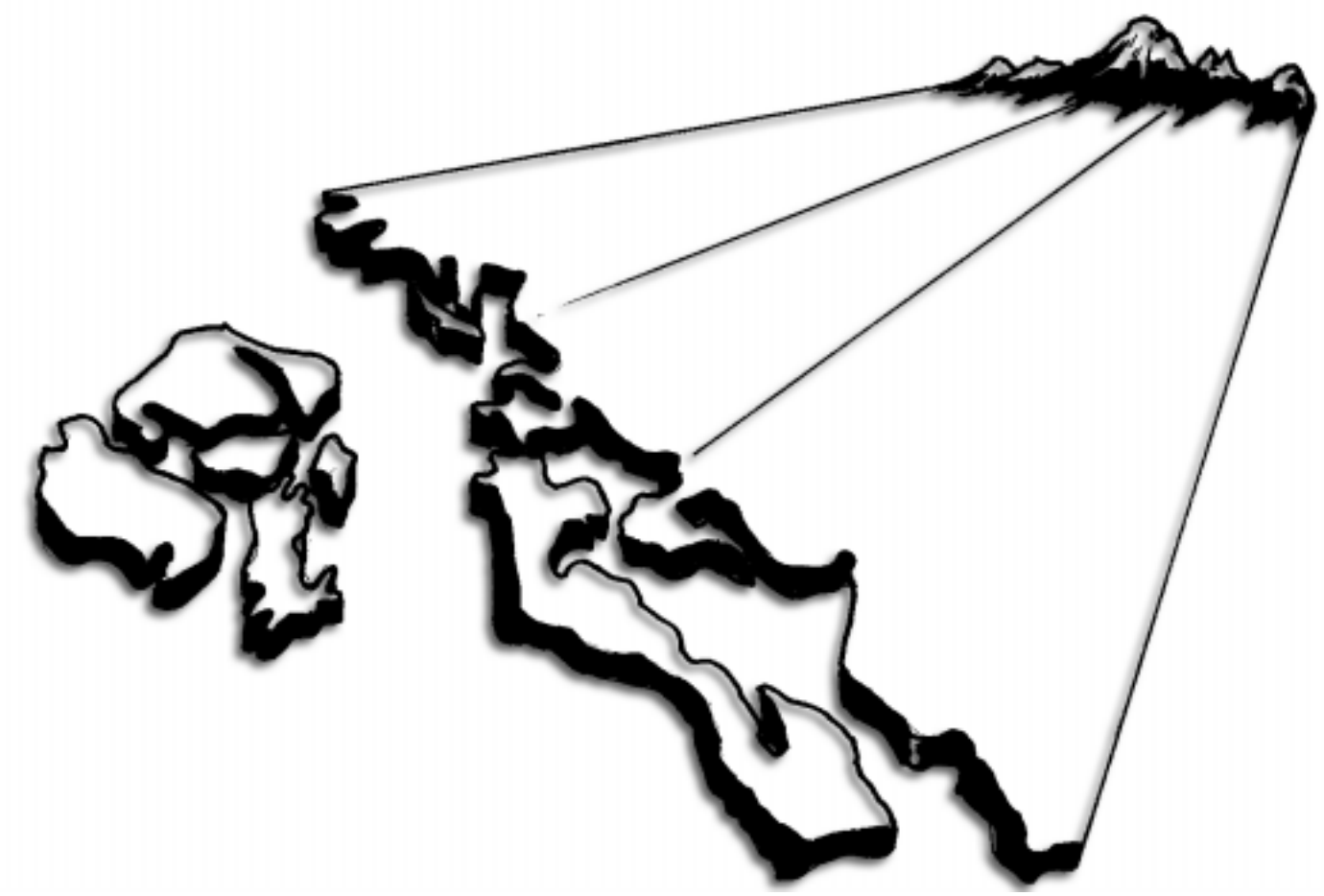


NORTH SOUND REGIONAL SUPPORT NETWORK
QUALITY MANAGEMENT AND OVERSIGHT COMMITTEE
COMMITTEE MEETING PACKET
MAY 18, 2000

North Sound Regional Support Network
QUALITY MANAGEMENT AND OVERSIGHT COMMITTEE
MAY 18, 2000
12:30 – 3:00 p.m.
NSRSN Conference Room

AGENDA

			Time	Page #
1.	Call to Order & Comments from the Chair	Chair Benjamin	5 minutes	
2.	Approval of April 2000 minutes	Chair Benjamin	5 minutes	2 - 3
3.	Old Business			
	A. Quality Management Plan update	Mr. McDonough	30 minutes	4 - 5
	B. Snohomish County Evaluation & Treatment Facility	Ms. Thompson	20 minutes	6 - 14
	Break		10 minutes	
	C. CHAP Update	Mr. Long	10 minutes	15
4.	New Business			
	A. Ombuds Report	Ms. Niemann	15 minutes	16 - 18
	B. Geriatric Services Plan	Mr. Long	20 minutes	19 - 41
5.	Other Business		10 minutes	
6.	Adjourn	Chair Benjamin		

NORTH SOUND REGIONAL SUPPORT NETWORK
117 N. FIRST STREET, SUITE 8
MOUNT VERNON, WASHINGTON
QUALITY MANAGEMENT OVERSIGHT COMMITTEE
MEETING SUMMARY – MARCH 16, 2000
NSRSN CONFERENCE ROOM

Members Present:

Chuck Benjamin, Chair
Chuck Albertson
Pam Benjamin
Linda Benoit
Dan Bilson
Dave Gossett
Marcia Gunning
Dolores Holtcamp
Terry McDonough
Gary Ramey
Francene Thompson

Staff Present:

Greg Long
Annette Calder
Ardis Moa
Betsy Niemann

Guests:

Bob LeBeau

1. CALL TO ORDER & COMMENTS FROM THE CHAIR

Chair Benjamin opened the meeting at 12:40 p.m. Chair Benjamin addressed the committee regarding the revisions to the agenda. Introductions were made.

2. APPROVAL OF MARCH MINUTES

Chair Benjamin asked if there were any changes or amendments to the minutes of March 16th. Hearing no changes, the minutes were approved by consensus.

3. OLD BUSINESS

A. QUALITY MANAGEMENT PLAN 2000 – Mr. McDonough

Mr. McDonough presented the Quality Management Plan 2000 to the committee. Discussion took place during and after the presentation. Ms. Gunning made a motion to recommend approval of the Quality Management Plan 2000 to the Board of Directors, seconded by Mr. McDonough. Discussion took place and the following changes were recommended:

- 1st bullet page 1-2, remove "regardless of their ability to pay"
- chart on page 1-5, add dashed lines connecting Board of Directors to Advisory Board and also Board of Directors to QMOC
- page 1-6, "covered services", remove existing chart and add chart from new contract
- Page 1-10, delete first paragraph at the top of the page
- Page 1-11, 2 members of the Board of Directors will be voting members of QMOC

Chair Benjamin called for a vote to approve as amended, all in favor, motion passed unanimously.

The committee took a ten-minute break at 2:00, reconvened at 2:10.

B. FIVE PRIORITY ISSUES – Bob LeBeau, APN

Mr. LeBeau provided the committee with an informational packet regarding training for providers and staff. For more information see attachment A.

C. CHAP STATEMENT OF WORK – Ms. Gunning

Ms. Gunning made a presentation to the committee regarding the CHAP Statement of Work. Discussion took place. See Attachment B for more information.

D. CRITICAL INCIDENTS SUBCOMMITTEE – Ms. Thompson

Ms. Thompson made a presentation to the committee regarding the status of the subcommittee. Discussion followed.

E. TULALIP TRIBES QUALITY MANAGEMENT PLAN – Mr. Ramey

Mr. Ramey provided the committee with an informational packet and made a presentation on the Tulalip Tribes Quality Management Plan. Discussion took place. See attachment C for more information.

4. NEW BUSINESS

A. QRT – Ms. Holtcamp

Ms. Holtcamp made a presentation to the committee regarding the Quality Review Team survey process from beginning to end. Discussion followed.

5. OTHER BUSINESS

There was none.

.

6. ADJOURN

Chair Benjamin adjourned the meeting at 3:15 p.m.

Respectfully submitted,

Annette Calder
QMOC Secretary

Please Note:
Regarding the referenced attachments herein, they are on file at the NSRSN as part of the official record. If anyone would like copies of these attachments please contact the NSRSN at (360) 416-7013 extension 230.

NSRSN COMMITTEE DISCUSSION FORM

AGENDA ITEM: NSRSN QM Plan 2000, First Quarter Review

PRESENTER: Terry McDonough

COMMITTEE ACTION: Action Item ( ) FYI & Discussion (x) FYI only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- **The NSRSN QM Plan 2000 was reviewed, to determine the status of activities scheduled in the plan for the First Quarter 2000**

- **Scheduled activities of the following departments have been accomplished during the First Quarter;**

- **Clinical/Quality Management**
- **Information Systems/Technology**
- **Local Crisis Oversight Review Committee**
- **Ombuds Services**
- **Quality Review Team**

(Attachment provided)

CONCLUSIONS/RECOMMENDATIONS:

- **Activities scheduled for the First Quarter 2000 in the NSRSN QM Plan 2000 have been accomplished**
- **Quarterly reviews of the QM Plan are effective for keeping completion and/or revision of the QM Plan timely.**
- **Quarterly reviews of the QM Plan will continue throughout 2000**

TIMELINES: Quarterly reports of the QM Plan review to QMOC
Next scheduled QMOC report: August 17, 2000

ATTACHMENTS: Chart listing departmental accomplishments

Quality Management Plan 2000 Quarterly Report

for

First Quarter 2000

Clinical/Quality Management Team	♦ Conducted Concurrent Review on 125 randomly selected charts from throughout the Region. ♦ Conducted quarterly review of the QM Plan 2000.
Local Crisis Oversight Review Committee	♦ County coordinators (or designee's) met at NSRSN on 3-7-2000. Committee principles were established. Meetings will continue quarterly.
Information Systems/Technology	♦ Information specified in QM Plan 2000 is being tracked and included in Concurrent Review reports. ♦ Monthly IS/IT reports are being made available to NSRSN Management Team and Clinical/QM Team.
Ombuds Services	♦ Ombuds services continued throughout the quarter. A new Ombuds staff person was hired (Betsy Niemann).
Quality Review Team	♦ Conducted surveys, performed services, provided reports during First Quarter. Made test calls to VOA and provider agencies during the quarter.

NSRSN COMMITTEE DISCUSSION FORM

AGENDA ITEM: Snohomish County E & T Follow-Up

PRESENTER: Francene Thompson

COMMITTEE ACTION: Action Item ( ) FYI & Discussion (X) FYI only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
On May 1, 2000, a follow-up visit to the Snohomish County Evaluation and Treatment Center was conducted to monitor the implementation of the facility's Corrective Action Plan of December 17, 1999. Results were as follows:

- Most of the deficits requiring corrective action have been successfully resolved:
  - ✓ Physical exams are being completed within 24 hours of admission
  - ✓ Clients' Rights Forms are being provided to all new admissions and efforts made to obtain signatures are documented
  - ✓ Ombuds brochures are available to consumers at all times
  - ✓ Staff/patient ratios are recorded on tracking forms at all times
  - ✓ A Recreational Therapist provides 30 hours of activities per week
  - ✓ All alleged assaults are documented and reported
- One area of corrective action has not yet been implemented
  - ✓ Special Population/Multi-Cultural Consultations are not being obtained for all patients falling into those population groups
  - ✓ A plan to resolve this deficit has been submitted and accepted

CONCLUSIONS/RECOMMENDATIONS:

- The facility has successfully implemented most of the corrective action steps outlined in their plan of December 17, 1999. The only remaining issue is the provision of specialist consultations for all patients from multi-cultural/special populations. It is recommended that an additional 90 day monitoring period be established to assure completion of this objective.

TIMELINES:

- Final report made to QMOC following the 90 day monitoring period

ATTACHMENTS:

- Snohomish County E&T Follow-up Report and Attachments

MEMORANDUM

TO: GREG LONG

FROM: FRANCENE THOMPSON, CLINICAL/QUALITY MANAGER

SUBJECT: SNOHOMISH COUNTY EVALUATION AND TREATMENT CENTER UPDATE

DATE: 5/5/00

As a follow-up regarding the implementation of the Snohomish County Evaluation and Treatment Center's Correction Action Plan of December 17, 1999, a review team visited the facility on May 1, 2000. The team consisted of the NSRSN Clinical/Quality Manager and Manager of the Office of Consumer Affairs. Thana Martin, Director of Compass Inpatient Programs, assisted the team in accessing pertinent materials and files related to this review.

A. Eight randomly selected patient charts were reviewed with regard to the following previously cited areas of concern:

1. Ensuring histories and physicals are completed within 24 hours.

    - All consumers had received physical exams within 24 hours of admission.

    - Such physical exams usually included a TB test upon entry. (Although such tests are not statutorily required, they are highly advisable as a health precaution for both staff and other patients.)

    - Lab work was completed on all patients at the time of their physicals.

2. Signed copies of Client Rights are in every chart.

    - Six of the eight charts included signed Client Rights Forms, executed at the time of admission.

    - The remaining two charts had notations regarding efforts to obtain a signature and the reasons why Rights Forms were unsigned, including patient inability or unwillingness to provide a signature.

3. Documentation identifying that the individualized needs of patients from special populations are being addressed.

    - Three of the charts reviewed indicated consumers from special populations.

    - None of these charts reflected the use of special population consultations in treatment planning and/or implementation

B. Facility records were reviewed to verify monitoring of the following:

    1. Documentation of Ombuds brochures being available to patients at all times

        - Facility records showed that daily checks are made and recorded, assuring that Ombuds brochures are easily accessible to all patients at all times (See sample of report forms attached).

2. Documentation of staff / patient ratios

    - Excellent records of staff / patient ratios are being maintained by the facility. Staffing levels appear to be sufficient to provide for safety and quality services in the program.

3. Availability of a Recreational Therapist to provide activities for patients during their inpatient stay.

    - A qualified Recreational Therapist is now employed at the facility, 30 hours per week, including some evening and week-end schedules.

    - All patient charts include documentation of the offering of recreational activities whenever they are available on the unit. Notes reflect whether or not the patient chose to participate, along with observations about that participation.

4. Documentation of all alleged assaults.

    - Ms. Martin provided a report of a recent alleged assault by an employee on a patient, accompanied by investigative reports, copy of a Critical Incident Report, and information that the patient has been assisted in contacting the Ombuds Department for further support.

SUMMARY:

STRENGTHS:

This review revealed that most of the activities and goals outlined in the Corrective Action Plan have been achieved. These are as follows:

1. Physical Exams are being completed for newly admitted patients within their first 24 hours in the facility.

2. All patients are being advised of their rights and being asked to sign Consumer Rights Form at the time of admission. Only in situations which are clearly noted in patient charts, are signatures missing from these forms.

3. Ombuds brochures are available to all patients at all times in the facility.

4. Records of staff / patient ratios are being maintained on an ongoing basis.

5. A Recreational Therapist has been employed who schedules regular activities for patient, while patient charts reflect their participation in such activities.

6. Documentation of alleged assaults by staff members at the facility appear to be maintained as appropriate.

REMAINING ISSUES:

The only area of corrective action which has not yet been satisfied is the need to perform special population consultations whenever appropriate. Staff have been have advised of this deficit and have responded by providing a new procedure for assuring the appropriate use of consultation for special populations. See attached the procedure and form proposed by the facility to assure correction of this concern. Performance of this new procedure may be monitored by NSRSN as follows:

- NSRSN Quality Management will monitor the program for the next 90 days to ensure implementation of this new special population consultation procedure.

RECOMMENDATION:

The Snohomish County Evaluation and Treatment Center has demonstrated commitment and expended considerable effort in resolving the issues raised in the December 17, 1999, on-site review.

It is recommended that, following monitoring of implementation of the new Special Population Consultation Procedure for 90 days, the Snohomish County Evaluation and Treatment Center will have successfully completed the Corrective Actions Plan initiated on December 15, 1999.

Pages 10 – 14 are not available electronically. They are forms from the provider. If you would like copies please contact the NSRSN @ 360-416-7013

NSRSN COMMITTEE DISCUSSION FORM

AGENDA ITEM: Children's Hospital Alternative Program (CHAP)

PRESENTER: Greg Long & Linda Benoit

COMMITTEE ACTION: Action Item ( ) FYI & Discussion (x) FYI only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
CHAP is designed and funded to be an intensive community treatment program in foster homes for high need children. It is intended to be an alternative to the hospital or residential group treatment. For several years, the utilization of this program has been low in most counties in the North Sound Region, despite tremendous demand for this type of service. Outcomes had been less than desirable with a number of children being hospitalized from this program.

The NSRSN and DCFS have been closely reviewing this program for the last year. Significant deficiencies were found so corrective action plans were required and developed. As described last month, a new, more specific contract was developed.

Problems are continuing in at least three counties in the North Sound Region. A major shortcoming has been the lack of sufficient foster homes.

CONCLUSIONS/RECOMMENDATIONS:
This is the most intense and lengthy clinical quality improvement process the NSRSN and its member counties have undertaken.

Skagit County is recommending that their CHAP be shifted to a different provider. Island and San Juan Counties as well as the NSRSN are considering how their programs can be improved.

TIMELINES: Monitoring is occurring on a monthly basis. Current contract ends December 31, 2000.

ATTACHMENTS: None

NSRSN COMMITTEE DISCUSSION FORM

AGENDA ITEM: Ombuds 1st Quarter 2000 Report

PRESENTER: Nancy Johnson/Ardis Moa/Betsy Niemann

COMMITTEE ACTION: Action Item ( ) FYI & Discussion (x) FYI only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

- Additional Ombuds staff has been hired
- First draft of Ombuds Policies and Procedures Manual has been completed
- First meeting of Ombuds Oversight Committee convened on February 23, 2000
- Placement of anti-stigma information in school libraries, along with book markers, brochures and other information about mental illness

CONCLUSIONS/RECOMMENDATIONS:

None

TIMELINES:

Not Applicable

ATTACHMENTS:

Quarterly Report

NORTH SOUND REGIONAL SUPPORT NETWORK
QUARTERLY OMBUDS SERVICE REPORT

January 1, 2000—March 31, 2000

Number of New Cases: 28

Number of Cases Carried Over from the Prior Period: 23

30 days: 8
60 days: 3
90 days: 2
Prior: 10

Source of New Cases:

Consumer for self: 33
Relative: 11
Other: 5

Demographic Information: *(Identify number in each category if client provides information)*

Male:	19	Adults:	48
Female:	27	Children: (0-17)	6
Elderly: (55+)	2		

Cultural/Ethnic:

African American:	1	Asian/Pacfiic Is:	0	Caucasian:	33
Hispanic:	4	American Indian/Alaskan Native:	1		

Cases by County:

Island:	5	San Juan:	0	Skagit:	7
Snohomish:	22	Whatcom:	17		

Total Contacts: 637 **Total Unduplicated Contacts:** 120

Information Request: 17 Referral Request: 0

Complaint Data:

Denied or Reduced Access to Services: 19	Physicians & Medications: 18
Dignity and Respect: 13	Financial Administration Services: 6
Quality/Appropriateness: 7	Residential: 17
Phone Calls not returned: 3	Transportation: 0
Service/Client not Involved in Treatment Planning: 7	Emergency Services: 8
Violation of Client Rights: 11	Other: 5

Type of Resolution:

Telephone Information/Referral Provided: 5
Referral to Quality Review Team: 0
Resolved through Conciliation/Mediation: 3
Arbitration: 0
Fair Hearing: 0
Other: 2
Not pursued: 10

CC: Executive Director, NSRSN
NSRSN Board of Directors
Office of Consumer Affairs Manager
Quality Management Oversight Committee
NSRSN Advisory Board

Mental Health Division
P.O. Box 45320
Olympia, WA 98504

NSRSN COMMITTEE DISCUSSION FORM

AGENDA ITEM: Mental Health Services for Older Adults Plan

PRESENTER: Greg Long

COMMITTEE ACTION: Action Item ( ) FYI & Discussion (x) FYI only ( )

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
The NSRSN is facing a dramatic and continuing growth in the older adult population over the next twenty years. The amount of services to older adults has remained stable due to restrictions on the provision of mental health services under Medicare. The growing demand for mental health services for older adults is likely to effect the nature, quantity and quality of services for all age groups.

The plan presents twenty-three (23) recommendations and prioritizes ten (10). A value system underlying how services should be delivered to older adults is also presented. Many key proposal are recommended in this plan including:

- Far greater collaboration with other systems.
- Expansion of housing/residential to allow older adults to be released from Western State Hospital or to allow people to live in the least restrictive setting possible.
- Need to expand the number of geriatric staff and retrain existing staff to be prepared to effectively serve older adults.
- Development of better crisis and consultative services to nursing homes.
- Dramatic expansion of the peer counseling program
- Clearer commitment to serving the mental health needs of people with dementia.

CONCLUSIONS/RECOMMENDATIONS:
Currently, this plan is being circulated to the public for comment. At this time, there has been much praise for the plan, but few changes have been recommended. Additions, questions, and critiques are welcomed at this time.

TIMELINES:
Comments are accepted until June 1, 2000

ATTACHMENTS:
Mental Health Services for Older Adults

DRAFT

MENTAL HEALTH SERVICES FOR OLDER ADULTS

EXECUTIVE SUMMARY

The older adult population in the United States and in the North Sound Region will nearly triple in the next twenty (20) years. Planning for this major shift is fundamental in being prepared to provide high-quality community mental health services in the future.

When the NSRSN signed the integrated inpatient/outpatient contract, the optimum coordination and handling of acute and inpatient mental health services became a significant challenge and opportunity. Excellence in acute and inpatient mental health services will assure the quality of these services, as well as potentially provide additional financial resources to enhance the entire community mental health system. This is the third planning process aimed at improving services conducted by the NSRSN. Previous planning processes studied the Evaluation & Treatment Centers (E & Ts) and acute services for children.

The following report and recommendations indicate that inpatient service capacity is expanding and will most likely continue to expand to meet the needs of older adults in the North Sound Region. Significant initiatives need to be implemented to prepare the North Sound Region's community mental health services to more effectively serve older adults. More mental health services will be needed in light of the rapid growth in the number of older adults. More effective crisis outreach services are needed to prevent older adults from being hospitalized or institutionalized. More specialized housing alternatives are needed for mentally ill older adults—especially for those currently at Western State Hospital. More and better services for demented, uncooperative or combative older adults should be developed. The needs of this dramatically increasing older adult population will best be served through an unprecedented, new and increased level of collaboration and advocacy among all organizations serving seniors. Finally, even with excellent collaboration, advocacy for additional funding for expanding and enhancing services for this dramatically increasing population needs to occur.

PRIORITIZATION OF RECOMMENDATIONS

Below are the top ten priority recommendations. In the body of the report, each of these recommendations are discussed in more detail and ordered by the length of time and probable cost of implementation. Many additional, lower priority recommendations are made in the main report.

- Significant expansion of mental health services to older adults will be needed to keep pace with the expanding older adult population. Since the majority of older adults would prefer to live in their own homes, mental health services need to be designed to support this preference.

MENTAL HEALTH SERVICES FOR OLDER ADULTS

- Better collaboration and coordination with other organizations serving older adults offers the best chance at significantly improving mental health services for older adults. An aim of these collaborative efforts should be to resolve categorical funding issues so older adults receive coordinated and comprehensive services without significant gaps and advocate for additional funding.

- Older adults who are medically and physically stable or are known to be effectively treated at an E & T should be sent to an E & T. Older adults who have a concurrent medical condition/disorder or are fragile should be treated at a community hospital. CDMHPs when committing an older adult who has concurrent, unresolved medical issues, is physically fragile, or would otherwise be better treated in a hospital, should send this individual to a community hospital.

- Western State Hospital discharge placement options and other specialized housing need to be increased for older adults.

- Traditional caregivers must be encouraged to be involved in treatment. Families need to be trained and supported in care giving. Special attention and training of staff in using, supporting and building natural supports should occur.

- Significantly expand Senior Peer Counseling Programs. Currently, small programs are operating in Snohomish, Skagit, and Whatcom Counties.

- Expand outreach access to older adults by expanding the Gatekeeper Programs.

- More collaborative relationships need to develop between Crisis Counselors/CDMHPs and nursing homes and other senior facilities. The mental health system needs to take leadership in developing more constructive relationships.

- Provide educational/consultative programs for nursing homes, adult family homes and family caregivers on handling resistive/unmanageable older adults.

- Services should be designed to assure greater availability and more rapid scheduling of older adults with psychiatrists.

MENTAL HEALTH SERVICES FOR OLDER ADULTS

This report is designed to focus on the recommendations. The recommendations are presented three ways. In the Executive Summary, the top ten proposals are prioritized. All recommendations are developed in more detail in the section on Recommendations-Best Practices. Finally, the all recommendations are prioritized based on development-time and cost factors.

TABLE OF CONTENTS

MENTAL HEALTH SERVICES FOR OLDER ADULTS

INTRODUCTION/OVERVIEW

The NSRSN Planning Committee has evaluated acute services over the last year. Initially, this started with an in-depth study of the Evaluation and Treatment Centers. Coming out of that planning process, the major decision was made not to close or convert an evaluation and treatment center into some other type of facility. In follow-up to this decision, it was deemed necessary to review acute services for children and older adults. The children's acute services study was completed in May of 1999 and reviewed by the NSRSN Board. This report on older adult mental health services has widened to cover many areas beyond just acute services.

In the context of this report, Older Adults are people who are 60 years or older.
Mental Health Services for older adults are comprised of hospital services, crisis services (which includes outreach services, ITA services, crisis beds, in-home aids, etc.), access to general ongoing services including gatekeeper services, peer counseling services, case management and outpatient counseling services. Many older adults entering the mental health system are not long term chronically mentally ill individuals, but individuals who through the aging process are encountering serious mental health issues like bereavement, depression, and dementia.

Planning and programming need to begin to be preparing for the major demographic change of our aging society. Washington State recently began a major study of mental health services for older adults. The results of this study will not be available for approximately 12 months.

This study was conducted with the guidance of the following individuals and organizations:

- Mary Good, *NSRSN* Consumer
- Sandi Jones, Betty Rogers, and Sandy Stork, Managers of NSRSN Providers' Older Adult Programs
- Bob LeBeau, Director of Clinical Operations, *APN*
- Josselyn Winslow, Executive Director, *Alzheimer Society of Washington*
- Gary Williams, Geriatric Specialist, *NSRSN*
- Greg Long, Assistant Director/Planner, *NSRSN*
- Numerous other professionals were consulted or provided information for this study, including: Selena Bolotin, *Stevens Hospital*, Reed Henry, *Affiliated Health Service - Sedro Wooley*, Dottie Collins, *Valley General Hospital*, Thana Martin, *E & Ts,* and John Piachetelli, *Washington Institute*.

VALUES/PRINCIPLES UNDERLYING SERVICES

- Elderly individuals have the right to the same quality and quantity of services as all other persons.

- Elderly individuals have unique needs that should be addressed by specialized (trained) staff.

MENTAL HEALTH SERVICES FOR OLDER ADULTS

- Older adults should be housed and treated in the setting of their choice and should live in the least restrictive setting that is appropriate. The majority of older adults desire to live in their own homes.

- Family and natural supports are the traditional caregivers for older adults. They should be involved in treatment as much as they and the consumer want and to the extent that they are able.

- Older Adults, their families and their advocates should be involved in the planning of services, supports and policies necessary to meet their mental health needs. (Consumer-driven System)

- The community mental health system has partial and shared responsibility to treat people with dementia.

- An integrated/collaborative, medical/mental health treatment approach is fundamental to good treatment for older adults. Significant improvement in services to older adults is most likely to occur through the improvement of coordination of services and funding sources.

NEEDS/PROBLEMS

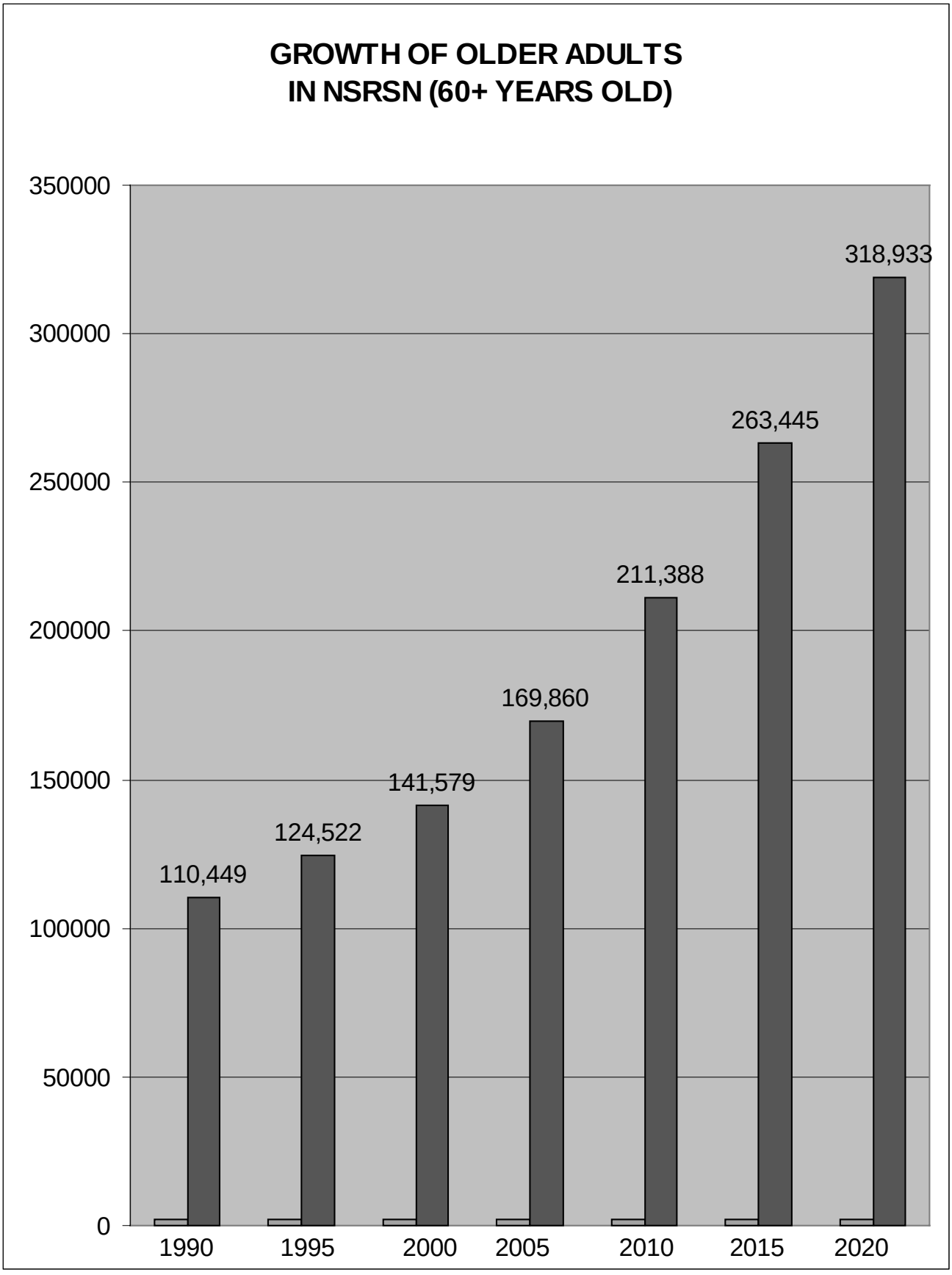
- The North Sound Region, along with the entire United States, is facing enormous growth in the number of older adults over the next 20 years. The number of older adults is expected to more than double in the next 20 years and will be increasing 20% or more every five years in the North Sound Region. The tables below and the bar graph on the following page display the major change in service population that the mental health system needs to prepare for.

GROWTH OF OLDER ADULTS IN NS REGION *(60+ YEARS OLD)*							
YEARS							
COUNTIES	**1990**	**1995**	**2000**	**2005**	**2010**	**2015**	**2020**
ISLAND	10,875	12,789	15,053	17,753	21,531	25,988	30,597
SAN JUAN	2,797	3,025	3,292	3,802	4,637	5,511	6,368
SKAGIT	16,156	17,584	19,170	21,737	26,202	32,070	38,980
SNOHOMISH	59,658	68,609	79,811	98,992	125,481	158,685	193,785
WHATCOM	20,963	22,515	24,253	27,576	33,537	41,191	49,203
TOTAL	110,449	124,522	141,579	169,860	211,388	263,445	318,933

Data is from WA State OFM/Forecasting 1/19/96

PERCENT GROWTH OF OLDER ADULTS IN NSRSN (60+ YEARS OLD)						
	1990-1995	**1995-2000**	**2000-2005**	**2005-2010**	**2010-2015**	**2015-2020**
NSRSN	12.74%	13.90%	19.98%	24.45%	24.63%	21.06%

Data is from WA State OFM/Forecasting 1/19/96


GROWTH OF OLDER ADULTS
IN NSRSN (60+ YEARS OLD)
350000
300000
250000
200000
150000
100000
50000
0
110,449
124,522
141,579
169,860
211,388
263,445
318,933
1990
1995
2000
2005
2010
2015
2020

MENTAL HEALTH SERVICES FOR OLDER ADULTS

Attachment A contains demographic projections for the growth of older adults in each county by age group.

This growth suggests that there will be a dramatic increase in demand for mental health services along with all other support services for older adults.

- Currently, the number of older adults receiving mental health services has not grown and is actually decreasing.

Number of Older Adults Receiving Services from NSRSN

	1993	1994	1995	1996	1997	1998
Adults Served	1732	1877	1997	2257	1931	1789

Data is provided by Marsha Murray, APN. From NSRSN/BDS database. Includes both Medicare and Medicaid Consumers.

- This decrease in services is attributed to the many financial barriers to mental health treatment for older adults. Billing of Medicare for outpatient community mental health services in the North Sound Region and in many other areas has decreased significantly or even stopped. Medicare policies have restricted what types of provider professionals can bill Medicare and there are greater restrictions on where services can be provided. Medicare payment is often too low to cover the cost of services.

  Older adults are frequently reluctant to engage in mental health treatment for there may be significant out-of-pocket expense. These individuals frequently are not eligible or have notable spend downs before they become eligible for Medicaid because they are on Social Security and have Medicare. The community mental health system's payment structure based on Medicaid eligibility works better for low-income children and chronically ill young adults than for low-income older adults.

- The North Sound Region Community Mental Health System is meeting its parity targets for older adults for all ethnic groups, except for African-Americans. The NSRSN needs APN to develop a plan to achieve parity for African-American older adults. Outreach should be conducted to the African-American Community to develop relationships. Below are parity figures for 1-1-99 to 6-30-99.

Parity Data for Older Adults (60+)

			Parity			Parity Status	
Ethnicity	**MHD**	**RSN**	**Minimum**	**Standard**	**Exemplary**	**MHD**	**RSN**
African-American	3	3	23	28	40	Non-compliant	Non-Compliant
Asian/ Pacific Islander	53	53	10	14	22	Exemplary	Exemplary
Hispanic Native American	13	13	8	14	19	Compliant	Compliant
Other/Unknown	307	318	-	-	-	N/A	N/A

Data is from NSRSN/MHD database. Parity requirements are from NSRSN/MHD Contract.

Technically, the NSRSN is not meeting parity for white older adults because more than half of all older adults served by the community mental health system are on Medicare. Individuals on Medicare-only are not entered into the NSRSN database at present. If this problem is not resolved, the NSRSN may face sanctions in the future which would in turn be passed on to APN.

- Too often older adults do not receive all of the available services that might assist them, or they are not received promptly because of these multiple organizations and funding systems. Many agencies with many different sources of funding provide services to older adults. Each program and each agency has different restrictions on who can be served and scopes of services. Below are only partial listings of the systems involved in serving older adults and the multiple funding sources.

Other systems serving Older Adults

- Area Agencies on Aging
- Home and community services
- Home health care agencies
- Senior information and referral
- Nursing homes
- Adult family homes
- Private practitioners

Etc.

Possible Funding Sources

- Private pay
- Private insurance
- Medicare
- Medicaid
- Social Security
- Federal Block Grant funds

Etc

- Older adults frequently need more psychiatric services than younger people do for they have complex blends of psychiatric, medical, and pharmacological issues. Psychiatrists need to evaluate them earlier in the course of treatment and be more actively involved in monitoring their progress in treatment. General medical practitioners need psychiatric consultation around older adults, especially those living in nursing and adult family homes.

  Mis-management/non-compliance with medications by older adults is a significant treatment issue and requires close supervision. Lack of money for expensive psychiatric medications is sometimes a contributing factor.

- Due to the complexities of the funding systems, mental health providers believe they lack the resources in older adult programs to hire sufficient staff. Recruitment of trained geriatric specialists, especially those with the appropriate credentials to bill Medicare is difficult and expensive.

- Residential placements for older adults with serious and persistent mental illnesses are becoming more difficult to find. The general public, family members of consumers, and most human service organizations are becoming more conscious and more conservative about public safety. This is understandable in light of the tragic deaths that occurred in the nursing home in Arlington. Governmental and facility regulations and procedures are becoming more cautious. Older adults with any history of combativeness or violence are becoming harder to place in nursing homes and boarding homes. These organizations are also demanding more rapid and effective interventions when a mental health consumer becomes agitated.

- More/better treatment of alcohol/substance abuse is needed for older adults.

MENTAL HEALTH SERVICES FOR OLDER ADULTS – CURRENT PRACTICES

Community Inpatient Services

In the North Sound Region, there are five hospitals that have psychiatric inpatient programs. Three of these programs are designed specifically for Older Adults. Older adult consumers also use hospitals in King County.

The E & Ts are used for a limited number of older adult involuntary hospitalizations. Many older adults who need involuntary hospitalizations have medical conditions requiring full hospital services so these individuals are sent to the community hospitals or occasionally directly to Western State Hospital.

The majority of these services are paid for by Medicare and not by Medicaid or the NSRSN. Many low-income older adults never become Medicaid eligible, as they receive Social Security and Medicare Benefits. If a Medicaid-eligible older adult is hospitalized, the NSRSN typically only pays the Medicare co-payment from its Medicaid Inpatient funds, which is only $720 for the entire hospitalization. Hence, the NSRSN has limited direct data on the majority of the older adult psychiatric hospitalizations. See *Attachment B* for descriptions of the inpatient programs in the North Sound Region.

Community Hospitals' Concerns about Community Mental Health Services for Older Adults

- More residential placement options are needed for mentally ill older adults:
  - Improved coordination with Home and Community Services is needed
  - More residential placement options with sufficient staff who are trained to work with older adults with challenging behaviors
  - Creative residential options are needed (Elder respite beds in nursing homes, crisis stabilization beds in nursing homes, crisis stabilization aids working in homes, etc.) and
  - Older adults end up staying in the hospital longer than necessary until appropriate hospital alternatives can be established.

- More intensive community mental health supports are needed when older adults are discharged from the hospital:
  - Hospital staffs believe that community mental health services are limited due to lack of funding; and
  - Hospital staff report that community mental health staffs say they cannot do outreach to older adults' homes.

- Hospitals report problems with community facilities not being able to use any kind of restraints. This state policy may need advocacy. Older adults are being kept in hospital longer than otherwise medically necessary due to this issue.

- Better coordination is needed between all community agencies in supporting older adults before and after inpatient care.

MENTAL HEALTH SERVICES FOR OLDER ADULTS

Inpatient Services-Western State Hospital

Currently, twenty-eight (28) of the NSRSN's approximately ninety (90) patients at Western State Hospital are older adults. Fourteen (14) of those patients are older adults with dementia. The average length of stay of these demented patients is twenty-seven (27) months. See *Attachment C* for details on NSRSN older adult patients at Western State Hospital. There are only very limited discharge resources for these individuals. Many of these older adults were sent Western State Hospital because they were unable to live in their own homes, adult family homes, or nursing homes. Once a person has been sent to Western State Hospital, many facilities are reluctant to take them. They fear that they will be difficult to manage or dangerous to other residents. More restrictive Nursing Home and Adult Family Home regulations are also limiting placement options.

Crisis Services

Older adults use of the crisis line appears to be limited. Only 6,358 of the 89,108 calls to the crisis line between July 1, 1998 and June 30, 1999 are identified as being in regards to individuals over age fifty-five (55).

The major area of concern in crisis services is services to facilities. Many nursing homes, assisted living facilities, adult family homes, and boarding homes have concerns that they cannot get rapid enough response, nor will the crisis worker or CDMHP be able to resolve the problem to a facility's satisfaction. (See Nursing Home section)

Outpatient Services

Outpatient services for older adults are provided in all parts of the North Sound Region. As documented earlier, the number of consumers served has been stable or even declined in the last several years. This can be attributed to the tightening of Medicare regulations on the billing for mental health services and less emphasis on outreach to older adults as the mental health system has shifted to managed-care approaches. There are gatekeeper programs in Whatcom and Skagit County providing training to key community members to make referrals. In general, more mental health services are needed for older adults.

Nursing Homes

Nursing homes play a critical role in mental health care of older adults. Nursing homes are frequently the last stop before an older adult is psychiatrically hospitalized, and the initial resource when an older adult is being discharged. There are thirty-nine (39) nursing homes by the DSHS registry in the North Sound Region with approximately 3,600 beds. Currently, several hundred NSRSN Consumers reside in these facilities.

The NSRSN staff conducted a mail-out/phone survey of nursing homes. Thirty-three (33) of the thirty-nine (39) nursing homes in the North Sound Region responded to the survey. The Directors of Nursing Services were interviewed at each of the nursing homes. A detailed summary of this report is available upon request.

MENTAL HEALTH SERVICES FOR OLDER ADULTS

There is a dynamic tension between nursing homes and the community mental health system that underlies the criticism of the mental health system in this survey. Both nursing homes and the community mental health system are under requirements to provide mental health services to older adults. None of the organizations believe they have the level of funding to provide the ideal level of mental health services. APN has put considerable effort into developing protocols and procedures to improve crisis services to nursing homes in the last year. Now, these protocols need to be implemented and used by all parties. Further, efforts by the mental health system are needed to meet the needs of nursing homes. Below is a summary of the findings of the survey.

Nursing Homes' ideas for improving crisis and commitment services:

- More rapid responses for crisis services are needed. Issues around response time need to be reviewed and resolved between nursing homes and the mental health crisis system.
- More outreach assessments/investigations are wanted.
- Crisis workers/CDMHPs and the mental health system need to develop approaches to managing people who nursing homes feel cannot be served safely and believe should be committed.
- Crisis Workers/CDMHPs need to have more training and experience with older adults and nursing homes. Crisis Workers/CDMHPs need to understand the capabilities and limitations of nursing homes, especially around the handling of acting-out individuals.
- Crisis Workers/CDMHPs need to be more collaborative and cooperative with nursing homes.

Nursing Homes' suggestions for improving on-going Mental Health Services:

- More rapid response for on-going services is needed.
- More services are needed.
- More psychiatric medical services are needed.
- Better education of community about services.
- Perception of nursing homes is that community mental health staffs are overworked and not available enough.

RECOMMENDATIONS – BEST PRACTICES SUMMARY

Inpatient Recommendations

- **Older adults who are medically and physically stable or are known to be effectively treated at an E & T should be sent to an E & T. Older adults who have a concurrent medical condition/disorder or are fragile should be treated at a community hospital. CDMHPs when committing an older adult who has concurrent, unresolved medical issues, is physically fragile, or would otherwise be better treated in a hospital, should send this individual to a community hospital.** Older adults have a higher frequency of physical illnesses and chronic medical conditions than do children or younger adults. The availability of a range of doctors, allied medical staff and labs may provide a higher quality of service for older adults. Several community hospitals are developing specialized gero-psychiatric units within our region. A quality of care clinical decision is made by CDMHPs on whether an older adult when being involuntarily committed should be involuntarily detained to a community hospital or an E & T. A thorough medical review and screening by the CDMHP and Emergency Room physician should direct this decision.

MENTAL HEALTH SERVICES FOR OLDER ADULTS

- **Community Hospitals' psychiatric units, gero-psychiatic units, and the E & Ts are willing and able to serve older adults at acute inpatient levels of care. There is sufficient involuntary inpatient capacity at this time in this Region. The North Sound Mental Health System should collaborate with community hospitals in serving older adults.** Medicare pays for the majority of inpatient costs for most older adults. Inpatient capacity for older adults is likely to expand in the future as long as Medicare funding is sufficient to support inpatient psychiatric services. If Medicare funding policies shift, significant impact on the community mental health system will occur. The community mental health system needs to monitor these policies, as it is depending on the Medicare System to cover these expensive services.

  Western State Hospital discharge placement options and other specialized housing need to be increased for older adults. NSRSN needs to collaborate closely with Home and Community Services in developing and maintaining Adult Family Homes and Nursing Homes that are capable and willing to take demented and mentally ill older adults with behavioral issues. Greater use of in-home crisis aids to support older adults and staff at these facilities should be considered as short-term stabilization interventions. Medicaid Personal Care also can be used to pay for longer-term in-home supports.

  Continued emphasis needs to be placed on utilizing Western State Hospital for only those older adults whom need specialized inpatient care. As the older adult population increases, efforts will need to be increased to direct individuals to the least restrictive, clinically appropriate community setting possible. The NSRSN will be at financial risk for increased use of Western State Hospital. NSRSN staff is participating in the Western State Hospital/RSN Geriatric Task Force.

Outpatient Treatment Recommendations

- **Expansion of services will be needed because of the expanding older adult population**. **Since the majority of older adults would prefer to live in their own homes, mental health services need to be designed to support this preference.** The demographics of our society are changing and the community mental health system needs to begin to shift its emphasis, funding of services and staffing patterns. Special emphasis needs to be placed on increasing services to African American and Caucasian (white) Older Adults.

- **Traditional caregivers must be encouraged to be involved in treatment. Families need to be trained and supported in care giving. Special attention and training of staff in using, supporting, and building natural supports should occur.** When desired and appropriate, this is the most humane, normalizing and cost-efficient way to serve older adults.

- **More outpatient staff will need expertise in working with older adults.** Priority needs to be placed on hiring and/or training staff to assure a sufficient number of staff with expertise in treating older adults. NSRSN or provider agencies may want to consider training paradigms to increase existing staff expertise in working with older adults for the need for these services will be increasing dramatically.

MENTAL HEALTH SERVICES FOR OLDER ADULTS

- **Expand Senior Peer Counseling Programs.** Currently, small programs are operating in Snohomish, Skagit, and Whatcom Counties. This type of program builds upon the growing number of older retiring adults. Many want to assist others in their community. It helps to overcome the problems of loneliness and isolation that too many older adults experience. These programs are not replacements for outpatient mental services provided by geriatric mental health specialists, but they can expand the capacity of these more expensive programs. They should continue to clinical counseling focus and as such need to be connected with a mental health organization. Senior Peer Counseling Programs should be significantly expanded in the counties where they are functioning and extended into the other counties in the Region. Regular, high-quality supervision is essential to expand and manage these programs. The book, In the Company of their Peers, is a book written by Community Mental Health Services staff describing this model of service.

- **Expand outreach access to older adults by expanding the Gatekeeper Programs.** Traditionally, it has been difficult to reach and engage older adults in mental health services. Gatekeeper programs train community members who are in contact with older adults to enable them to refer individuals who appear to be experiencing mental health problems for mental health services. Currently, small programs are operating in Skagit and Whatcom Counties.

- **Expand outreach access through initiating strategies to develop collaborative relationships with community physicians (systematic approach).** Government studies indicate that nearly 90% of older adults see a primary care physician at least once a year. Hence, outreach educating primary care physicians on how to use the community mental health system for Medicaid eligible and low-income older adults could be effective in engaging older adults. Consideration might be given to seeking grant funding and hiring a physician or a nurse to conduct this outreach effort. Another approach would be to get a signed release from the older adult at intake and send copies of treatment plans, psychiatrist notes and treatment updates to the primary care physician. More collaborative relationships with community physicians might develop if mental health treatment is viewed as an adjunctive medical treatment.

- **Expand outreach to African-American Older Adults.** The community mental health system is below parity to this important yet small group in our North Sound Region. A special plan needs to be developed to meet State Parity requirements. A minority mental health specialist suggested doing out reach to African-American Churches.

- **Provision of outreach mental health services to older adults needs to continue and expand.** In attempting to create greater system efficiency, pressures exist to deliver clinical services to older adults from mental health center offices. Outreach-based mental health treatment works better. It is to deliver services on an outreach basis so adequate funds need to be allocated to follow this approach to serving older adults. Many older adults cannot or will not come to a mental health center office. Services need to be designed recognizing that the majority of older adults would prefer to live in their own homes. Studies around the nation report that eighty (80) percent of older adults living in their own homes prefer this arrangement. Over thirty (30) percent of older adults living in nursing homes or other facilities would prefer to be in their own homes.

- **Develop better services for acting-out older adults.** Nursing homes, adult family homes, and family caregivers provide enormous amounts of care, including emotional support and supportive mental health services. A major concern of these groups is how to react when an older adult becomes aggressive and difficult to manage. When an older adult becomes aggressive, these groups want rapid response and practical actions to control these behaviors. Educational/consultative programs for nursing homes, adult family homes and family caregivers on handling resistive or unmanageable older adults would give these groups support and direction in handling this aggressive behavior. Crisis Workers, CDMHPs and outpatient staff needs to be trained and able to consult constructively on the handling of acting-out older adults with these caregivers. On-line crisis plans should be developed ahead of time on individuals who are likely to have crises. The use of in-home crisis aides could become an important resource to families, facilities and crisis staff.

- **More collaborative relationships need to develop between Crisis Counselors-CDMHPs and nursing homes and other senior facilities. The mental health system needs to take leadership in developing a more constructive relationship.** APN has made significant effort to develop protocols to serve nursing homes and adult family homes. The nursing home surveys indicate there continues to be a high level of frustration with mental health services by these organizations. Some nursing homes are acknowledging that these services may be getting better. Crisis Service and CDMHP programs need to improve services, resolve systems barriers, and develop positive relationships with these organizations. A concerted and ongoing effort is needed to improve these facilities' satisfaction with community mental health services. Collaboration and coordination of services needs to occur between crisis service workers and CDMHPs with geriatric specialists working with these facilities. Even when these staff work for the same agency, follow-up services need to be coordinated.

- **Community Mental Health Providers should develop a standard package of mental health services, which they would offer to nursing homes and adult family homes on a contractual basis.** The packages might consist of assessment, counseling, consultation, in-facility psychiatrist services, medication consultation, and coordinated/enhanced crisis services. These facilities could then choose to contract for these more comprehensive services. This would lead to greater clarity about what the community mental health system is able to provide to nursing homes.

- **Services should be designed to assure greater availability and more rapid scheduling of older adults with psychiatrists.** The aim would be to reduce hospital placements and improve relationships with nursing homes and other community agencies that are requesting this service. This is a highly requested service, but is expensive. Creative approaches should be explored to meet this need.

Coordination of Services and Advocacy

- **Better Collaboration/coordination with other organizations serving older adults offers the best chance at significantly improving mental health services for older adults.** An aim of these collaborative efforts should be to resolve categorical funding issues so older adults could receive coordinated and comprehensive services with out significant gaps and advocate for additional funding.

MENTAL HEALTH SERVICES FOR OLDER ADULTS

- **County or Regional Geriatric Coalitions should be set up to coordinate services for Older Adults at management levels and advocate for better services.** These coalitions should include all groups that serve older adults. AARP and NIMH are advocating this approach. Training has been conducted in Whatcom County on developing these coalitions. Participants should be as inclusive as possible and include consumers, family members, advocates, mental health agencies, private mental health providers, medical doctors, Area Agencies on Aging, HCS, Senior Services, nursing home and adult family home operators, home health care, hospitals, substance abuse agencies, etc.
- **Clinical coordination teams (community teams) that meet on a regular basis are needed to coordinate care for high-need individual older adults.** Again, participants in these groups should be as inclusive as possible and include mental health agencies, private mental health providers, medical doctors, Area Agencies on Aging, HCS, Senior Services, home health care, hospitals, substance abuse agencies, etc. Snohomish County has done development work in forming the "A Team" to coordinate adult clinical services. In the past, Whatcom County had a cross-functional geriatric community team that even paid some private professionals to attend.
- **On-line Crisis Plans should be developed on acting-out individuals or other complex clinical situations with all interested parties having input.** The availability of these plans need to be publicized to the community and then utilized.
- **Geriatric Program Managers from the NSRSN provider agencies should meet on at least semi-annually to focus on quality improvement and system improvement.** Since major expansion and changes in Geriatric Mental Health Services will be necessary in the coming years to meet the enormous increase in older adults, these expert specialists need to be collaborating with each other, the NSRSN, and other organizations to lead this major system shift.

- **Responsibilities for services to people with dementia need to be clarified and collaborative relationships across service systems must be established. The NSRSN and its providers should commit to treating the mental health needs of Medicaid eligible and low-income adults with dementia.** The community mental health system has the expertise to handle the mental health needs of people with dementia and therefore must accept this responsibility. Collaborative partnerships must be developed with family members, nursing homes, adult family homes, primary care physicians, assisted living programs, and home care organizations aimed at providing coordinated and holistic care to people with dementia. These parties share joint responsibility in improving services to people with dementia.

MENTAL HEALTH SERVICES FOR OLDER ADULTS

PRIORITIZATION OF IMPLEMENTATION OF RECOMMENDATIONS BASED UPON COST AND DEVELOPMENT –TIME FACTORS

Recommendations that could be implemented with minimal cost and within one year:

- Older adults who are medically and physically stable or are known to be effectively treated at an E & T should be sent to an E & T. Older adults who have a concurrent medical condition/disorder or are fragile should be treated at a community hospital. CDMHPs when committing an older adult who has concurrent, unresolved medical issues, is physically fragile, or would otherwise be better treated in a hospital, should send this individual to a community hospital.

- Community Hospitals' psychiatric units, gero-psychiatic units, and the E & Ts are willing and able to serve older adults at acute inpatient levels of care. There is sufficient involuntary inpatient capacity at this time. The North Sound Mental Health System should collaborate with community hospitals in serving older adults.

- Traditional caregivers must be encouraged to be involved in treatment. Families need to be trained and supported in care giving. Special attention and training of staff in using, supporting, and building natural supports should occur.

- More collaborative relationships need to develop between Crisis Counselors/CDMHPs and nursing homes and other senior facilities. The mental health system needs to take leadership in developing a more constructive relationship.

- Expand outreach to African-American Older Adults.

- Better Collaboration/coordination with other organizations serving older adults offers the best chance at significantly improving mental health services for older adults. An aim of these collaborative efforts should be to resolve categorical funding issues so older adults receive coordinated and comprehensive services without significant gaps and advocate for additional funding.
  - County or Regional Geriatric Coalitions should be set up to coordinate services for Older Adults at management levels and advocate for better services.
  - Clinical coordination teams (community teams) that meet on a regular basis are needed to coordinate care for high-need individual older adults.
  - On-line Crisis Plans should be developed on acting-out individuals or other complex clinical situations with all interested parties having input.
  - Geriatric Program Managers from the NSRSN provider agencies should meet on at least semi-annual basis to focus on quality improvement and system improvement.

MENTAL HEALTH SERVICES FOR OLDER ADULTS

Recommendation that will require one to two years to implement and require some additional funding or re-allocation of existing funding:

- Western State Hospital discharge placement options and other specialized housing need to be increased for older adults.

- More outpatient staff will need expertise in working with older adults. Priority needs to be placed on hiring and/or training staff so there is a greater number of staff with expertise in treating older adults.

- Crisis workers, CDMHPs, and outpatient staff need to be trained and able to consult constructively on the handling of acting-out older adults.

- Develop better services for acting-out older adults. Provide educational and/or consultative programs on handling resistive/unmanageable older adults for nursing homes, adult family homes and family caregivers.

- Develop region-wide packages of recommended mental health support services for which nursing homes and other residential services could contract. This would reduce frustrations about mental health services.

- Responsibilities for services to people with dementia need to be clarified and collaborative relationships across service systems must be established. The NSRSN and its providers should commit to treating the mental health needs of Medicaid eligible and low-income adults with dementia. NSRSN and its providers need to work collaborative with nursing homes, physicians, families, and other systems to multiple needs of individuals with dementia. These parties share joint responsibility in improving services to people with dementia.

- Provision of outreach mental health services to older adults needs to continue and expand.

- Services should be designed to assure greater availability and more rapid scheduling of older adults with psychiatrists competent and experienced in serving elders.

MENTAL HEALTH SERVICES FOR OLDER ADULTS

Recommendations that will require significant additional funding and/or require two or more years to implement:

- Significant expansion of services to older adults is needed because of the expanding older adult population. Since the majority of older adults would prefer to live in their own homes, mental health services need to be designed to support this preference. Special emphasis needs to be placed on increasing services to African American and Caucasian (white) Older Adults.

- Significantly expand Senior Peer Counseling Programs. Currently, programs are operating in Snohomish, Skagit, and Whatcom Counties.

- Expand outreach access to older adults by expanding the Gatekeepers programs.

- Expand outreach access through initiating strategies to develop collaborative relationships with community physicians.

Attachment A

POPULATION GROWTH IN EACH OF THE NORTH SOUND COUNTIES

All data from the following tables is from the Washington State Office of Financial Management from the forecasting study of January 19, 1996.

ISLAND COUNTY							
	YEARS						
AGES	**1990**	**1995**	**2000**	**2005**	**2010**	**2015**	**2020**
60-64	2,652	2,767	3,515	4,536	6,017	6,975	7,539
65-69	3,104	2,983	3,130	3,825	4,899	6,448	7,431
70-74	2,345	3,013	2,943	3,051	3,671	4,707	6,176
75-79	1,531	2,065	2,670	2,608	2,693	3,221	4,145
80-84	747	1,222	1,638	2,108	2,070	2,141	2,559
85+	496	739	1,157	1,625	2,181	2,496	2,747
TOTAL	10,875	12,789	15,053	17,753	21,531	25,988	30,597
SAN JUAN COUNTY							
	YEARS						
AGES	**1990**	**1995**	**2000**	**2005**	**2010**	**2015**	**2020**
60-64	664	707	925	1,223	1,652	1,809	1,908
65-69	792	741	720	897	1,157	1,547	1,727
70-74	581	694	632	621	749	968	1,297
75-79	391	452	522	487	478	570	743
80-84	207	246	280	325	308	304	364
85+	162	185	213	249	293	313	329
TOTAL	2,797	3,025	3,292	3,802	4,637	5,511	6,368
SKAGIT COUNTY							
	YEARS						
AGES	**1990**	**1995**	**2000**	**2005**	**2010**	**2015**	**2020**
60-64	3,824	3,787	4,521	5,782	7,914	9,503	10,667
65-69	3,953	3,955	3,840	4,553	5,842	8,011	9,752
70-74	3,240	3,717	3,668	3,587	4,231	5,484	7,598
75-79	2,500	2,773	3,167	3,143	3,096	3,662	4,828
80-84	1,467	1,901	2,114	2,431	2,435	2,429	2,908
85+	1,172	1,451	1,860	2,241	2,684	2,981	3,227
TOTAL	16,156	17,584	19,170	21,737	26,202	32,070	38,980

MENTAL HEALTH SERVICES FOR OLDER ADULTS

SNOHOMISH COUNTY							
	YEARS						
AGES	**1990**	**1995**	**2000**	**2005**	**2010**	**2015**	**2020**
60-64	15,827	17,349	21,183	29,979	41,105	50,299	56,496
65-69	14,954	15,739	17,190	21,293	29,342	40,235	48,773
70-74	11,347	14,017	14,757	16,324	19,752	27,258	37,199
75-79	8,331	9,834	12,224	13,066	14,174	17,161	23,620
80-84	5,217	6,507	7,751	9,797	10,327	11,231	13,582
85+	3,982	5,163	6,706	8,533	10,781	12,501	14,115
TOTAL	59,658	68,609	79,811	98,992	125,481	158,685	193,785
WHATCOM COUNTY							
	YEARS						
AGES	**1990**	**1995**	**2000**	**2005**	**2010**	**2015**	**2020**
60-64	4,997	5,004	5,745	7,789	10,772	12,881	13,966
65-69	4,950	4,968	4,899	5,550	7,485	10,347	12,368
70-74	4,016	4,596	4,559	4,481	5,083	6,881	9,500
75-79	3,238	3,428	3,919	3,871	3,834	4,384	5,952
80-84	2,035	2,466	2,629	3,010	2,995	3,004	3,465
85+	1,727	2,053	2,502	2,875	3,368	3,694	3,952
TOTAL	20,963	22,515	24,253	27,576	33,537	41,191	49,203

Attachment B

INPATIENT SERVICES IN NORTH SOUND REGION

In the North Sound Region, there are five hospitals that have psychiatric inpatient programs, three of which have programs designed specifically for Older Adults. Two Evaluation and Treatment Units (E & T) also provide involuntary inpatient services. Older adult consumers, especially from Snohomish County, also use hospitals in King County.

The North Sound E & Ts are used for a limited number of older adult involuntary hospitalizations. Many older adults who need involuntary hospitalizations have medical conditions requiring full hospital services so these individuals are sent to the community hospitals or occasionally directly to Western State Hospital.

Affiliated Hospital – Sedro Wooley: *Ten (10) beds in a special psychiatric unit for older adults.*

The older adult unit at Affiliated Hospital opened in December of 1997. It is a locked unit that treats both voluntary and involuntary patients. Approximately 70% of the population coming into the unit have dementia and usually are having problems with unmanageable behavior and/or disorientation. Average length of stay is 10.25 days.

Affiliated Hospital – Mt. Vernon: *Fifteen (15) beds in a community hospital setting.*

This is a general psychiatric unit, which served twenty-seven (27) Older Adults in 1998. This unit accepts both voluntary and involuntary patients. This program serves older adults who still have good cognitive functioning. Disoriented or demented older adults may be referred to the Affiliate Hospital-Sedro Wooley Program.

Valley General Hospital – Monroe: *Twelve (12) beds in a special psychiatric unit for older adults*.

The older adult unit at Valley General Hospital opened in December 1998. It is a locked unit that treats both voluntary and involuntary patients. The most common diagnoses for individuals coming into this unit are dementia, depression and psychosis.

Stevens Hospital – Edmonds: *Up to ten (10) older adults in specialized geriatric program. This program is part of a twenty-two bed community hospital psychiatric unit.*

In the fall of 1999, Stevens Hospital developed a specialized geriatric inpatient program. This program is designed for disoriented and wandering older adults.

St. Joseph's Hospital – Bellingham: *Twelve-bed community psychiatric unit.*

St. Joseph's is a general community psychiatric unit. It does not have a specialized older adult unit, but it treats a significant number of older adults. It handled 29 older adults of the 265 total psychiatric admissions in 1998.

Attachment C

WESTERN STATE HOSPITAL OLDER ADULT/DEMENTIA STUDY

Data was from NSRSN staff members who manage resources at Western State Hospital (WSH). Data was obtained between 8/1/99 and 10/11/99.

Number of Patients:	28
Oldest:	98
Youngest:	61
Average Age:	72.1

County of Origin of Patients

Island:	2
San Juan:	0
Skagit:	4
Snohomish:	19
Whatcom;	3

Age Range in Months

60-69 yrs:	14
70-79:	7
80-89:	6
90+:	1
TOTAL:	**28**

Length of Stay At WSH in Months

0-3 mo.:	5
4-6 mo.:	7
7-12 mo.:	1
13-24 mo.:	8
25-36mo.	2
37-59 mo.	0
60+ mo.:	5
TOTAL:	**28**

Diagnosis:	**Number of Patients**	**Percentage of Patients**
Dementia:	14	50%
Schizophrenia, Undiff.:	2	7%
Schizophrenia, Paranoid:	2	7%
Schizo-affective Disorder:	3	11%
Bi-Polar/Mood Disorder:	4	14%
Unknown:	3	11%
TOTAL:	**28**	

Resources Needed for Discharge:

Skilled Nursing home:	14
Adult Family Home:	3
Private home with supports:	2
TBI Facility:	2
Not dischargeable: (Stay at WSH):	4
Type of placement is currently unknown:	3
TOTAL:	**28**