ALEXANDRIA COMMUNITY SERVICES BOARD PROGRAM DESCRIPTION

Older Adult Clinical Services Team

DATE: January 2023

The Older Adult Clinical Services Team (Geriatric MH team) provides comprehensive mental health services to City of Alexandria Residents over *65 in a manner that promotes quality of life and preserves independence. The Team meets older adults where they are, at home and in other community settings, providing intensive mental health services including consultation and assessment, individual and family therapy, intensive mental health case management, individual and family therapy, service coordination, outreach, advocacy, community education and support to caregivers.

Comprehensive geriatric mental health assessments are provided to all new or referred consumers. Services are provided to individuals with a mental health diagnosis, serious mental illness and/or dementia with behavioral problems and /or co-occurring (MH/SU or DD) disorders who, because of reasons related to their illness, are often reluctant to engage in services and experience homelessness, frequent psychiatric hospitalizations, or incarcerations. The team also provides emergency assessments for consumers; the Department of Behavioral Health and Developmental Services (DBHDS) guidance is that if possible older adults in need of pre-admission screening should be assessed by a clinician with skills and experience in assessment of older adults. The team leader also consults and coordinates with the Regional Older Adult Facilities and Treatment (RAFT) program regarding consumers from Alexandria with Serious Mental Illness who require assisted living or nursing home care with intensive mental health treatment needs. The RAFT program has a mental health team who consults with partnering facilities and provides services to the consumers in their residences.

I. Purpose and Goals

The Older Adult Clinical Services team is a multidisciplinary geriatric mental health program/service that helps individuals with a mental health diagnosis and/or dementia with behavioral problems, serious mental illness and/or co-occurring (MH/SU or DD) disorder. The team is modeled after Best Practice Guidelines for geriatric mental health programs that include the recommended elements of a multidisciplinary geriatric mental health team comprehensive care system including outreach, community assessment and treatment, case management, care coordination with medical providers and other supportive programs, consultation services, education and prevention. Services are delivered with the goal of achieving sustained recovery, promoting quality of life and preserving independence. The services are directed at: maximizing the consumer's level of functioning, coordination of medical and psychiatric care and promoting independence living by coordinating supportive services, while reducing symptoms. Thereby minimizing the frequency of psychiatric hospitalizations or incarcerations are vital recovery components. The team also provides emergency assessments for consumers of the team or community referrals during business hours, in response to the recommended DBHDS policy that

if possible older adults in need of pre-admission screening should be assessed by a clinician with skills and experience in assessment of older adults. The program goals are to: instill hope, support/improve self-sufficiency, and increase ability to live independently in community using appropriate supports as needed, increase periods of abstinence from substances, provide caregiver supports, education and outreach.

II. Older Adult Clinical Services Team's Vision Statement.

To further elaborate on the framework that the Older Adult Clinical Services Team is hoping to build, the following is the Vision Statement:

Through advocacy and innovative leadership, we envision an older adult clinical team that models empowered partnerships with our colleagues, consumers, families, and community. We provide accessible and integrated treatment and consultation services which exemplify culturally driven and equitable geriatric mental health specialty care and contribute to quality of life, independent living and coordinated physical and psychiatric care.

1. III. Eligibility Criteria

Eligible applicants will:

1. Present with symptoms of a mental health need or require a mental health evaluation.
2. Person will have one or more co-morbid chronic medical condition(s)
3. Person should be 65 years of age, (unless functionally geriatric*).
4. Reside in the City of Alexandria.
5. * Functionally Geriatric will be considered on a case-by-case basis.

Definition of Functionally Geriatric:

This definition is considered on a case-by-case basis for persons that are biologically not age 65 or over, but present with the following:

The comorbidity of chronic conditions, and /or geriatric syndromes and the frailty of older adults, combined with reduced adaptivity that affects the capacity to perform Individual Activities of Daily Living or Activities of Daily Living.

Common Geriatric Syndromes include frailty, failure to thrive, osteopenia, sarcopenia, falls and gait disturbance, incontinence, neurocognitive impairment and chronic depression.

Predictors of successful aging are (1) avoiding disease and disability, (2) maintaining physical and mental function, and (3) continued engagement with other persons in productive activities.

Consumers may have Medicare, Medicaid, private insurance, or no insurance. Limited assessment and referral services are available to those with HMO insurance.

IV. Ineligibility and Exclusionary Criteria

Applicants who at time of application or while in the program:

- Do not meet criteria for a mental health diagnosis or require assessment for one.
- Do not require therapy, intensive case management, outreach, engagement or assessment services.
- Choose not to participate in an individualized service plan and are competent to do so.
- Have needs that cannot be met with available program resources.
- Are under the age of 65 at time of referral (unless assessed as functionally geriatric).

V. General Program Information

Hours of Operation: The program operates Monday - Friday 8:30- 5:00 P.M.

Program Capacity: The program's capacity is approximately 100 ongoing clients, with additional brief community or emergency assessments.

Address of Program: 4850 Mark Center Drive Alexandria, VA 22311.

Program rules: All program rules are in the Client Handbook.

VI. Description of Services

The Older Adult Clinical Services Team provides comprehensive, clinical services including therapy and assessments, intensive case management services and consultations provided by staff that is specialty trained in gerontology and mental health; to assist individuals and their family members access needed services that are responsive to the person's individual needs and preferences. Services are delivered in accordance with consumer choice, are person centered, culturally driven, and recognize individual differences, abilities, and goals. Services include the following:

The best practice recommended elements of a multidisciplinary geriatric mental health team comprehensive care system are outreach, community assessment and treatment, case management, individual and family therapy, consultation services, education and prevention.

Outreach: is critical, because of a disproportionate amount of stigma regarding mental health treatment. Older adults and their family members often do not want to be identified with

the traditional mental health system. This stigma is a major barrier to care those results in underutilization. Only one third of older adults with a mental illness living in the community receive mental health services. Older adults will go to their medical doctor, complaining of ailments, but not discussing their mental health or substance abuse symptoms. Outreach has been shown to be an effective means of breaching this barrier. Older Adult Clinical Services staff are mobile and meet the individual in the home, with family members, or in other community settings and slowly develop a trusting relationship leading towards engagement in treatment.

Community Assessment and Treatment: Due to the barrier of stigma, community assessment and treatment is a critical part of Geriatric Mental Health care. In addition, there are also very frail, homebound elders, and/or demented elders being cared for in their homes that find it extremely difficult to come to scheduled office appointments due to fluctuating health, frailty, transportation barriers, and for severely the neurocognitively impaired persons and their caregivers, increased agitation may also be of concern. Assessment, therapy, and case management are all provided in the community.

Case Management: Case management is key to successful treatment due to the complexity of comorbid physical and mental health conditions, barriers with access to services, and the need to coordinate with other community resources for elder adults. The coordination of service networks, including primary care and specialty health care providers is a significant part of case management services with Geriatric mental health teams. This coordination enables the Senior citizen to live independently in the community with appropriate supports longer, and to improve their health and well-being.

Consultation Services: Geriatric Mental Health Specialists are rare. However, their expertise is valuable to the other community agencies and programs that are providing services to a geriatric person with mental illness. When clinical consultation is provided, an effort is made to share knowledge with the contacts and care providers. This assists them in better serving the geriatric mental health population and reduces barriers.

Education: Education has been found to be critical to providing care and services to the Geriatric Mental Health consumer. Education in the form of sharing knowledge, skills and experience, is provided to other care providers, services, families, and the community. Education helps to fight ageism and stigma and reduce barriers. It also has been found to reduce caregiver stress. An exchange of education and information with the primary care medical provider has been found to significantly improve the medical condition of the elderly person in mental health services.

Prevention: Education and preventive efforts regarding successful aging and mental health related topics have been found to help reduce stigma, ageism, and increase awareness regarding older adults and mental health. Prevention is also critical to the community, as family, friends and neighbors are often a significant source of referral for the geriatric person presenting with mental health symptoms.

Assessment and planning: Through the development of a trusting relationships, staff

partner with the consumer and families to complete a comprehensive geriatric mental health and psychosocial assessment and with the consumer. They identify specific needs, as well as barriers to service. This assessment process is recovery focused and culturally driven. Moreover, it forms the basis of an individualized service plan, reflecting consumer choice. Family members are encouraged to participate in this process, if permitted by the consumer/guardian. The consumer centered individual service plan (ISP) documents strengths, needs, goals, objectives and specific interventions.

Linking: With the individual service plan (ISP) as a guide, the older adult services clinician and consumer work together to access services necessary to manage and identify symptomology, secure entitlements, locate stable housing, maintain sobriety, and coordinate supportive services through other City and private programs and medical providers, serving older adults.

Assisting and Supporting: Once the consumer is linked to services, the older adult clinical staff and the consumer identify any potential barriers and need for on-going support or assistance to continue progress towards the goals in the ISP. Assistance might include travel training, fall risk or independent living assessments and skills or accompanying the consumer to medical and psychiatric appointments or services appointments to reduce anxiety. Regularly scheduled supportive counseling or therapy can provide hope for recovery and forward movement towards goal attainment. Monitoring service delivery and consumers' progress through coordination with other providers helps ensure continuity of care and early identification of new needs or medical concerns that may impact mental health, quality of life and progress towards goals.

Advocacy: Older Adult Clinical Services staffs also teach advocacy skills and are a proponent of support and assistance for consumers to overcome barriers in accessing needed services.

State Geriatric Hospital Discharge Planning/Coordination: Due to extensive barriers and challenges for Older Adults in the State Geriatric Hospital, and need for specialty geriatric assessments, an Older Adult Clinical Team staff is designated to provide care coordination and discharge planning with the support of the discharge planners from this agency to geriatric consumers in State hospitals under the guidance of the Team Supervisor.

VII. Service Modalities

Interventions used in the program are based on best practice guidelines in the field of geriatric mental health and substance abuse rehabilitation. Services are designed and implemented to enhance the quality of life of the persons served, improve functioning, and support the integration of the persons served in the community. Services are provided using the various modalities: individual therapy, group therapy, supportive counseling, family meetings, crisis intervention, treatment team meetings, case management, consultations, office visits, home visits, and visits throughout the community.

VIII. Special Populations

Persons served may be visually or hearing impaired or medically or neurocognitively impaired, or physically handicapped. The staffs are well trained in use of adaptive equipment. Specialized staff trainings in adaptive assessments and equipment may be used to support consumers in the provision of case management or therapy services. The Older Adult Clinical Team serves individuals who speak other languages, and efforts are made through bi-lingual staff or use of the Language Line Service to effectively engage and provide services to non-English speaking consumers.

IX. Resources Available to Provide Services

The Older Adult Clinical Services Team offices are located at 4850 Mark Center Drive Alexandria, VA 22311 The building is close to public transportation, shopping, banking, restaurants, and other City of Alexandria services. This building is highly accessible to individuals with mobility impairments. Vehicles are available for the transportation of consumers. There is space available to staff for private counseling sessions, group meetings and larger group activities. The Department Behavioral Health and Disabilities Services administrative management and clinical services are available to staff for consultation, as well as computer systems used for assessment and treatment planning.

X. Program Staff

The Older Adult Clinical Services Team staff is composed of a team of supervisory and direct service staff who work together to address the needs of consumers. The team also works with Masters level Internship Programs from Universities and at times has student interns assisting with basic supports and learning about Older Adult Mental Health. The team is under the Aging and Adult Services Division of The City of Alexandria Department of Community and Human Services, and coordinates/consults regularly with other DCHS programs especially Mental Health, Adult Protective Services, Aging Adult Services, Adult Day Care, Senior Transportation and the Area Agency on Aging staff. In addition, Older Adult Clinical Services staff members regularly interact with and coordinate care with other public and private service providers. These staff may include Department outpatient therapists, nurses, psychiatrists, residential staff, substance abuse staff, intellectual disabilities staff, probation officers, Wellness Center staff, detention center staff, residential program staff discharge planners from the state hospital and any other staff associated with the treatment needs of the consumer. All Older Adult Clinical Services staff meet or exceed the minimum requirements of their positions as described in the City of Alexandria Office of Personnel's Class Specifications and Job Descriptions. All staffs have gerontology experience and gerontology certificates or course work as well as previous experience working with adults who have a serious mental illness and/or dementia with behavioral problems, substance abuse disorders, and intellectual disabilities. The Senior Therapists and Therapist Supervisor are experienced in crisis intervention and able to evaluate competency and geriatric syndromes with expertise.

Family Services Specialist I: (1 FTE). The Family Services Specialist I provides outreach and case management with an emphasis on coordination of medical care and psychiatric care needs, as well as supports in the community. The FSSI also provides supportive counseling services to older adult mental health consumers and their families/caregivers as a member of the Older Adult MH Team. Coordinates consumer care and facilitates referrals to various community resources and service agencies. Performs some work with this population in consumer's residences, senior centers, and supportive living facilities.

Family Services Specialist II: (2 FTE). The Family Services Specialist II focus is on developing and expanding consumers' strengths and capacities and emphasizes medical care coordination, autonomy skills development and service coordination. The Social worker provides mental health case management services, group and individual supportive counseling, completes assessments including geriatric assessments, and develops individual service plans in collaboration with the consumer, family and other service providers, makes referrals to needed services, provide skills training, and coordinate and monitor care among the different programs and providers.

Senior Therapist: (3 FTE). Older Adult Clinical Services Therapists provide therapy, clinical assessments, home based intakes, emergency crisis intervention and assessments, case management, psycho-education services to consumers who have multiple complicated issues and minimal resources, requiring a more comprehensive array of services that will keep consumers engaged in treatment and the recovery process.

Therapist Supervisor: **(1 FTE).** The team supervisor is responsible for ensuring program compliance with all applicable licensing, Medicaid, and other regulatory and QA/UR standards; monitoring quality of service delivery; supervising and coordinating clinical screening, including risk assessments, with referral sources and determines suitability of each referral; completing monthly reports and reviewing quarterly statistical data; providing supervision and consultation to staff. The team supervisor makes recommendations for program and capacity changes and implements changes as indicated. The team supervisor also provides clinical assessments, emergency preadmission screenings and emergency community assessments, consultations, and trainings regarding older adult mental health. Team supervisor consults to the Regional Older Adult Facilities and Treatment program (RAFT), screens program referrals from Alexandria, provides care coordination for Alexandria RAFT program participants and advocates for the program.

Position	FTE	Schedule
FSS I	1	M-F 8:30 am – 4:30 pm
FSS II	2	M-F 8:30 am – 4:30 pm
Senior Therapist	3	M-F 8:30 am – 4:30 pm
Therapist Supervisor	1	M-F 8:30 am – 4:30 pm

Other Collaborating Center for Adult Services and Aging and Adult Services Division Staff

Medical Staff: Department psychiatrists and nurses provide case consultation to address and coordinate the medication needs of our consumers. Medical staffs also participate in treatment team meetings and/or family meetings on an as needed basis. Additional services may include intramuscular injections, pill box management/instruction, brief health assessments and laboratory work and home visits.

Emergency Services: Emergency Services staff is available 24 hours a day to provide consultation and evaluation of consumers in crisis. The Older Adult Clinical Team will provide emergency evaluation and screenings for consumers whenever possible during business hours. The team coordinates and consults with Emergency Services.

Aging and Adult Services Teams: Adult Protective Services, Aging and Adult Services and Adult Day Care provide collaborative services as needed. The Older Adult Clinical Services Team supervisor consults to Adult Protective Services regarding evaluations of competency and may assign other team Senior Therapists to assist as needed.

All Other CSB Programs under Residential, Community Supports, Substance Abuse, Detox, Forensic Psych and Intellectual Disabilities: The Older Adult Clinical Services Team coordinates for the optimum level of supports and care with any of the other Community Services Board Types of Programs aimed at serving persons with mental health, substance abuse or intellectual disabilities, as the older adult needs may be highly varied. The Older Adult Clinical Services Team also consults to these other programs, providing training, assessment and other interventions to assist staff across the Center of Adult Services with meeting needs of aging consumers.

Aging and Adult Services Division Center Director and Adult Services Center Director: directors are both available to provide leadership and administrative oversight to the program.

XI. Referral, Screening and Admission Procedures

Most referrals to the Older Adult Clinical Services Team are made by family or community members to the Team Supervisor. Home visit intake assessments are provided by the Team supervisor or Senior Therapists. The team also accepts referrals through Central Intake, but less than 25% come through that system because most older adults do not self-refer for treatment. When referrals come through Central Intake, the Older Adult Clinical Team Supervisor receives from the Intake Unit coordinator a referral for services. The Older Adult Clinical Services Team Supervisor screens the referral and reviews the clinical record to ensure eligibility criteria has been met and the need identified in the Individual Service Plan (ISP) that will be addressed through team services of therapy and/or case management. The team supervisor determines the therapist and case management staff availability and assigns the consumer to a team member and notifies the referral source. The assigned staff orients the consumer to the CRT, office hours, parking, transportation, waiting room and reception, emergency and crisis intervention, safety procedures for the building, confidentiality and program rules. The Older Adult Clinical Services staff meets with the consumer to revise the ISP to reflect the consumer's strengths, abilities, and preferences. If the consumer is found to be ineligible for services, the reason for the disapproval will be documented in the consumer's clinical record by the Team Supervisor. Consumers have

the right to appeal decisions.

XII. Wait List and Priority for Service

The Older Adult Clinical Services wait list is maintained by the Team Supervisor and is reviewed at least weekly. Consumers 65 years of age and above with a mental health diagnosis or evaluation need or *functionally geriatric are eligible. Consumers being discharged directly from *state and local* psychiatric hospitals are a priority for services and are assigned to a team member and not placed on the waiting list. Consumers referred by emergency programs including Adult Protective Services, Police, Fire/EMS, Code or referred following incarceration are urgent referrals. In general, priority will be given to those individuals who are at serious and immediate risk if not served. Level of need and ability to benefit from services will also be considered in prioritizing consumers who are on the waiting list.

Prioritization Codes used:

1 = Urgent: Adult Protective Services, Police, Fire/Code and other Urgent MH referrals for persons at risk/in crisis, and State or Local Hospital Discharge.
2= Moderate: Needs services or evaluation, has comorbid medical condition(s), but not an emergency, many community referrals are in this category.
3= Lower Risk: needs services or assessment, but supports are currently in place, or there is question of the individual's motivation for treatment.

NOTE: Urgency is triaged by Older Adult Clinical Team Supervisor with the information provided at time of referral.

***Meets Functionally Geriatric criteria and presents with a mental health need.**

XIII. Discharge Criteria

Discharge from CRT will occur when the consumer:

- Leaves the City of Alexandria; or is deceased.
- Meets the goals and objectives in the individual service plan and no longer demonstrates need for services.
- Demonstrates a need for an increased level of supervision and support not offered by the program, i.e., long term care.
- Chooses not to accept program services offered.
- Opts out of treatment and requests services be terminated.

XIV. Discharge Procedures

The consumer or guardian and family members, if appropriate, and the treatment team are active participants in the transition and discharge plan. The discharge is discussed with the consumer and a discharge plan developed. Based on the consumer's needs and preferences, a transition plan is made for continued support or supervision and for the sharing of necessary information with other service providers. If the consumer terminates without the development of a discharge or transition plan, all efforts are made, within confidentiality limitations, to ensure the consumer is informed about other service availability.

NOTE: Need for expansion and career ladder

The requests for services for the Older Adult Clinical Team exceed the ability to meet the demand. The team needs at minimum the addition of:
(1FTE) Family Service Worker 1 position for additional outreach and case management services.

1 MH Supervisor/ Team Leader to allow adequate time and supervision of the quality of work and program development of the entire team, continued clinical supervision as well as regional collaboration.

(At this time the Therapist Supervisor of the team provides all the above as well as the hands-on training and supervision of the staff, development, and consultations and clinical back up for all the team.)

Revised 1/2023
Rhonda Williams, LCSW
Supervisor, Older Adult Clinical Services

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