

***HPR V REGIONAL
GERIATRIC PSYCHIATRIC TASK FORCE***

***Regional Plan for Geropsychiatric Services
Strategic Recommendations***

Approved June 2, 2008
HPR V Executive Directors

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**EXECUTIVE SUMMARY
March 31, 2008**

At the direction of the Executive Directors of the nine CSBs and two State Facilities, representatives of the nine community service boards in Region V, have formed a Regional Geriatric Task Force. The group is led by co-chairs Kathy Drumwright and Rick Jackson. The purpose of the group is to outline and implement a regional response to the services needs of older adults. This group meets monthly to discuss operational issues and opportunities for growth of the service delivery models. Particular attention is paid to the development of services and programs that will either divert patients from the Hancock Center at Eastern State Hospital, or serve as a means to increase the number of patients who can be successfully transitioned into the community from the state facility.

The task force has conducted a needs assessment using literature review, data collection using existing data sets and survey techniques, and stake holder interviews. Stake holder interviews include individual and focus group techniques. The needs assessment also includes the results of site visits to Utah and local service providers. The task force has charged Kathy Drumwright, Rick Jackson and John Dool with the assembly and writing a draft Regional System of Care Plan.

The Regional Plan will include the following elements:

- Mission statement.
- Vision statement.
- Assumptions that provide the underlying philosophy of the development of the continuum.
- Strategic goals and supportive objectives.
- Background information to include a comprehensive market analysis, existing services at all levels and obvious gaps in existing services. The description of the gaps will instruct us as we make our final recommendations.

The Task Force has included in the plan service descriptions including cost estimates, and assets for using that would comprise a system of care, including:

- Current ongoing services and activities of the various regional, sub-regional and individual community service boards in developing geriatric services and programs.
- Services in Long Term Care Facilities, Inpatient Programs, Partial Hospital Programs, Outpatient Services, Home Based Services, Case Management Services, Mobile Assessment Teams, Respite Care Programs.

- Detailed costs and revenue projections for each and every level of care described in that continuum. Additionally, a cost estimate will be provided for a fully funded continuum.
- Recommendations for creation, implementation and coordination of a comprehensive continuum of care for our geriatric population.

Executive Directors of the HPR V community service boards upon receipt of this system of care plan should review the suggested programs, costs and revenues associated with these programs and make decisions regarding which of these services is most needed and appropriate for their community. This plan may also be used in legislative advocacy efforts as we seek a fully funded regional geriatric psychiatric continuum of care. The draft document is also available, with assistance by the co-chairs, as a source of relevant information in presentations or planning.

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Preamble

Older Americans are the fastest growing segment of the population in the nation. In 2000¹, persons over the age of 65 make up 12.4% of the total population in the U.S. By 2030, this number is estimated to be 25% (representing over 70 million Americans). Current estimates have Virginia reaching the 25% level as early as 2025. Of the aging population, the “oldest of the old” (85 and older) is the fastest growing segment of the population.

Mental illness is the leading threat to independence and quality of life for older adults. Although only a small percentage of the elderly reside in institutional settings, there is a high prevalence of diagnosable psychiatric and behavioral problems among nursing home residents. Approximately 1.5 million older adults reside in nursing homes and 65 to 91% have significant mental health disorders. Of that figure, dementia represents the most frequent diagnosis that affects these individuals in terms of their behavior and functioning. For those individuals still living in the community, the impact of missed diagnosis and inadequate treatment of early cognitive decline and depression results in significant morbidity and increased burdens on care givers and the health /social care delivery system.

Psychiatric illness in older persons is a public health problem which adversely affects general health outcomes and the cost of health services. These individuals frequently have unmet health needs due to difficulties accessing assessment and treatment by geriatric mental health providers. Fewer than 3% of older adults report receiving treatment from a mental health professional, a rate lower than any other adult age group. Many factors account for this low rate of treatment. Few mental health providers have specialty training in geriatrics. Aging patients often have complex co-morbid medical conditions that make accessing behavioral health care difficult. Financial constraints and cultural attitudes are also barriers to accessing behavioral health care for geriatric patients. Often older adults seek mental health treatment through primary medical care, a system often stressed by demands of other complex medical disorders, time constraints and attitudes that promote ageism. Unless these barriers to appropriate geriatric behavioral health care are removed, mental health services for seniors will remain suboptimal, fragmented and inefficient.^{2, 3}

To respond to the needs of the senior citizens of the Southeastern Virginia, the HPR V Consortium is developing a comprehensive continuum of geriatric behavioral health services. This model of care is consistent with the direction of the Department of Mental Health, Mental Retardation and Substance Abuse Services and promotes recovery, consumer choice, and service in the least restrictive, clinically appropriate setting.

¹ US Census Bureau population statistics, 2000

² Improving Primary Care for Depression in Late Life: The Design of a Multicenter Randomized Trial. Jürgen Unützer; Wayne Katon; John W. Williams, Jr.; Christopher M. Callahan; Linda Harpole; Enid M. Hunkeler; Marc Hoffing; Patricia Arean; Mark T. Hegel; Michael Schoenbaum; Sabine M. Oishi; Christopher A. Langston. *Medical Care*, Vol. 39, No. 8. (Aug., 2001), pp. 785-799.

³ Evidence-Based Practices in Geriatric Mental Health Care. Stephen J. Bartels, M.D., Aricca R. Dums, B.A., Thomas E. Oxman, M.D., Lon S. Schneider, M.D., Patricia A. Areán, Ph.D., George S. Alexopoulos, M.D. and Dilip V. Jeste, M.D. <http://www.psychservices.psychiatryonline.org/cgi/content/full/53/11/1419>

Background

Although the US census bureau projects that by the year 2030 the population of senior citizens in the United States will reach 25%, the Weldon Cooper Center for public service at the University of Virginia estimates that the number of citizens aged 55 and older in Region V now make up 20.4 % of our total population. This study estimates that as of the year 2006 Region V has a total population of 1,790,208. The number of citizens aged 55 and older are estimated to be 366,322 or 20.5% of that number. Clearly then Region V's total population of citizens aged 55 and older is growing at a much faster pace than the rest of the country.

While our senior population is growing at a pace faster than the rest of the country, the resources available to assist them are on the decline in both number of providers and ability to provide services. JLARC (Inpatient, 2007) identified that Medicaid reimbursement decreased by a range of 16 – 24% between 2000 and 2006. This has caused health care practitioners and systems to attempt to control the number of seniors they choose to accept into their practices.

Additionally, during this fiscal year Eastern State Hospital will reduce bed capacity at Hancock Geriatric Treatment Center to 150 beds. Community Service Boards over the past year have developed and will continue to develop community based services and programs to serve the populations historically served in our institutions. All of these factors combined place a unique burden on the public sector in Virginia to create implement and coordinate a comprehensive continuum of care for our senior population. We will be required to seek innovative means of forming coalitions and joint ventures with the private sector to meet these needs.

Vision

To create a system of care for seniors experiencing mental illness which allows them to succeed in the community and receive care consistent with the values of recovery, self determination and empowerment.

Mission

To create a coalition of public- private Geriatric psychiatric service providers that will develop a plan for specialized Geriatric services. This plan will rely on a broad and expansive continuum of specialized services to meet the complex unique needs of individuals who are aging.

Assumptions

1. Aging in place is preferable, whenever possible, in lieu of institutional levels of care.
2. Consumer and family centered treatment will be the hallmark of the system.
3. In order to assure good stewardship of resources, the system must produce consistent service outcomes, cost effective treatment, and place accountability on system managers and service providers.
4. Provision of services for seniors in the least restrictive environment.

5. Treatment of the whole person using bio-psychosocial philosophies.
6. Adoption of evidence based best practices.
7. Promotion of strategic partnerships with the private sector is desirable.
8. Due to the complex needs of vulnerable older adults the system of services must integrate various disciplines across all sectors and assure easy access to care.
9. There is a unique burden on the public sector to coordinate provision of services to this vulnerable population due to ever shrinking reimbursements from Medicare for services provided to seniors.
10. Commitment of resources from state, local and federal governments, as well as resources from the private sector, will be necessary to continue the provision of these services to our senior population.

Strategic Goals and Objectives - 2008

1. Implementation of a full continuum of geriatric behavioral health services serving HPR V Virginia
2. Utilization of a bio-psychosocial model of care to deliver services that are responsive, compassionate, accessible, and economical and provided by staff with specialized training in geriatric behavioral health care.
3. Provision of services in the least restricted environment that meets the needs of our consumers and families.
4. Adoption of evidenced-based, best practices.
5. Collaboration with private sector where appropriate and mutually beneficial.
6. Integration of care among medical providers and social agencies.
7. Promotion of strategic partnerships.

Comprehensive Continuum of Services – What Exists among the Region V CSBs for Geriatric Services

Southside Services FY 08 – Chesapeake, Norfolk, Portsmouth, Virginia Beach and Western Tidewater

Southside Gero-psychiatric services represent the Norfolk, Portsmouth, Chesapeake, Virginia Beach, and Western Tidewater CSB's. Service components include purchased slots in two locked ALF dementia units, ongoing psychiatric assessment and med management for those placements, psychiatric consultation, home-based assessments and consultation, respite care, caregiver support, case management, and training for ALF and nursing home providers and other community caregivers. The FY 08 Budget is \$354,000. Staffing includes 2.2 FTE's (1 FTE Nurse Practitioner, 2 geropsychiatrists on contract up to 16 hours per week, 1 contract nurse educator, part time case manager, and part-time program manager. Services provided through February, 2008 include:

Consultations, psychiatric assessments and med management: 76 unduplicated clients have been served for a total of 414 service hours. Ongoing psychiatric care and medication management is provided in two facilities and consultation and assessment has been provided in all of the participating localities.

Respite Care: 48 unduplicated clients, 10,434 service hours

Sponsored placements in two ALF's: 10 unduplicated served, 957 bed days (8 in local hospitals diverted from Hancock, 2 discharged from Hancock)

Training: 850 people have received training in Dementia Basics, Managing Medications, Managing Difficult Behaviors, Dementia and Behavior Management, Communication and Behavior, and Mental Health and Aging. Trainings have been provided to ALF and Nursing Home staff, Adult Daycare and Respite Care staff, family caregivers, and other professionals. Trainings are supported by the DSS Licensing office and have been extremely well attended. Total training hours: 100,300

Virginia Beach staff have also facilitated a stakeholders group for the past 16 months, comprised of representatives of the participating CSB's, Sentara Norfolk General and Chesapeake General Hospital, participating ALF's, Beth Shalom Nursing Home, private providers, three local psychiatrists, DSS Licensure, DMHMRSAS, Catholic Charities, and DMAS. The focus of the group has been relationship building, assessing community need, advocacy, and planning.

OASIS: The Center for Quality Aging: Hampton Newport News CSB

Current Geriatric Psychiatric Commitment

- 1) **OUTREACH SERVICES:** Hampton Newport News Community Services Board now provides a board certified geriatric psychiatrist to three different long term care facilities in our area. This physician visits the three facilities weekly and provides consultative services to include psychiatric evaluations, recommendations for introduction of psychotropic medications, management of medications, training for staff and other services designed to meet the needs of the residents on site and decrease need for more intensive care. We have provided services to more than 60 unduplicated patients. As a result of our work at St. Francis Nursing Center we have been successful in placing one patient from the discharge list from Eastern State and now have two additional patients on their waiting list. On one other occasion we were successful in diverting a patient from admission to Eastern State.

- 2) **RIVERSIDE PACE PROGRAM:** Effective March 5, 2008 the Hampton Newport News Community Services Board will provide on site geriatric psychiatric services to the new Riverside PACE Program. Our psychiatrist will be on site providing consultative services to include psychiatric evaluations, recommendations for introduction and management of psychiatric medications, staff training, participation in multi-disciplinary treatment planning, community education presentations and other related services. The center will ultimately provide services to 150 participants who have been found eligible for admission to a nursing facility but desire to remain in their homes.

- 3) **COMMUNITY EDUCATION:** The Hampton Newport News Community Services Board has provided geriatric specific training to over 700 staff who serve older adults and caretakers of infirmed seniors to include the following organizations:
 - Newport News Senior Independent Housing (joint venture with PAA)
 - Alzheimer's Association Annual Conference
 - Bon Secours "Faith in Mental Illness: series held at the three facilities in Hampton Roads.
 - First Baptist Church of Hampton
 - Kecoughtan Senior Center.
 - State Wide Long Term Care Ombudsman Training.
 - VHDA state wide training.
 - Eastern State Hospital Family Conference.
 - Peninsula Agency on Aging Annual Conference.
 - Newport News Division of Social Services Adult Protective Services.
 - Christopher Newport University Undergraduate Health administration class.
 - Peninsula Agency on Aging Caregiver's conference.
 - Hampton Roads Life Long Regional Planning Conference

- 4) **PARTICIPATION IN ADVOCACY AND STRATEGIC PLANNING:**

Staff members from the Hampton Newport News Community Services Board now participate in the following activities:

- **Geriatric Interagency Task Force:** twenty members of organizations who serve seniors on the Peninsula meet to determine gaps in services and develop strategies to develop continuum of care.
- **Newport News Task Force On Aging:** a group of representatives from private and public agencies who serve seniors appointed by the city manager to develop a long term city wide response to needs of older adults in Newport News.
- **Peninsula Task Force on Aging:** a group of professionals who serve seniors who are involved in legislative advocacy, community education and other related activities to improve the lives of seniors on the Peninsula.
- **Hampton Roads Life Long Regional Planning Partnership: Steering Committee.** A group of private and public agencies appointed by the city manager of Norfolk to develop a region wide plan to meet the needs of seniors.
- **Geriatric Leadership Group (DMHMRSAS)** a state wide group appointed by Frank Tetrick directed to develop a state wide master plan for provision of services to our older adult population.

Colonial Services Board Geriatric Program: Colonial Mental Health (Pathways)

“PATHWAYS to Senior Empowerment”

Geriatric Services staff added with Transformation funding;

- Geriatric Program Coordinator hired to oversee Gero services.
- LCSW hired to do outpatient and nursing home counseling / social work / case management.
- Psy.D. hired to do outpatient and nursing home therapy for individuals, families and groups, psychological assessments and competency evaluations.
- Psychiatrist hired to work part-time within nursing homes providing psychiatric consultations.

Geriatric Program Accomplishments;

- Behavioral health services are being provided in 3 nursing homes. Since beginning these services in August 2007, 97 unduplicated patients have received psychiatric consultation and follow-up visits to total 312 contacts. 64 patients have been evaluated through health and behavioral assessments. 12 patients have received individual counseling. 3 have received competency evaluations. 7 more competency evaluations have been completed on community referrals.
 - Outpatient referrals are growing as a result of marketing efforts which include articles in newspapers and monthly health journals, participation in local health fairs and conferences on aging, direct contact with ALF's, letters mailed to all catchment area PCP's describing our services and requesting referrals and community presentations. Presentations have been made to the following groups;
 - AARP Annual Education Conference.
 - York-Poquoson Multidisciplinary Treatment Team
 - James City County Multidisciplinary Treatment Team
 - Senior Advocate Network Group
 - College of William & Mary doctoral Psychology class
 - Williamsburg Landing Woodhaven staff and residents
 - Williamsburg Baptist Church
- PATHWAYS staff are active members of the following aging network organizations;
- Senior Service Coalition
 - Peninsula Task Force on Aging
 - Long Term Care Liaison Group
 - Senior Advocate Network Group
- New outpatient programs have been initiated which include a caregiver's therapy group and animal assisted therapy. For the last 2 semesters our LCSW has supervised a VCU-MSW student intern, majoring in Geriatrics.
 - CSB crisis services staff report a reduction in crisis calls from the nursing facilities where PATHWAYS is providing services. There has been a substantial reduction in the number of requests for preadmission screenings for involuntary hospitalization from these 3 facilities.

Middle Peninsula Northern Neck Community Services Board: Geropsychiatry Outreach

1. Outreach to Nursing Homes and ALF's:
 - Geriatric Specialist provides 5-10 consults to local facilities per month.
 - Psychiatric Medication Consultation visits
Onsite at ALF's 2x per month- 10 patient contacts per visit.
Onsite at NH's 2x per month- 8 patient contacts per visit.
2. Geropsychiatry Outpatient services
 - Care coordination/Case Management of 8-10 persons per month by Geriatric Specialist.
 - Case consultation, information and referral, and community outreach regarding mental health issues of geriatrics.
 - Access to urgent outpatient psychiatric appointments- 5 per week.
3. Reducing Acute and Intermediate Care over-utilization
 - Diversions from and follow-up of Emergency Services referrals made by facilities and community sources.
 - Specialized transitional and discharge planning for geriatrics hospitalized at Hancock.
 - Estimated that 10 geriatric admissions have been avoided.
3. Community Education, Training, and Stakeholder groups
 - Conducting trainings for facility direct care staff and CSB clinicians- 3 trainings totaling 30 attendees.
 - Stakeholders- participation in No Wrong Door, Sr. Advocate Network Group, local DSS staff meetings, facility treatment/admission committees, multi disciplinary safety net committees.
4. Respite Care
 - Crisis stabilization is made available to Geriatrics.
 - Respite agreement with local ALF.
 - Referrals made to Adult Day services (AAA Adult Day Care), Geriatric Intensive Outpatient/Partial Hospitalization, and Respite through local AAA.
5. Strategic Planning
 - Pending contracts with 5 additional facilities for on-site Psychiatric consultation.
 - Development of environmental and behavioral consultation service at request of local facility.
 - Pursuit of additional respite options to maintain caregiver resilience.
 - Partnering with other CSB's for additional psychiatric coverage.

Level of Current Investment

Consumers receive services from CSBs through a variety of service and program portals. Individual CSBs vary in the number of consumers and services, and this variance is dependent on the number of consumers in a given community, the number of types of senior services available, and the location of those services. HPR V Transformation funds have been designated to augment these existing services and or expand services. Additional funds have been allocated using the following schedule.

HPR V Geropsychiatry Programs	Transformation and Reinvestment Funds
Chesapeake - Limited services	\$50,000
Colonial	\$257,450
Hampton-Newport News/Norfolk	\$400,000
Hampton-Newport News	\$500,000
Middle Peninsula Northern Neck	\$152,039
Southside Program (Chesapeake, Norfolk, Portsmouth, Virginia Beach)	\$354,000
	\$1,713,489.00

Comprehensive Continuum of Care: Needs Assessment

The regional and subregional teams and many of the individual CSBs have conducted stakeholder group activities to identify the needs and the opportunities within the HPRV for senior psychiatric services. In addition to these local stakeholder activities, the region participates at the state level in state agency sponsored work groups.

Inpatient Psychiatric Facilities

Region V is served by 8 facilities that provide 268 adult inpatient psychiatric beds. Of these, 36 beds are geriatric specific. Chesapeake General Hospital has 24 beds and 12 beds are at Sentara Norfolk General (Appendix A).

Long Term Care Facilities for Geropsychiatry

- There are a large number of private practices in HPR V and throughout the state who provide on site geriatric psychiatric services to Long Term Care Facilities. Unfortunately, these organizations are struggling for survival as Medicare continues to reduce reimbursement for services rendered to these patients. CMMS has reduced reimbursement by 14% in the past two years. This trend is causing agencies, practices and individuals who provide these services to reconsider the resources they are willing to commit to these efforts.
- Most of these practices rely on Licensed Clinical Social Workers and Psychologists to provide these services. The facilities, although appreciative of these efforts, are most in

need of psychiatrists who can prescribe and manage medications for a population suffering from dementia and aggressive behaviors.

Community Service Boards in Region V are now providing on site psychiatric services to more than 13 facilities. In 2007 we have provided psychiatric evaluations, medication management and/or counseling services to more than 250 residents of these facilities. An important distinction of our services, as compared to ones provided by private providers, is that we are providing psychiatrists and/or nurse practitioners who can prescribe and manage medications. These practitioners can also provide consultation to facility physicians around psychiatric issues.

General and Senior Population Totals of Region V Localities

TOTAL STATISTICS FOR REGION V⁴ (Appendix B)

Total for Region V = 1,790,208

Adults age 55 and older = 366,322

Total population of adults over age 55 in Region V is 20.5 %

Nursing Facilities in Region V⁵

78 Nursing Facilities 8,445 (Appendix C)

Assisted Living Facilities (ALF) in Region V⁵

5,802 ALF beds located at 122 sites or facilities (Appendix D)

Summary Findings of the 2006 Market Analysis

Southside Stakeholder Feedback

In determining system of care needs for the geriatric population, we have obtained feedback from a variety of sources. The Southside project representing Norfolk, Portsmouth, Chesapeake and Virginia Beach has convened a stakeholders group that has been meeting for over a year. This group is represented by psychiatrists and administrative staff from the two hospitals accepting gero-psych patients (Chesapeake General and Sentara Norfolk General), representatives from the Alzheimer's Association, local assisted living and nursing home facilities, private providers, EVMS Dept. of Psychiatry, CSB's, Social Services Licensure, and DMHMRSAS. As a group, there is recognition of the need for further partnerships in meeting the needs of an aging population and we have continued to work together to identify what a

⁴ 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.

⁵ Information gained from "Senior Navigator" Website; September 20, 2007

continuum of care should look like and who should be at the table. There is general agreement from the group that Hancock Geriatric Center needs to be a resource for those with behaviors unable to be managed in a community ALF or nursing home setting. Other services needed as part of the system of care should include residential, respite, day support, home-based supports, mobile treatment teams, outpatient, case management, and training to caregivers in home and ALF and nursing home settings.

We have also widely distributed the survey developed by the State Geriatric Leadership Team to obtain additional feedback from providers, consumers and family members. The data obtained from that survey was compiled and included in our building of the system of care proposed in this document (Appendix G: Chart – Seniors in Need of Counseling/Support Services; Appendix H: Region V portion of the State Survey).

HNN CSB Survey Results

In October 2006 the HNN CSB mailed out a community survey to approximately 55 persons who are involved in providing services to seniors in our region. Additionally, we handed out another 20 surveys at a conference at Eastern State. The following are some important results taken from the responses from the survey.

- 1) Number distributed 75
- 2) Number returned 21
- 3) Percentage of surveys returned 28%

Question 6 asked what service is most needed in our community for older adults. Listed below are the results:

Item	Responses
Outreach	13
Emergency services	11
PHP	10
Case management	10
Inpatient	9
Outpatient	9
IOP	8
Training	8
All of the above	4
Other – SA Treatment	1

Summary of survey comments:

- not enough psychiatrists
- not enough psychiatrists willing to come to facilities
- no one will come out to remove a patient who has become dangerous to other residents

- The elderly seem to fall through the cracks of the safety net, especially for in home service delivery and for physically disabled seniors. Services for patients with dementia are very limited. Emergency response for senior patients is very inadequate.
- Lack of transportation, lack of understanding of geriatric issues, eligibility criteria is not clear for seniors in need of mental health, lack of understanding of how seniors process medication.
- 2 persons wrote when ES workers from CSB were involved they were excellent
- Too many physicians involved in care who are not communicating with each other.
- More training to caregivers and nurses in home health, how to handle crisis situations
- Not enough Nursing homes willing to accept patients with psych issues.
- SA treatment for seniors needed
- We need help for elderly homeless in shelters on site...
- no services for seniors dealing with depression are available
- We need a team approach to evaluation of seniors with depression, dementia, delirium
- More family support

Needs and Gaps – Geropsychiatry Task Force

1. Housing, housing supports, and housing assistance
2. Staff Training
 - a. Human Resources, recruitment of geriatric specialists and work force development.
 - b. Staff Respite
 - c. Documentation issues related to provision of services to severely cognitively impaired patients.
3. Resolution of issues related to patient's ability to consent and LAR'S when they cannot.
4. Locked Wards/limited egress wards in skilled and adult living facilities
5. Improve access to and availability of:
 - a. Skilled Nursing Beds
 - b. ALF beds
 - c. Acute Inpatient Services
 - d. Continuum of Outpatient Day Support
6. Resolution of issues related to services for seniors involved in criminal charge
7. Support Services
8. Address the availability of specialized services for consumers experiencing total brain injury effects (TBI) and the impacts of developmental disability coexisting with mental health needs (MR/MH)
9. ESH HGTC will be reduced to 150 beds on or about April 1, 2008.

Moving to the Future: Components of a System of Care

The system of care and the movement towards a responsive and healthy community involves the development of consensus on effective program and service strategies. The continuum should include inpatient programs, long term care, day treatment programs, intensive outpatient programs, outpatient services, outreach services, crisis intervention, crisis stabilization, consultative services, community and professional education programs and services to families and caretakers. In addition proper linkages with the private sector, community based organizations and faith based organizations will be an important aspect of our planning for a comprehensive continuum. These program and services strategies include but are not limited to:

1. **Acute Inpatient Care (7-10 Days)** for those times where all efforts at reducing symptoms in less restrictive care have failed, the system requires bed capacity in inpatient centers for a brief stay providing diagnosis and stabilization.
2. **Discharge Planning** that is collaborative efforts among CSB'S, state institutions, Long Term Care Facilities and other organizations necessary for the appropriate placement of seniors and our desire to allow them to age in place.
3. **Care Options to exclude TDO'S in dangerous situations:** Our successful implementation of outreach services and "less intensive" programs will reduce the volume of TDO calls received by CSB emergency service departments as we will diagnosis and treat early and in a preventative manner.
4. **Crisis Stabilization Programs:** We will look at the ability of existing crisis stabilization programs to serve our senior population.
5. **Crisis Intervention Services:** will use mobile assessment team to respond to crisis calls regarding homicidal, suicidal and aggressive seniors.
6. **Forensics:** as our aging population continues to grow, the issue of forensic evaluations and placement will expand commensurately. (regulatory)
7. **Substance Abuse Treatment Programs:** Abuse of prescriptive medications and alcohol continues to grow in our senior patients. As is the case with other services, we will need to look at substance programs specifically designed for seniors.
8. **Capacity for Psych follow-up (Partial Hospital, IOP):** Less intensive, restrictive programs for seniors are a vital part of a comprehensive continuum of care that seeks to treat the senior in the appropriate setting. (LOC)
9. **Develop pilot and ongoing contracts with Nursing Homes** to develop relationships with Nursing Homes to provide on site psychiatric services to their residents. These services will serve several purposes. Early diagnosis and treatment services to decrease the numbers of patients requiring services at state facilities. Additionally, these facilities once comfortable with the level of care provided by the various CSB'S should be more

amendable to accepting patients ready for discharge from the Hancock Center at ESH. Evaluation of pilot programs would include documentation of the experience, has it reduced the gap identified, and what issues remain after implementation.

10. Identify ALF/NH who will accept patients with Behavioral Health issues: Our Extensive Outreach efforts and Mobile Assessment teams will expand the number of facilities who will be willing to consider acceptance of residents with behavioral health issues.
11. Respite Care: will provide respite for caretakers of home bound seniors. Presently being provided on the south side via a joint venture with Catholic Charities and a sub-regional consortium of CSB'S. Negotiations underway to expand these services to the Peninsula and Middle Peninsula.
12. Companion Services: will be included in our "Respite Care" efforts.
13. Geriatric Outpatient Case Management: Senior specific case management will be a vital part of our continuum of care.
14. Day Support: for those patients with cognitive impairments that would preclude them from participation in a PHP or IOP, we will need to expand the ability of the community to provide day support and day care. Collaborative efforts with the newly established PACE programs in this Region will be emphasized.
15. Mobile Teams (geographic): will provide on site geriatric consultations and evaluations at hospitals, long term care facilities, physician's offices and private homes on an on-going basis or on an as needed or one-time basis.
16. Training for staff who serve seniors: will provide training for CNA's and other health care professionals who serve our senior population in Long Term Care Facilities and agencies.
17. Rapid Response: Response must be immediate as an appropriate disposition is needed quickly for safety of the senior and all involved.
18. In Home Supports for seniors. (Respite, ADL): we will look at meeting these needs through our case management services and Respite Care Programs.
19. Family Support/Follow-up: A comprehensive continuum of care for seniors must provide family therapy, support groups and education for family members and caretakers. (LOC)
20. Age in Place Partnerships: Our regional efforts will emphasize joint ventures with private organizations who serve seniors in such a way to increase their ability to age in place. These organizations will include home health, faith based organizations, area agencies on aging and other appropriate partners. (regulatory)

21. **DMAS & Auxiliary Grants:** many of the seniors who require both residential and behavioral health services will not be appropriate for skilled or nursing facility care. Consequently, Assisted Living Facilities and Adult Homes will serve those seniors. For those seniors who do not have financial resources completely pay for those services, we will be required to creatively use Auxiliary Grants and other sources of revenue. (regulation)
22. **Geriatric Education:** topics of interest to the general public and for health care professionals will be provided by Region V CSB'S and their private partners.
23. **Specialized Transportation:** Seniors participating in our community based services will require transportation to include wheel chair lifts to take advantage of these opportunities.
24. **Guardianship Rules & Regulations:** For our most cognitively impaired patients we will be required to have a thorough understanding of the issues of consent to care and the ability of the patient to make an informed decision regarding treatment options.
25. **Prescription Assistance:** Our seniors and caretakers will require education and advocacy regarding proper utilization of Medicare Part D benefits. Our senior case managers will be a source of information in this regard.
26. **Specialized Services Similar to DAP.**
27. **Skilled Nursing Facilities:** Assistance with management of residents with behavioral health issues will be an important part of our comprehensive geriatric continuum.
28. **Education, training and consultation**
29. **Ramps, Rails and other issues related to access to care will be a concern as we expand our continuum.**

Model for the System of Care - Service Continuum

There are a significant number of issues that play a role in the financial sustainability of any services we may offer in the development of a comprehensive geriatric continuum. The model should also emphasize the role and dominance of community based care. In order to strategically plan for new services, expand existing services and evaluate the system itself, the proposed study model is:

System of Care – HPR V Geropsychiatry Services				
<ul style="list-style-type: none"> • Coordination of services across agencies, geography • Funding systems • Regional information systems 				
Adjuncts and Supports	Outpatient	Day Support	Long-term Care Facilities	Inpatient
Training	IOP	PSR	Nursing Homes	HGTC
Education	Partial Hospitalization	Adult Day Care	Geropsychiatric specialty services supplementing existing NH staff (RFI)	Inpatient hospitals
Care giver supports	Outreach/Mobile Assessment Teams		Assisted Living Facilities (ALF)	
Respite	Emergency Services		Adult Foster Care	
Mental Health Supports	Mobile Triage			
Supportive Residential Services				
Case/Care Management				

The key task to evaluating and promoting an effective system of care requires the identification of the needs/gaps. By using the prior focus group and survey results, the starting tasks are, but not limited to:

Inpatient care

- Preserves safety functions for older adults
- Geographic barriers to services exist for the Peninsula, Middle Peninsula, and the Eastern Shore
- Financial barriers exist due to reduced reimbursement
- Financial incentives are missing to expand services among private providers making the addition of any geriatric beds unlikely

- Limited numbers of acute care beds (medical /psychiatric)
- Limited beds for consumers experiencing behavioral challenges

Less Restrictive Alternative Treatment Settings

- Few locked units for consumers experiencing dementia
- Limited auxiliary grant opportunity
- Insufficient depth in outpatient services and service providers

In home/Aging in Place Supports

- Preserves the ability of the consumer to receive social and community supports without disrupting the quality of life
- Geographic barriers exist to services in rural and remote areas for:
 - Respite
 - Crisis Stabilization
 - In home support services (medical and psychiatric)
 - Care Giver Supports and Training
 - Family Supports and Training
 - Support and mental health services for care takers
 - Outpatient
 - Day Treatment and Day Supports
 - Case Management
- Integrated and comprehensive outpatient assessment and treatment programs. Development of a “Center for Quality Aging” that provides a comprehensive multi-dimensional assessment including medical, behavioral and functional assessments. Care will be driven by a comprehensive interdisciplinary treatment plan and coordinated with families and health and social services care providers. This program will provide specialized services in the areas of expertise in memory loss, depression, prescription drug abuse/dependency issues. Development of collaborative relationship with expanded primary health care network
- Partial Hospitalization – a structured, multidisciplinary, time limited physician supervised approach to treatment of geriatric psychiatric issues. Patients attend 4 hours a day for up to 5 days a week.
- Intensive Outpatient Services – also structured and physician supervised, however patients typically attend 2 to 3 hours a day 3 days a week.
- Adult Day Care – development of expanded Adult day care services in partnership with other pre-existing partners in the community. Adult day care for seniors provides leisure, recreation and diversion for patients with more severe cognitive impairments. Also provides respite for caretakers of these patients.
- Extensive Outreach Services
 - Mobile Intervention Program that provides assessment of behavioral needs in residential and treatment settings and provides a full range of treatment modalities including behavioral interventions, psychopharmacological assessment and intervention, counseling, behavior management, education and support.
 - Long-term care Facilities
 - Retirement Communities
 - Assisted Living Facilities

- Adult Homes
 - Private residencies
 - Hospitals / Healthcare Facilities
 - Church / parish ministries
- Specialized Care Management Services to insure coordination, communication and collaboration among health and human services providers. Care Management is an essential and unifying factor in services delivery throughout the continuum of care. It will focus on the clinical picture, benefits, concern about restrictiveness and intensity of care, and anticipation of the course of treatment over time. It will coordinate clinical resources to address issues such as what level of care is needed to ensure safety or to prevent significant risk, what intensity of treatment is required to bring about effective and timely change, when might restrictiveness and intensity change and what should the next balance be, do available resources permit the needed care now, and will they permit the anticipated course of treatment, and if not, what alternatives are available and acceptable? These and other questions lead to the development of focused, concrete goals for the initial phase of treatment as well as the entire episode of care. Such goals should be developed with and for the consumer and other significant persons in the consumer's life. This type of focused treatment planning will include regular reviews by the treating clinicians and care manager, focusing on progress made toward the agreed-on treatment goals and necessary modifications.

System of Care Services – Adoption of a No Wrong Door System

- Fragmentation exists in the coordination of services across agencies, made more acute with rural and remote locations
- Funding relies on programmatic models and not consumer-directed funds
- Hardware and legal barriers exist to the development of regional information systems
- Education and training for service providers
- Workforce development; development of specialized services in entry and advanced practices
- Educational / Support
 - Annual Symposium on Aging opened to community
 - Training and education for health care providers (physicians, nursing and mental health)
 - Development of a certification program for care providers (e.g., Certified Nursing Assistants (CNA) in behavioral interventions strategies and approaches
 - Expansion of community based educational and support group services for consumers and family

Preliminary Costs for a Full Continuum of Services

1. Inpatient Care – we propose a partnership with a private health care system on the Peninsula and expansion of existing partnerships on the Southside. As third party insurers continue to reduce reimbursement for mental health services to seniors, and costs of providing this care continues to rise, there is little incentive for the private sector to provide these specialty services. Consequently, we believe that certain financial incentives will be required to have a health system join us in this effort. Additionally, we believe that a collaborative approach to admission and discharge planning for these patients will be necessary to ensure good resource management. The provision of extensive outreach services will be extremely valuable in this effort. We propose a fund of \$300,000 be available to purchase bed days at inpatient facilities in the region with specialized inpatient services for uninsured seniors. Additional uses for this fund would be to assist in renovation costs to the private health care system that joins us in provision of this level of care. As there are no revenues associated with these expenses, we would request \$300,000 to cover these costs. This estimate provides for 63 admissions at an average length of stay of 7 days, or a total of 444 bed days per year.

2. Long Term Care Facility – for those patients who require more care than can be provided in a short 7 to 9 day stay we would seek a relationship with a provider of Long Term Care. These facilities have historically been reluctant to accept patients who have a history of a severe mental illness and/or severe cognitive impairment resulting in behavioral and management issues. The key to our success in forming such a relationship with a provider would be the placement of a multi-disciplinary treatment team on-site at the facility. The staff would provide medication management, psychological testing, counseling, behavioral interventions and training to the staff employed at the facility. The staffing for this effort would require the following:

Project Director	Nurse Practitioner	Registered Nurse
LCSW	Office Associate	Psychologist
Psychiatrist (20 hours)	CNA Pool	

Additionally, personnel expenses would total \$367,400. In the second year we would be able to better predict revenues generated by these professional staff and reduce costs of providing these services. This estimate provides supplemental services for an existing medical support of 30 nursing facility beds, 10,950 bed days per year.

3. Long Term Care Facility: Purchase of Nursing Home Beds. As a means to augment capacity, \$540,000 would be devoted to the purchase of 10 beds for a total of 3,650 bed days.

4. Purchase of beds at Assisted Living Facilities: Many patients being discharged from Eastern State or who can no longer remain at home as a result of co-existing medical and psychiatric issues do not require either skilled care or nursing facility care. Assisted Living facilities are most appropriate for many of these patients. A subset of these patients would require a secure or locked unit in an ALF. As ALF'S are reluctant to

accept these patients we would be required to purchase a number of beds throughout the region for these patients. As the average price of an ALF bed can cost \$40,000 a year we would request 400,000 to purchase 10 beds in Region V for fiscal year 2009. This provides for 3,650 bed days per year.

5. Partial Hospitalization Programs

- Providers would be required to have certification with Medicare as community mental health centers in order to participate.
- The PHP Medicare per diem is now \$208.00 per day
- At a projected 10 patients a day and if the PHP = gross charges of \$2,080 per day
 - i. $\$2,080 \times 21 \text{ days in a month} = \$43,680$ per month in gross charges.
 - ii. $\$43,680.00 \times 12 \text{ months} = \$524,160$ in annual gross charges.
- If the patients are covered by Medicare and some secondary 100% collections are possible.
- If we assume 20% indigent and 5% additional discounts for no secondary insurance then our projected net revenue could be:
 - $\$524,160 \times .75 = \$393,120$
 - Projected costs of \$728,566
 - shortfall would be \$335,446
 - This revenue does not include physician charges.
- Rent and other overhead costs may vary depending on where the program is housed.

6. Outpatient Services - IOP

Providers would be required to have certification with Medicare as community mental health centers in order to participate.

- Revenue projections are based on our ability to bill Medicare part A coverage at 80% of charges and the secondary insurance (to include Medicaid) will pay the remaining 20%.
- The projected revenues are discounted by 25% as we will potentially serve as high as a 20% indigent population.
- Medicare IOP can bill for up to 2 groups a day (LCSW) and provide no more than 11 billable hours a week to the patients. My plan has been to offer two tracks. Track 1 would meet Tuesday and Thursday from 10 to 1, with a 30 minute recreational therapy group (not billable) added to the two psychotherapy groups and a light lunch. This would be a track for a more physically and cognitively compromised group (SPMI).
- Track 2 would meet Monday, Wednesday and Friday, also from 10:00 to 1:00. This track would serve a group that is more physically intact and is perhaps late onset depressed patient.
- 10 patients a day who receive 2 billable process groups a day.
- Each group would be billed at \$92.00. Therefore each patient would create \$184.00 in gross charges each day.
 - i. $\$184.00 \times 10 \text{ patients} = \$1,840$ gross charges per patient day.
 - ii. $\$1,840 \text{ per day} \times 21 \text{ days in a month} = \$38,640$ gross charges per month
 - iii. $\$38,640 \text{ a month} \times 12 \text{ months} = \$463,680.00$ a year.

iv. $\$463,680.00 \times .75$ (decrease by 25%) = $\$347,760.00$ a year in potential collections.

7. Outreach/Mobile Assessment Teams:

Psychiatrist (16 hours)	\$75,712
Nurse Practitioner (1 FTE)	\$96,000 salary/fringe
Case Manager (1 FTE)	\$60,000 salary/fringe
RN (1 FTE)	\$60,000 salary/fringe
Administrative Aide (0.5 FTE)	\$20,000 salary/fringe
Nurse educator/trainer	\$15,000
Operating Costs 12%	

The budget for this service is:

Total Personnel	\$326,712
Total Operating and Administration	\$49,006
Total Expense	\$375,418

Service goals: Each team could cover up to three facilities and have capacity for community based assessments, 300 service providers trained and 200 individual clients per year.

8. Psychosocial Rehabilitation (PSR) – Develop and implement a senior adult day support program. These programs would provide specialized day support services and the cost of a 15 person program is estimated at \$113,396.
9. Adult Day Care - An important part of our continuum would include Adult Day Care specifically designed for a senior population. We would propose a joint venture with an established provider of these services. As our referrals to this center would have a higher incidence of an Axis I disorder than is customary, we would offer training and assistance to this center to assist them with management and treatment of this population. Many of our referrals to this level of care would be patients referred to either PHP or IOP with cognitive impairments that precluded them from admission to one of those programs. Anticipated staffing and costs for this venture are as follows:

- LCSW (8 hours per week)
- RN (10 hours a week)
- Psychologist (2 hours a week)
- Psychiatrist (2 hours a week)

Total personnel cost for this service of \$95,200. As we do not anticipate billing for these services we would request \$95,200 to cover these personnel expenses.

An alternative model is to purchase from existing capacity at local providers 2,610 days for a total of \$117,450, an estimated \$45 per day.