Support**	**Long-term Care Facilities**	**Inpatient**
Training *(included in mobile assessment team)*	IOP • *Cost $475,285* • *Fees $347,760* • *Total ($127,525)* • *Service units – 5,040*	PSR • *Cost $113,396 for 15 persons* • *Service units – 2 units per day; up to 15 individuals per day*	Nursing Homes • *Cost $4,500 per person per month* • *Fees – SSI, Medicaid/Medicare* • *Total $540,000* • *Service units – 10 beds; 3,650 bed days*	HGTC
Education *Cost $160,000*	Partial Hospitalization • *Cost $728,566* • *Fees $393,120* • *Total ($335,446)* • *Service units – 2,520 days*	Adult Day Care • *Cost $117,450* • *$45 per slot* • *Service units - 2,610 days of day care* • *Can contract with existing provider or supplement with staffing*	Geropsychiatric specialty services supplementing existing NH staff (RFI) • *30 bed unit* • *Total cost $367,400* • *Units – 10,950 bed days*	Inpatient hospitals • *Cost $675 per day* • *Total ($)300,000* *Service units – 444 bed days*
Care Give supports *(included in mobile assessment team)*	Outreach/Mobile Assessment Teams • *Cost $375,418* • *Total ($375,418)* • *Service units –*		Assisted Living Facilities (ALF) • *Cost $40,000 per slot* • *Fees – auxiliary grant, SSI* • *Total*	

[6] Advisory: funding models and evidenced based practices should be considered in final decision on the relevance of service programs.

	200 clients, 300 service providers		*($400,000) Service units – 3,650 or 10 slots*	
Respite • *Fees – no fees* • *Total ($80,000)* *Service units – 800 hours per month up to 100 families*	Emergency Services *CSB mandated service*		Adult Foster Care • *Cost $2,200 per month per bed* • *Fees auxiliary grant, SSI or state funds* • *Total ($237,600)*	
Mental Health Supports *Existing CSB service, consider impact of any additional new consumers to board*	Mobile Triage • *Cost - $197,039* • *Fees $97,950; 25% Medicaid* • *Total Cost ($99,089)* • *Service units – 100 consumers per year*			
Supportive Residential Services *Existing CSB service, consider impact of any additional new consumers to board*				
Case/Care Management • *Cost $540,000* • *1 FTE per CSB*				

Recommendations that would make the system of care complete and responsive to the needs of the community

Adopt the following principles when determining the number, location and priority of services:

- Preserve the existing capacities and investment
- Replicate and increase the capacity for additional mobile team capacity to work with care givers in the home.
- Increase the capacity for workforce development by increasing student capacity in the technical, college and universities. Paid internships.
- Increase the availability of specialized service providers by increased funding for physician, nursing and health worker recruitment and development.
- Develop opportunities for direct operation or in partnership with long term nursing facilities as alternative to ESH
- Develop and implement the role of ESH as the provider of choice for individuals whose behaviors or symptoms are so severe that services locally are not accessible.
- Develop multi-agency cooperation to promote aging in place and seamless access to services
- Information systems and technology, development of regional information system (RIOS)
- Promote and implement the philosophy of No Wrong Door
- Establish housing priorities
- Support mobility of housing grants, that is auxiliary grants.

Services needed	Unit Cost[7]	Units Recommended	Total Cost
HGTC			
Inpatient	$300,000	1 program	$300,000
SNF/NF			
• Purchased slots	$540,000	1 program	$540,000
• Supplemented team	$367,400	2 programs	$734,800
ALF	$400,000	1 program	$400,000
Foster Care	$237,600	1 program	$237,600
Respite Care	$40,000	2 programs	$80,000
PHP	$335,446	1 program	$335,446
IOP	$127,525	4 programs	$510,100
Day Support	$113,396	6 programs	$680,376
Day Care	$117,450	9 programs	$1,057,050
Outreach/Mobile Team	$375,418	4 programs	$1,501,672
Case Management	$540,000	1 program	$540,000
Mobile Triage	$99,089	6 programs	$594,534
Education - Workforce development	$160,000	1 program	$160,000
Totals	$3,453,324.00		$7,371,578.00

[7] Costs are with estimated fees deducted.

Conclusion

This report addresses primarily the needs of individuals aged 65 years and older. The data in the appendices refers also to those individuals who are aged 55 years and older. Further exploration is warranted to expand this plan to include the needs of individuals under age 65 who also have dementia, with or without mental health symptoms. There is a recent growth in awareness of this potentially underserved population who would not have been eligible for Hancock Geriatric Services. However, due to limited resource options in the community, these individuals present a challenge for accessing services.

In order to preserve the system of care, safety net needs and promote a continuum of care, the state facility capacities should be reserved for individuals whose behaviors or symptoms are so severe and or unmanageable that they cannot be safely served in a community setting. The system of care maintains accountability under existing commitment procedures, and augments the draft recommendations related to mandatory outpatient treatment and involuntary commitment. Fully funding the system of care would enable seniors to age in place, promote and preserve healthy community systems, and minimize the reliance on more restrictive and/or more intrusive options. The amount, type and cost of services estimated are $7,371,578.

Appendix A: Inpatient facilities serving consumers in Region V

Listed below are the facilities where these beds are in operation:

1) Chesapeake General: Chesapeake General has 24 inpatient geriatric beds. Additionally, the hospital has a geriatric Partial Hospital Program which has a capacity of 10 patients. Chesapeake General does accept TDO'S.

2) Norfolk General: Norfolk General has 32 adult beds. Twelve of those beds are inpatient geriatric psychiatric beds. Norfolk General does not accept TDO'S. Norfolk General also has a specialized geriatric IOP, intensive outpatient program. This program has a capacity of 12 to 15 patients and remains full.

3) Shore Memorial Hospital: this facility on the Eastern shore has 14 adult beds, but no geriatric specific inpatient beds. They do operate an outpatient practice for geriatric patients and their families.

4) Maryview Behavioral Medicine: Maryview has 54 psychiatric beds. 42 of those beds are Adult beds. Maryview does accept TDO'S. They have no specialized geriatric services in either their inpatient or outpatient programs.

5) Riverside Behavioral Health: Riverside has 56 Adult beds. Their intensive treatment area has 36 beds and their higher functioning unit has 20 beds. They have no specialized outpatient or inpatient geriatric services. This facility does accept TDO'S.

6) Virginia Beach Psychiatric Center: VBPC has 100 beds. According to Deb Evans, marketing director, 80 of those beds are for an adult population. There are two ITA units of 20 beds each, one 20 bed unit for higher functioning patients and one 20 bed unit for substance abuse services. They have no specialized outpatient or inpatient geriatric programs. TDO'S are accepted.

7) Obici Medical Center: 10 adult beds. They have no specialized inpatient or outpatient geriatric programs. TDO'S are accepted.

8) Rappahannock General: 10 Adult beds, no geriatric specific beds. Rappahannock General also has an Intensive Outpatient Program that serves both young chronic and geriatric patients. TDO'S are accepted.

Appendix B: General and Senior Population Totals of Region V Localities

- Hampton: total population = 145,708. Age 55 and older = 27,943 or 19.7 % of total population (HNNCSB)
- Newport News: total population = 181,416. Age 55 and older = 33,349 or 18.3% of total population. (HNNCSB)
- Norfolk: total population = 236,092. Age 55 and older = 42,170 or 17.8% of total population. (NCSB)
- Portsmouth: total population = 98,733. Age 55 and older = 21,975 or 22.2 % of total population. (PBHS)
- Virginia Beach: total population = 433,549. Age 55 and older = 58,635 or 13.5% of the total population. (VBDHS)
- Williamsburg: total population = 13,330. Age 55 and older = 2,480 or 18.6% of total population. (Colonial Mental Health)
- James City County: total population = 59,183. Age 55 and older = 19,815 or 33.4% of the total population. (Colonial Mental Health)
- York County: total population = 63,139. Age 55 and older = 14,395 or 22.7% of the total population. (Colonial Mental Health)
- Chesapeake: total population = 215,586. Age 55 and older = 40,955 or 18.9% of the total population. (CCSB)
- Suffolk: total population = 79,524. Age 55 and older = 16,918 or 21.2 % of total population. (WTMH)
- Poquoson: total population = 11,800. Age 55 or older = 1314 or 11.4% of total population. (Colonial Mental Health)
- Isle of Wight: total population = 33,065. Age 55 and older = 8,573 or 25.9% of the total population. (WTMH)
- Southampton County: total population = 19,188. Age 55 and older = 9,993 or 54.9% of total population. (WTMH)
- Franklin: total population = 8,304. Age 55 and older = 2,224 or 26.7 % of total population. (WTMH)
- Essex County: total population = 10,520. Age 55 and older 3,003 or 28.5% of the total population (MPNN).
- Gloucester County: total population= 35,931. Age 55 and older 9,396 or 26.1% of the total population.(MPNN)
- King and Queen County: total population = 6,969. Age 55 and older = 4,539 or 65% of the total population.(MPNN)
- King William County: total population = 14,906. Age 55 and older = 3,676 or 24% of the total population. (MPNN)
- Matthews County: total population = 9,176. Age 55 and older = 3,668 or 39.9% of the total population. (MPNN)
- Middle Sex County: total population = 10,253. Age 55 and older = 4,307 or 42% of the total population. (MPNN).
- Lancaster County: total population = 11,565. Age 55 and older = 5,357 or 46.3% of the total population. (MPNN).

- Northumberland County: total population = 13,161. Age 55 and older = 6,312 or 47.9% of the total population. (MPNN).
- Richmond County: total population = 9,695. Age 55 and older 2,962 or 30.5 % of the total population. (MPNN).
- Westmoreland County: total population = 16,741. Age 55 and older = 6,043 or 36% of the total population. (MPNN).\
- Accomack County: total population = 39,459. Age 55 and older 11,830 or 29.9 % of the total population. (ESCSB).
- Northampton County: total population = 13,215. Age 55 and older = 4,490 or 33.9% of the total population. (ESCSB).

These statistics were gathered from the Weldon Cooper Center for Public Service at the University of Virginia. They are projections for population of the various cities and counties of Virginia for the year 2006.

Legend
CCSB – Chesapeake CSB
Colonial Mental Health – Colonial CSB
ESCSB – Eastern Shore CSB
HNNCSB – Hampton-Newport News CSB
MPNN – Middle Peninsula-Northern Neck CSB
NCSB – Norfolk CSB
PBHS – City of Portsmouth Department of Behavioral Healthcare Services
VBDHS – Virginia Beach Department of Human Services
WTCSB – Western Tidewater CSB

Appendix C: Nursing Facilities in Region V

Total number of beds to include skilled and nursing facility level of care

- Norfolk: 8 nursing facilities and 1,163 beds.
- Portsmouth: 3 nursing facilities and 360 beds
- Chesapeake: 4 facilities and 535 beds.
- Virginia Beach: 13 facilities and 1,398 beds.
- Hampton: 4 facilities and 456 beds.
- Newport News: 6 facilities and 867 beds.
- Williamsburg: 5 facilities and 625 beds. (330 beds at ESH).
- Poqouson: 1 facility and 60 beds.
- James City County: 4 facilities and 295 beds.
- York County: 2 facilities and 120 beds.
- Suffolk: 4 facilities and 440 beds.
- Franklin: 1 facility and 131 beds.
- Isle of Wight: 2 facilities and 209 beds.
- Southampton County: 1 facility and 90 beds.
- Essex County: 2 facilities and 85 beds.
- Accomack County: 3 facilities and 196 beds.
- Northampton County: 2 facilities and 158 beds.
- Gloucester County: 2 facilities and 389 beds.
- King and Queen County: 0 facilities and 0 beds.
- King William County: 2 facilities and 72 beds.
- Matthews County: 1 facility and 60 beds.
- Middlesex County: 2 facilities and 124 beds.
- Lancaster County: 2 facilities and 162 beds.
- Northumberland County: 0 facilities and 0 beds.
- Richmond County: 2 facilities and 270 beds.
- Westmoreland County: 1 facility and 60 beds.
- Sussex County: 1 facility and 120 beds.

Information taken from Medicare.Gov web site. Information on web site did not differentiate between skilled and nursing level regarding beds.

Appendix D: Assisted Living Facilities (ALF) in Region V

- Norfolk: 14 sites providing 616 beds.
- Portsmouth: 8 sites providing 345 beds.
- Hampton: 7 sites providing 196 beds.
- Newport News: 19 sites providing 842 beds.
- Williamsburg: 9 sites providing 672 beds
- Chesapeake: 23 sites providing 1008 beds.
- Virginia Beach: 19 sites providing 1, 236 beds.
- Suffolk: 5 sites providing 221 beds.
- James City County: 0 sites.
- York County: 1 site providing 12 beds.
- Franklin: 2 sites providing 82 beds.
- Isle of Wight: 2 sites providing 37 beds.
- Southampton County: 0 sites.
- Essex County: 2 sites providing 20 beds.
- Accomack County: 0 sites
- Northampton County: 0 sites
- Gloucester: 4 sites providing 182 beds.
- King and Queen County: 0 sites.
- King William County: 1 site providing 20 beds.
- Mathews County: 0 sites
- Middle Sex County: 0 sites.
- Lancaster County: 2 sites providing 122 beds.
- Northumberland County: 0 sites.
- Poquoson: 1 site providing 48 beds.
- Richmond County: 2 sites providing 125 beds.
- Westmoreland County: 1 site providing 18 beds.
- Sussex County: 0 sites.

Information gained from "Senior Navigator" Website, September 20, 2007

Appendix E: Long-term care definitions

SKILLED CARE/INPATIENT REHABILITATION:

This level of care is provided in any number of facilities to seniors who meet certain admission criteria. It becomes clear when discussing reimbursement with facility administrators that this is the level of care where margins of profit are generated for those facilities. The services provided are reimbursed by Medicare Part A. Patients who wish to be served in a skilled care environment must have spent at least 3 days in an acute care medical facility in the prior 30 days to their admission to a skilled unit. Additionally, they must need total assistance with at least one ADL, or activity of daily living. The typical patient in a skilled care unit is in rehabilitation from a stroke, heart attack, broken hip, wound care, diabetes, pneumonia, infected surgical site or other issues. Reimbursement is governed by a PPS or prospective payment system by the fiscal intermediary for Medicare in this region. The PPS system provides a daily rate (per diem) to the facility based on the acuity of the patient's diagnosis and the level of care provided. The admission process is started by the completion of a UAI (uniform assessment instrument) and a referral from a physician and hospital discharge planner. The admission and nursing staff of the facility then complete a MDS (minimum data sheet) which outlines the patient's issues and needs for this level of care. Depending on acuity and services provided the daily rate can vary from a low of $193.94 to $564.83. Many skilled care facilities have an average "per diem" of roughly $350.00. In regards to length of stay the patient may stay up to 20 days and have their entire stay totally reimbursed by Medicare. After 20 days the patient is responsible for 20% co-pay as Medicare reduces their reimbursement to 80% of total charges. Many patients have a secondary insurance such as Medicaid or a commercial insurance that pays the remaining 20%. Patients in skilled care have a maximum of 100 days stay per episode assuming this level of care can be justified clinically. After a 100 day stay if the patient has another incident requiring this level of care they are entitled to Medicare reimbursement as long as 60 days have lapsed since their last admission and they spend another 3 nights in an acute medical unit. Patients under the age of 65 may have these services reimbursed by commercial insurance if covered.

1) SKILLED CARE AT HOME/HOME HEALTH: Certain patients can be maintained at home and have their rehabilitation needs met outside of a facility and therefore not require 24 hour nursing observation. Where the patient meets admission criteria Medicare will reimburse providers for these services. Services provided include physical therapy, rehabilitation therapy, occupational therapy and other necessary services. The patient must be declared "homebound" to receive this level of care. Other services provided include wound dressing, feeding, personal care and education regarding their diagnosis and coping skills to recover from illness or surgery that preceded their need for this care. A typical length of service delivery for these patients is 6 to 9 weeks. As is the case with all other levels of care Medicaid, private insurance and long term care insurance can cover co-pays and deductibles and be the primary payer for patients not covered by Medicare. A number of private home health agencies are now offering psychiatric home health care.

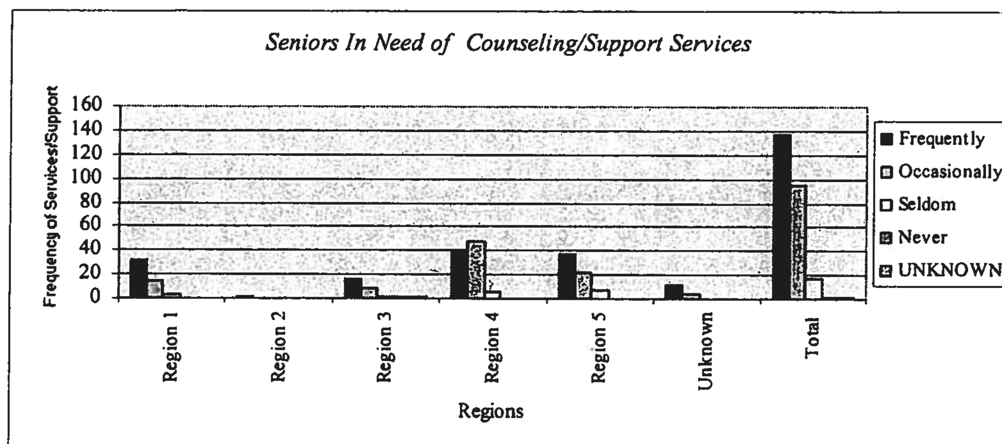
2) NURSING FACILITY: Patients who continue to require an intense level of care, but no longer meet the criteria for skilled care or home health often have their needs met in Nursing Facilities. The vast majority of patients in these facilities have their care paid for by Medicaid. As is the case with patients who need skilled care a UAI must be completed showing that the patient meets admission criteria. Patients seeking this level of care must need total assistance with at least three ADL'S. The typical patient needs assistance with dressing, bathing, feeding, administration of medications and other services. Except for those rare patients who have their stay paid for by private pay the patient must also meet Medicaid eligibility requirements. The nursing staff must complete the MDS form and routinely and periodically submit to DMAS to substantiate their need for this level of care. The MDS forms must be submitted at the following intervals of their lengths of stay: 5,14,30,60 and 90 days and thereafter every 90 days. Additionally, the patient must reapply for Medicaid every year. The facility receives a per diem from Medicaid based on allowable costs. Each year the facility submits costs reports to DMAS who then determines the appropriate per diem. Most administrators of Nursing Facilities indicate that they have little or no profit margin generated by residents who have their stay reimbursed by Medicaid. Therefore, they also have skilled units in their facilities to create margins to off set loses created by serving the Medicaid population. The basis for fee determination may not include individuals experiencing symptoms of serious and persistent mental illness.

3) ASSISTED LIVING FACILITY: These facilities are non-medical facilities that provide 24 hour coordinated personal and health care for 4 or more individuals. Although these individuals cannot continue to live at home alone they do not need the level of assistance as required in either a skilled care or nursing facility environment. They may need food prepared and house keeping, but they do not need total assistance with Activities of Daily Living like dressing or bathing. The majority of seniors who live in Assisted Living Facilities pay privately for their care. Monthly rates for ALF'S can run from $1,000 to $6,000. Patients who have long term care insurance can have all or part of their monthly fee paid by that coverage. Some older adults who qualify for Auxiliary Grants can attempt to find ALF'S that accept a combination of their Auxiliary Grants and Social Security Checks as payment for their stay. Unfortunately, there are very few ALF'S that will accept patients with these sources of income and who have chronic health conditions, including symptoms of serious and persistent mental illness.

Appendix G:

Chart – Seniors in Need of Counseling/Support Services from the DMHMRSAS State-wide survey. Geriatric Project Team: Results of Feedback Form Presentation made June 8, 2007.

In your experience, do you see/know of seniors in need of counseling and/or support services?



	Region 1	Region 2	Region 3	Region 4	Region 5	Unknown	Total
Frequently	31	1	16	40	37	12	137
Occasionally	14	0	8	47	21	5	95
Seldom	3	0	1	6	7	0	17
Never	0	0	1	0	0	0	1
UNKNOWN	0	0	1	0	0	0	1

Appendix H

Below is a summary of the results of our Geriatric Project Team Feedback Form for Region V. I trust this will be helpful as you move forward with Region's V strategic planning for the continuum of Care for Geriatric Services. Please call me if you have any questions or if I can support/assist in any other way.

Responses from 9 consumers, 8 family members, 22 providers, 30 staff and 1 Unknown

37 responded that in their experience they frequently see/know of seniors in need of counseling and/or support services. 22 responded occasionally and 8 responded seldom and 0 responded never.

59 said they were aware of resources that would help meet these needs and 9 responded they were not aware of any resources.

In priority order, the following counseling/support services for seniors were identified from the selected (13) senior programs/needs.

- Geriatric Education for primary care physicians, psychiatrists, mental health and other care providers.
- Geriatric Education and support services for family members.
- Respite Care to relieve families that provide care for elders.
- Geriatric outpatient counseling and/or case management at clinics.
- Geriatric mental health counseling, case management and psychiatrist services in the senior's residence when elders are not able to travel to clinic sites.
- Geriatric day treatment programming.
- Expand housing options for older adults.

The individuals who responded to the feedback form were knowledgeable about or interested more in mental illness, second mental retardation/intellectual disabilities and third co-occurring disorders (MR/MI; MI/SA) and fourth ALL. They were less interested in substance abuse.

In your experience, what are the counseling and or/support services in your community/Region that would help meet the needs of counseling and/or support services for seniors.

- Catholic Charities/ Jewish family Services/OASIS. Community services Boards. Geropsychiatric units at Chesapeake General Hospital and SNGH.
- Alzheimer's Association, Adult Protective Services, Social Services, Eastern Virginia Medical Center.
- Respite programs, Senior Corp. Home Instead, Daycare Programs, Sentara, Georgian Manor, Stephens Ministers.
- Transportation, In-home health, support groups, nutrition, caregiver education.
- Psychiatrists, Therapists, Recreation centers, YMCA, Case management.
- AARP, Senior Resource Guide, Caregiver Support groups, Department of Medical Assistance Services.

- Senior Services, City agencies, Area Agencies on Aging.
- Food Banks, Volunteer programs at hospitals and nursing homes.
- Chapman Senior Care, Bridges Program, Senior Centers, E & D Waiver Services (DMAS), Social Security Administration, Section 8 Housing, Sunrise House, PACE, Department of Health.
- Emergency MH services at area hospitals.

Some of these were mentioned by more than one respondent.

From your experience, what counseling and/or support services are needed the most in your community/Region for seniors.

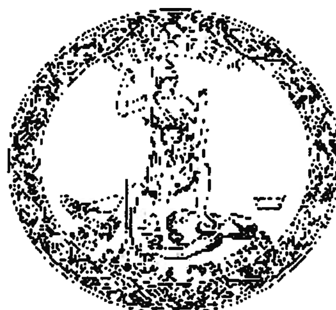
- Housing (Specialized and Affordable)
- In-Home Care/Support
- Caregiver Counseling, Legal Aspects
- Care Options not involving TDO's for dangerous, abuse situations.
- Care Coordination
- Specialized Transportation
- Respite
- Companion Services
- Counseling for Geriatric Depression
- Treatment for mild to severe cognitive impairments(Dementia)
- Non-medical support services for low-moderate to moderate income earners
- More psychiatrists and more treatment facilities to care for the chronically mentally on a long term basis
- Financial assistance for families that are trying to care for loved ones at home
- Recreational services
- No cost counseling for seniors as most cannot pay
- Elder friends services
- Counseling and monitoring of medications
- Support with shopping and errands
- Mental Health counseling without having to be admitted to an inpatient psychiatric unit
- Re-evaluation of Assisted Living Facility care
- Geriatric care managers/senior advisors
- Case Managers
- Field trips for Seniors
- Financial Counseling
- More education/awareness of what is available in the community/Region
- Nurses
- Shopping Services
- Specialized evening activities for senior adult services
- Improved prescription services
- More mental health programs especially in the City of Virginia Beach
- Specialized counseling to deal with issues of loneliness and relating to family and friends
- Supportive services for seniors to leave their house and be in the presence of other seniors with similar needs
- Specialized overnight respite care for Alzheimer's care

- The population of seniors in the City of Virginia Beach warrants a Senior monthly newspaper that identifies topics of interest to seniors like health' agencies available; nutrition, etc.(Senior Beacon in Maryland is an example of this)
- Day Care for all populations(MH,MR and SA)
- Collaboration with No Wrong Door policy
- Dental services
- Mental Health activities for the homebound senior
- Training and sensitivity awareness for all medical care providers from CNAs to Medical Doctors
- Homeless shelters/housing for couples over age 62
- Information & Referral
- Gerontological education to augment geriatrics
- Assisted Living Facility for moderate income seniors
- Senior Centers for seniors who are eager, alert, cognitively intact to avoid issues of loneliness, depression and cognition
- Accessible locations for services for seniors
- Financial resources for home improvements
- Personal care for the elderly without family support
- Behavior management services for aggressive seniors
- Psychotherapy
- Transition services to Long-Term Care programs for the elderly and their families
- Psychologists and Psychiatrists who will come to nursing facilities on a regular basis to provide psychotherapy and just not prescribe medications
- More timely/faster response for elderly support services
- More cooperation/collaboration among service providers and the long term care programs
- Access to a psychiatrist for residents in nursing homes who are dually diagnosed and/or have serious mental health conditions such as schizophrenia, bi-polar or severe depression.
- Access by nursing homes for a visiting psychiatrists (1x no & PRN). This would reduce the number of calls to cope and the number of requests for TDO's and for hospitalization.
- Community Service Boards mental health services
- Mental health services in Assisted Living and Nursing facilities
- Desperate need for psychiatric services for long term care residents on psychotropic medications (long-term) and acute mental health issues with unmanageable residents
- In-home supports and assistance that would make it easier for seniors to age in place. An easy to contact emergency service(for example, if someone falls, etc.) and machinery that provides pill ore capsule form of medication on a timed basis especially for elders that don't remember to take their medications and a check-in service so elders do not become isolated.
- More consideration by assisted Living and nursing facilities to service elders who have a mental health diagnosis or have been aggressive.
- Number of Assisted Living Facilities that accept auxiliary grants have been declining and these needs to change.
- Aging in place services that are centralized/accessible
- Services for seniors with mental health/mental retardation do not fit neatly into the current array of community based services and need to be evaluated

- Mentor/intergenerational programs for the elderly
- Medical supplies and durable medical equipment
- More funding for services for seniors

Source:
August 6, 2007 – email communication
Beverly Morgan – Geriatric Specialist
Department of Mental Health, Mental Retardation and Substance Abuse Services
Office of Mental Health

The Commonwealth of Virginia State Plan for Aging Services October 1, 2007 – September 30, 2011



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