Virginia Department of Behavioral Health & Developmental Services

Report on the Item 321 N.4 of the 2021 Appropriations Act

Dementia Services Workgroup Report

To the Chairs of the Senate Finance and House Appropriations Committees

Tuesday, December 7, 2021

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797 PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

Contents

Preface

Item 321 N.4 of the 2021 Appropriations Act directs the Department of Health and Human Resources to convene a workgroup consisting of state agencies, providers, and other stakeholders to make recommendations for enhanced services for individuals with dementia in order to reduce preventable hospitalizations. The language states:

> *The Secretary of Health and Human Resources shall convene a workgroup including the Department of Behavioral Health and Developmental Services, the Department of Social Services, the Department for Aging and Rehabilitative Services, providers, and other stakeholders, to identify existing services and make recommendations for the development, evaluation, implementation, and scaling-up of evidence-based and evidence-informed services for persons living with dementia in order to improve quality and availability of care and reduce preventable hospitalizations. The workgroup shall also include as part of its analysis, an evaluation of the Northern Virginia Regional Older Adult Facilities Mental Health Support Team (RAFT) and determine the feasibility of replicating the RAFT model elsewhere in the Commonwealth to support persons living with dementia with disruptive behaviors or severe and persistent behavioral health conditions. The workgroup shall report to the Governor and the Chairmen of the House Appropriations and Senate Finance and Appropriations Committees, and the Joint Commission on Health Care by November 1, 2021.*

Introduction

Virginia's state mental health hospitals have been experiencing increasingly high bed census rates over the past several years. Efforts to curb high census rates – and improve safety for both patients and staff – have led to targeted efforts to divert individuals from unnecessary hospitalization in state facilities as well as quickly discharge those who are clinically ready to be discharged to appropriate community services. One large population with above-average lengths of stay is the population of individuals with dementia and other forms of cognitive impairment. Often, these patients have no underlying serious mental illness and yet may exhibit behavioral and psychological symptoms that result in a temporary detention order (TDO) and transfer to a state hospital. As a first step, temporary detention and inpatient hospitalization could be avoided through proactive prevention in individual's home and community environments, whether that be with a family member, in an assisted living facility (ALF), or nursing facility. Absent intervention, behavioral and psychological symptoms may escalate and make inpatient care unavoidable. However, state mental health facilities struggle to provide the type of treatment that these individuals require, which includes non-pharmacological interventions as a first line of treatment. This results in individuals being admitted to state psychiatric facilities with limited step-down or treatment options after they are stabilized. More appropriate care options would include memory care support in the community, ALF, a nursing facility or other residential environment. This report provides additional background on this issue, including recommended services for individuals with dementia, and makes recommendations for the creation or expansion of specific services in Virginia to better serve this growing population.

Background

Needs of Individuals with Dementia

Dementia is an umbrella term for several disorders that affect everyday activities and progressively worsen multiple cognitive skills such as judgement, visuospatial ability, language, memory and/or personality. It can cause enormous suffering and financial costs, and is a significant public health problem. According CDC data, the number of deaths from all forms of dementias in the US ranks just behind heart disease and cancer[1] and dementia is a major pre-exiting risk factor for COVID-19 death[2]. In the United States, Alzheimer's disease alone affects about six million individuals over the age of 65.[3] Individuals with dementia may require assistance in completing tasks, forget names or old memories, get easily lost, etc. Though there is no single underlying cause of dementia, there are multiple risk factors including age, family history, race/ethnicity, heart health, and traumatic brain injury.[4] According the 2020 Lancet Commissioner on Dementia Prevention, Intervention, and Care[5], there are 12 modifiable risk factors that could reduce the global burden of dementia by 40%. Some of these include decreased depression, decreased alcohol use, nutrition and exercise, and social engagement. The interventions recommended by the Lancet Commission include both person-centered as well as family-centered approaches that focus on psychosocial interventions, overall physical wellness,

[1] https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_02-508.pdf,
[2] https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm
[3] Alzheimer's Association Facts and Figures 2021
[4] https://www.cdc.gov/aging/dementia/index.html
[5] https://www.thelancet.com/article/S0140-6736(20)30367-6/fulltext

and caregiver mental wellbeing. According to the Commissioner, hospitalizations, including psychiatric hospitalizations, are "distressing and are associated with poor outcomes and high costs".

About 150,000 Virginians are impacted by Alzheimer's disease, which is the most common form of dementia (about 60 to 80 percent of cases). Still, other Virginians suffer from other forms of dementia, such as vascular dementia, Lewy Body dementia, frontotemperal dementia, and mixed dementias. Additionally, about nine percent of Virginians over the age of 45 have reported subjective cognitive decline, including memory issues that are getting worse over time.[6] Table 1 provides some background on Virginians living with dementia and highlights the increased demand for dementia services in the Commonwealth.

Table 1: Estimated and Projected Individuals Impacted by Alzheimer's and related dementias, or Subjective Cognitive Decline

Virginia FFS Medicare Beneficiaries with a Diagnosis of Alzheimer's and related dementias (data from CMS)

2015	2018
92,277	108,864
Percent growth	18%

Virginians with Alzheimer's (data from Alzheimer's Association)

2015	2020	2025
130,000	150,000	190,000
Percent growth	15%	27%

Virginians Experiencing Subjective Cognitive Decline (data from Virginia's annual Behavioral Risk Factor Surveillance System)

2015	2019
275,000	292,000
Percent growth	6%

Individuals living with dementia exhibit a wide range of symptoms and severity of symptoms. Some dementia related behaviors, also known as Behavioral and Psychological Symptoms of

[6] https://vda.virginia.gov/downloads/2020-2024%20VA%20Dementia%20State%20Plan%20Final_Accessible%20with%20bookmarks.pdf

Dementia (BPSD), can include aggression, hyper-sexuality, socially inappropriate behavior, anxiety, wandering, and repetitive questioning. It is estimated that up to 80% of individuals with dementia exhibit some form of BPSD during the course of their illness. BPSD dramatically increases professional and family caregiver burden, and are major risk factors for abuse and neglect. In a minority of these cases, these symptoms may exacerbate and result in a behavioral health crisis not dissimilar in appearance to individuals undergoing a mental health crisis. Enhanced support for caregivers, early intervention, appropriate training regarding the management of BPSD, person-centered and family-centered care, and access to a variety of non-pharmacological interventions in small, integrated settings are necessary in order to prevent or manage BPSD.

Available services in Virginia

The Dementia State Plan 2020-2024 (see Appendix B) provides a blueprint for a dementia-capable Virginia that includes comprehensive service provision, care coordination and training.[7] At present, Virginia offers some services for individuals with dementia through various funding sources which can help prevent and address worsening symptoms. Many of these services are not available statewide or lack the capacity to offer 24/7 coverage for individuals, families, and facilities.

Federal community-based supports for individuals with dementia are often provided by Area Agencies on Aging (AAAs) through the Older Americans Act, which targets funding for older adults (age 60+), caregivers of older adults, and caregivers of adults of any age with dementia. These services can include, for example, home and congregate meals, adult day care, respite care, care coordination, and limited transportation.

Low-income individuals with dementia who qualify for Medicaid long-term services and support (LTSS) may also receive Medicaid-covered services in nursing facilities or through the Medicaid Commonwealth Coordinated Care (CCC) Plus Waiver, which provides home and community based services (HCBS) for individuals living in the community and includes additional care coordination support.

State-supported services include Dementia Care Coordination, funded at $150,000 through the Department for Aging and Rehabilitative Services (DARS) that began July 1, 2021. This uses the evidenced-based Benjamin Rose Institute Care Consultation program and provides capacity for 50 families through one full-time employee. This effort is housed at the University of Virginia's Memory Disorders Clinic and is managed in partnership with the Alzheimer's Association. Current state funding also supports the Virginia Center on Aging, which administers the Alzheimer's and Related Diseases Research Award Fund, which has generated evidenced-based dementia research and care. Other state-funded organizations related to dementia care include the DARS Long-Term Care Ombudsmen Program; the dementia efforts of the Department of Corrections' Deerfield Correctional Centers; the DARS Public Guardianship Program, and the Department of Veterans Services dementia care centers.

State and federal grant-supported services include the U.S. Centers for Disease Control and Prevention (CDC) BOLD Infrastructure for Alzheimer's Act Grant for Public Health Programs

[7] The Dementia State Plan is available at: https://vda.virginia.gov/downloads/2020-2024%20VA%20Dementia%20State%20Plan%20Final_Accessible%20with%20bookmarks.pdf

(2020-2023) which supports the Virginia Department of Health (VDH) education on brain health in the Commonwealth. In past years, Virginia benefited from grants from the U.S. Administration for Community Living and the Virginia Commonwealth University Virginia Center on Aging to do work around evidence-based interventions for caregivers of individuals living with Alzheimer's disease, elder abuse, care coordination, training programs, and caregiver workshops. Additionally, the Virginia Lifespan Respite Voucher Program offers up to $595 in reimbursement for respite care for individuals with dementia.[8]

Locally-implemented services include the Regional Older Adults Facility Mental Health Support Team (RAFT) program, which operates out of Northern Virginia and will be covered further in this report, as well as programs at Riverside Center for Aging and Lifelong Health, the UVA Memory Disorders Clinic, the Memory Consultation Clinic at Eastern Virginia Medical School, Senior Advocate of Hampton Roads, Senior Corps in Virginia Beach, the Richmond Longevity Project, and the Coalition for Homeless Elders in Southeastern Hampton Roads.

RAFT Program

The Regional Older Adults Facility Mental Health Support Team, or RAFT, is one of the programs of the Regional Projects Office in northern Virginia. The program began in 2008 with the mission of working with older adults (defined as those 65 and up) with a serious mental illness and/or dementia with behavioral problems being discharged from state hospitals as well as diverting these individuals from hospitalization in state facilities.

To accomplish this mission, the RAFT model incorporates the following components:

- Mental health services that can be provided in the individual's residence including ALFs and nursing facilities
- Clinical services including multidisciplinary assessment and evaluation, development of a comprehensive plan of care, and provision of psychiatric services, medication management, intensive case management, and individual, group, and family therapy
- Support services such as case consultation to facilities and crisis intervention and plan coordination
- Administrative services including funds to support ALF placement, payment for medication co-pays, training and community education

RAFT teams are comprised of mental health therapists, psychiatric nurses, psychiatrists, administrative specialists, and managers. At the end of State Fiscal Year (SFY) 2021, RAFT was serving 50 individuals, all residents of the City of Alexandria or Arlington, Fairfax-Falls Church, Loudoun, or Prince William Counties. RAFT receives referrals from community services boards (CSBs) in the covered area as well as long-term care (LTC) partner facilities, which are reviewed monthly by the RAFT Referral Committee.

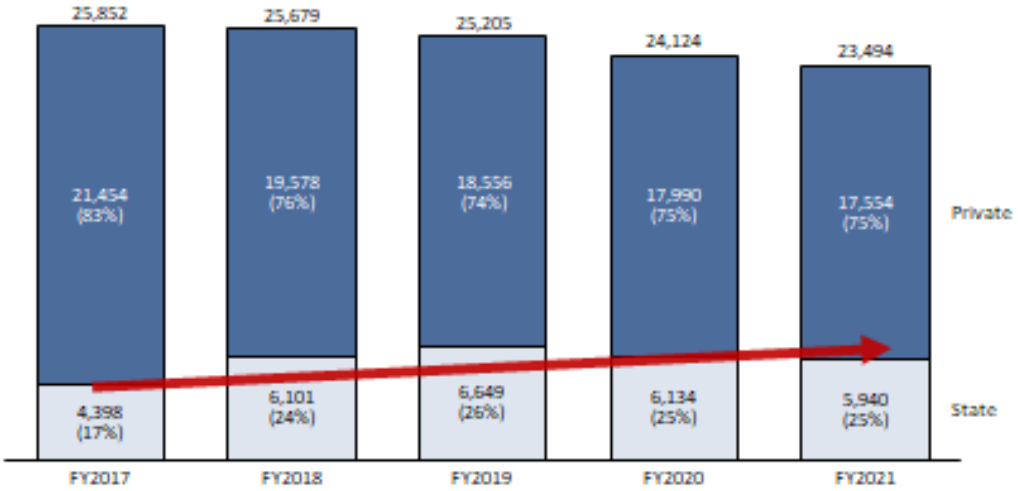
More outcomes data is needed regarding RAFT's cost-effectiveness, including savings to the Commonwealth of Virginia.

[8] More information about the Virginia Lifespan Respite Voucher Program is available at: https://vda.virginia.gov/vlrv.htm

Dementia Patients and Virginia's State Mental Health Hospitals

Over the past several years, Virginia's eight state mental health hospitals have struggled with consistently high census utilization, resulting in unsafe conditions for both patients and staff. Recently, this consistently high census combined with the impact of the COVID-19 pandemic has left the state hospitals, similar to other providers, with increasingly dire workforce constraints, further exacerbating capacity issues and conditions in state hospitals. Table 2 below details census rates over time in Virginia's state mental health hospitals.

Table 2: State vs. Private TDO Admissions FY17-21



The high state hospital census is felt most acutely in geriatric hospitals and units (reserved for individuals 65 and older) which consistently run above 100% capacity, even though 85% capacity or lower is considered safe. Fifty-seven percent of these admissions have a dementia diagnosis. Table 3 details admissions of individuals with dementia to each state hospital from 2017-2020. During that time period, there was a 48% increase in the total number of geriatric individuals with dementia who were hospitalized in state psychiatric hospitals.

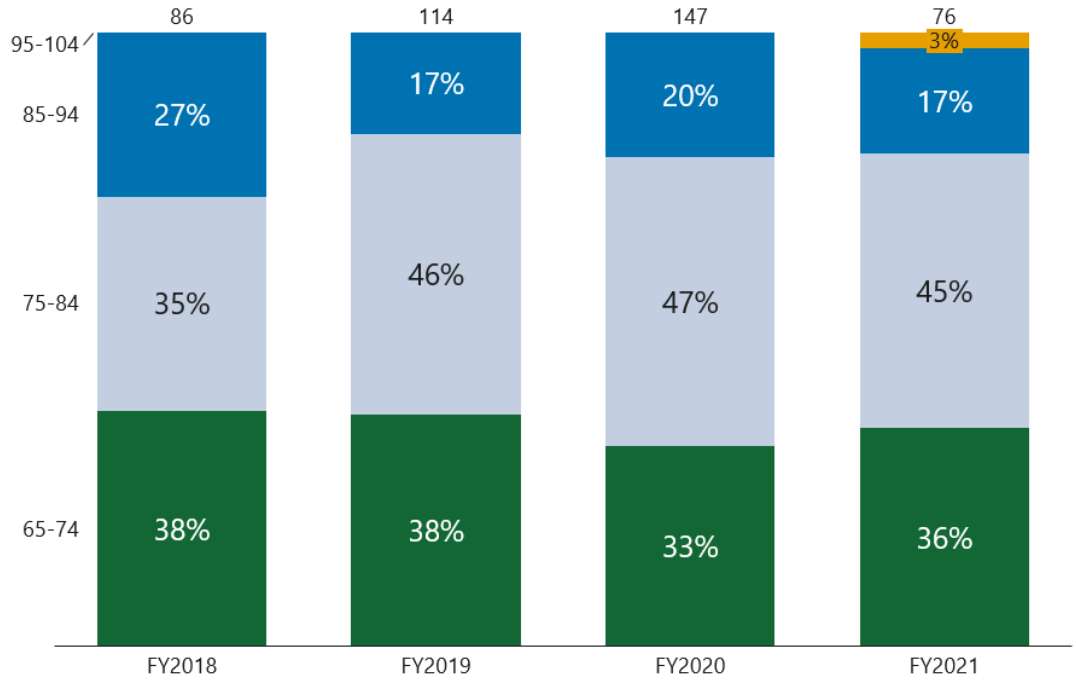
Table 3: Admissions of All Individuals with Dementia to State Hospitals (FY17-FY20)

	FY2017	FY2018	FY2019	FY2020
Catawba*	102	89	122	107
Central State Hospital	20	27	26	28
Eastern State Hospital*	31	70	61	66
Northern Virginia Mental Health Institute	10	19	24	18
Piedmont Geriatric Hospital*	86	99	134	170

Southern Virginia Mental Health Institute	9	18	20	8
Southwestern Virginia Mental Health Institute*	75	61	62	58
Western State Hospital	44	56	56	38
Total	377	439	505	493
Geriatric individuals	233	253	329	345

*Hospitals that have geriatric (65 and older) units

Figure 1: State Hospital Primary Dementia Patients by Age Group



For all state hospital patients discharged in SFY 2020, the average length of stay was 67.3 days. However, two-thirds of individuals stayed 30 days or less. For the geriatric population with dementia, the average length of stay was roughly 3.5 times higher at 229 days.

Virginia's state hospitals were never intended to treat the specialized care needs of individuals with dementia. Rather, they are intended to treat individuals with psychiatric disorders, specifically serious mental illness (SMI). These state facilities specialize in pharmacological treatments in large, crowded settings. Patients with dementia are not best served in the state's hospitals. Often, individuals with dementia who are admitted to Virginia's state hospitals do not have an underlying SMI. Furthermore, in treating individuals with dementia, pharmacological treatments are not the recommended first line of treatment for BPSD. Rather, non-pharmacological, evidence-based treatments such as person-centered dementia care, Montessori-based care, music therapy, and sensory therapies are recommended for dementia patients. These

services are challenging, if not impossible, to provide in state hospitals due to resource needs, workforce training and capacity issues, and facilities' structure. It is clear that persons with dementia with challenging behaviors require specialized care; that state psychiatric hospital treatment is less effective, more costly, and negatively impacts the hospitals' already strained capacity; and that more community-based and caregiver programs are needed.

Lessons Learned from Other States

In order to assist the workgroup in considering new and effective services for individuals with dementia, DBHDS staff interviewed individuals from three states – Oregon, Wisconsin, and Kansas – with experience in building out additional dementia services.

Oregon

The state of Oregon contracts with vendors throughout the state to provide behavioral support services for older adults.[9] These services are free to Medicaid beneficiaries and provide non-pharmacological interventions to individuals with dementia and challenging behaviors.

Oregon also provides additional enhanced care services for older adults, including teams similar to mobile crisis teams with 24/7 availability to respond to behavioral crises among older adults. The staff are employed by Oregon's Community Mental Health Programs, similar to Virginia's CSBs, and they provide support and education to families and caregivers of older adults as well as to staff at facilities that serve older adults. They also support a specialized unit in residential care facilities with 15 beds, supported through a bundled payment of $130 a day through Medicaid. One difference between Oregon's Community Mental Health Programs and Virginia's Community Services Boards is that Oregon's programs specifically include dementia care in their mission.

Finally, Oregon's Older Adult Behavioral Health Initiatives provides workforce development, training, complex case consultation, and other health and wellness promotion initiatives. There are 26 older adult behavioral health specialists positioned across the state, embedded in Oregon's Community Mental Health Programs. One of their activities was to develop a dementia care toolkit which they distributed to direct care providers in the state.[10]

Wisconsin

A task force in Wisconsin with the goal of redesigning the system of care for individuals with dementia resulted in innovation grants to localities across the state. This initiative resulted in various efforts which have shown early yet promising results in addressing challenging behaviors in persons with dementia. For example, dementia care specialists have been developed to provide education and caregiver support, and to partner with nurses to provide triage care in order to stabilize individuals with dementia in place and prevent any trauma that can arise from transporting individuals with dementia to new or acute care settings. There have also been intensive training efforts with behavioral health mobile crisis programs, caregivers, first responders, and law enforcement to prevent and address exacerbation of BPSD. These trainings were developed in partnership with a local university.

[9] More information available at: http://visionsllc.org/wp-content/uploads/2018/03/Visions_flyer_2.pdf
[10] More information about Oregon's Dementia Care Toolkit is available at: https://oregonbhi.org/

One county in Wisconsin developed the "Purple Tube Project", a collaboration among law enforcement, first responders, and a coalition of caregivers. This initiative aims to help first responders and families have information on-hand, such as important and emergency contact information, medical history, powers of attorney, and any information needed to interact with the person with dementia in order to stabilize the individual at home whenever possible.[11]

Finally, Wisconsin is beginning a pilot project to develop a dementia stabilization unit, similar to a crisis stabilization unit, for specialized services for individuals with dementia. This effort is a collaboration among four counties and will consist of six beds in private rooms. Staff will have specialized training and also provide community-based care. Medicaid billing for respite care will be available. This, and other initiatives, have been discussed in quarterly dementia meetings with managed care organizations. Importantly, the Wisconsin programs have generated cost savings to the state.

Kansas

The Kansas Bridge Project is a statewide initiative to provide targeted outreach and care recommendations for individuals with dementia. This initiative is a partnership with four AAAs to integrate dementia navigators in teams. These navigators work with psychiatric hospitals, crisis intervention teams, adult protective services (APS), and other systems and facilities in the geographic area. The navigators spend time with the individual with dementia and the individual's family or caregivers in order to develop targeted recommendations and then work with the individual's support system to implement them.

After implementing the Bridge Project in 2012, psychiatric hospitalizations for the targeted population decreased drastically. In addition, diversions from psychiatric care increased, and the state decided to require dementia specialized care in Medicaid managed care contracts. The state has also focused on significant training for all public community mental health staff, the development of a "neuropsych guide" for caregivers and paid staff who work with individuals with dementia, and partnerships with higher education schools of social work to provide annual intensive dementia trainings.

Workgroup Information

The Dementia Services Workgroup met four times between June and September of 2021. The workgroup consisted of representatives from a wide range of stakeholders (full list available in Appendix A) from partner state agencies, community-based providers, mental health advocates, and advocates for dementia, Alzheimer's, and the aging population.

The workgroup was charged with three principal goals, all focused on strengthening services for those living with dementia in order to avoid more restrictive levels of care – namely, hospitalization in Virginia's state mental health hospitals. The workgroup's goals included:

1. Identify existing services for individuals living with dementia.

[11] More information about the Purple Tube Project is available at: http://www.co.forest.wi.gov/docview.asp?docid=26439&locid=145

2. Make recommendations to increase access to evidence-based services for persons living with dementia.
    a. Consider alternatives to inpatient psychiatric hospitalization for individuals with dementia experiencing behavioral or psychological symptoms.
    b. Evaluate and propose needed changes to the current definition of mental illness regarding its impact on this population.
3. Evaluate the Northern Virginia Regional Older Adult Facilities Mental Health Support Team (RAFT) and feasibility of replicating it elsewhere in the Commonwealth.

The workgroup developed several consensus recommendations and began discussions around some additional areas of focus which would help further strengthen access to critical services for individuals with dementia, especially those experiencing BPSD, across the Commonwealth. Several of these recommendations echo those included in the Dementia State Plan 2020-2024 (DSP) (see Appendix B).

Workgroup Recommendations

Immediate Workgroup Recommendations

1. Provide funding for dementia behavioral specialists, to be integrated into the system of care (See tie into DSP Goal 4, Appendix B).
    a. These positions, housed at DBHDS or Community Services Boards, would coordinate care, link individuals to resources, and provide individual support, particularly related to an individual experiencing behavioral or psychological symptoms of dementia that put them at risk of losing their housing, whether that be a family home, ALF, nursing facility, or some other type of setting.
    b. Positions would be linked to their local Area Agencies on Aging (AAAs) and to their local chapters of the Alzheimer's Association for consultation, resource-sharing, and collaboration.
    c. Positions would also assist with transitions, provide caregiver (both paid and unpaid) training, support, and consultation.
    d. Positions would be integrated into regional older adult interdisciplinary teams (run by CSBs) that are currently in development. In Region 2 this may be an opportunity to integrate with the already existing RAFT team.
    e. Qualifications would include at least a bachelor's degree (preferably master's degree) in human services field and multiple years of direct experience working with older adults with behavioral health needs.
    f. Dementia specialists would have formal training in prevention of BPSD, as well as evidence-based interventions for BPSD, and caregiver support.
    g. Dementia behavioral specialists will also partner and coordinate with mobile crisis teams in their areas.
2. Collect data and explore partnerships in order to further develop a workforce that has the expertise to provide evidence-based, person-centered dementia care (See tie into DSP

Goals 2 & 3, Appendix B). DARS would take the lead on this as the lead agency on aging, however additional resources would be required to complete this work.

a. Utilize existing research to ensure identified trainings are based on current, evidence-based practices.
b. Create a catalog of existing dementia care training programs.
c. There are organizations and initiatives within Virginia (such as the Alzheimer's Association, Virginia Center on Aging, LeadingAge Virginia, VCU, UVA, EVMS, the BOLD Act, etc.) that are already focusing on this area. This is an opportunity for collaboration among these organizations and the state agencies involved.
d. Explore possible partnerships with existing higher education schools of social work and nursing, the Virginia Community College System, etc. regarding educational and training opportunities for students to enter the dementia care workforce and mitigate the critical staff shortages at long-term care facilities.
e. There is a need to not only identify the current workforce need in this area, but to also project the future workforce need.

3. Make targeted investments to DARS in the areas of awareness, education, and training to involved stakeholders and the community at large (See tie into DSB Goals 2 & 3)
    a. Education and training needs to target a variety of groups, including formal and informal caregivers, first responders, law enforcement, primary care physicians, other mental health professionals, etc.
    b. Leverage currently available trainings, which may include adding curriculum related to dementia care. These include Crisis Intervention Team (CIT) training for law enforcement, Mental Health First Aid for Older Adults, training programs developed by VCU, Virginia Center on Aging, Alzheimer's Association, etc.
        i. Partner with DARS to explore opportunity to integrate efforts into the BOLD Act.
        ii. Explore utilizing Project ECHO through VDH in regards to providing training opportunities to primary care physicians.[12]
    c. Strengthen public access to information about dementia and community resources that may be of assistance, such as support groups, diagnostic services, caregiver training, respite care, in-home care, advanced care planning, etc.
        i. Long-term goal of ensuring that all AAAs have a "dementia navigator" type position.
    d. Work with local health departments and AAAs to promote local dementia awareness campaigns, provide education to the public, identify underserved populations, etc. This is another possibility to partner with BOLD Project.
    e. Ensure mobile crisis teams that are in development through DBHDS's STEP-VA initiative are provided training in order to develop dementia care expertise.
    f. Partner with the Emergency Department Care Coordination Advisory Council to develop a program in which emergency room physicians would have access to

[12] More information about Project ECHO is available here: https://www.vdh.virginia.gov/project-echo/

individual's dementia care plans and preferences, similar to the Purple Tube Project in Wisconsin.[13]

4. Develop and pilot respite and crisis care options for individuals to receive treatment when they can no longer stay in their homes and communities (See tie into DSP Goal 1, Appendix B).
    a. Possibilities may include a specialized crisis stabilization unit (CSU), or temporary respite options, such as specialty Memory Care ALFs (e.g. Tidewater Cove memory care beds).
    b. Partner with ALFs and nursing facilities and advocacy/oversight organizations to gain more information regarding the training and resource needs of these facilities in order to provide needed behavioral dementia care to residents, rather than seeking out of facility treatment.
    c. These pilots may also include resources for transportation in order to aid individuals in accessing them, rather than inpatient hospitalization.
5. Provide resources to DARS to spearhead increased collaboration across agencies and among public and private organizations involved in dementia care and advocacy (See tie into DSP Goal 1, Appendix B).
    a. The workgroup made clear that there are various organizations who have already put effort into the above initiatives. These efforts, however, are often silo-ed and occasionally duplicative of each other. It is essential that efforts regarding improved dementia care in Virginia are coordinated. Therefore, it is recommended that a statewide dementia services task force that meets regularly is created (or further developed) that includes all involved state agencies and private organizations. This would be led by DARS and would require funding for staff.
    b. In addition, collaboration should consider funding streams and reimbursement opportunities for needed services, including the care navigation and crisis services described above. This would benefit from collaboration with the DMAS and the Medicaid managed care organizations.
    c. Develop strategies with key stakeholders to expedite diversion of individuals from a psychiatric hospitalization to other settings (required assessments, forms, payment authorization, etc.).
    d. The recommendations of this workgroup should be integrated, to the extent possible, with the Aging Services Workgroup.[14]
    e. Consider asset-mapping as a tool to identify all existing resources and stakeholders.

The Northern Virginia RAFT program provides invaluable services to a subset of geriatric admissions to state hospitals. The RAFT census as of the June 30, 2021 was 50. Of those individuals, 25 are placed in an ALF, and the remaining 25 are in nursing facilities. In the past year, only one RAFT client has been re-hospitalized, accounting for 91 state hospital bed days.

[13] More information about the Emergency Department Care Coordination Program is available here: https://www.vhi.org/ConnectVirginia/edcc.asp

[14] Item 291(F) in Chapter 552 of the 2021 Acts of Assembly

RAFT representatives on the workgroup noted that the cost per individual served is approximately $30,000 on average, though this varies widely from individual to individual as it incorporates the ALF and nursing facility placement costs for some of the individuals served. Much of their work relies on building local relationships and collaborations with long-term care facilities over time. Program representatives noted that the RAFT program would benefit from additional investment, which could allow them to serve additional individuals in the Northern Virginia Area. In addition, the program could be piloted in additional areas of Virginia. Consideration would need to be given to areas that could maximize the benefits of the RAFT program, which may have the following characteristics:

- Geographic proximity to a state hospital with a high geriatric population,
- Geographic proximity to a multitude of community services and potential placements, and
- Existence of community relationships, partnerships, and supportive services.

In other words, replication of the RAFT program in other areas of the Commonwealth may first depend on the development of community services and available placements, which is addressed in the workgroup's immediate recommendations.

Additionally, while the RAFT program provides an invaluable service to the individuals it serves by identifying stable, long-term placements, decreasing hospitalizations, and reducing transfer trauma for individuals with dementia, the program is not designed to provide 24/7 safety-net support for individuals with dementia. This is a key need to address behavioral crises that arise among individuals with dementia experiencing BPSD, and to prevent escalation and the possibility of a TDO being issued. Therefore, the RAFT program complements the other recommendations put forth by the workgroup.

Future Areas of Focus

1. Support for DARS as the lead agency on aging to lead and coordinate key initiatives including the implementation of the Dementia State Plan critical to improving outcomes for the dementia population in Virginia.
2. Development of workforce pipelines for dementia care, such as middle school and high school education programs in order to further recruit providers for the workforce.
3. Support for various existing initiatives and programs in Virginia, such as the Dementia Friends Virginia initiative and training provided to the Virginia Medical Reserve Corps.
4. Increased access to education and training, including making new dementia care training freely available to the public (possibly through the Psych Hub platform), education and awareness around the national effort to reduce antipsychotic use for challenging behaviors in older adults and the CCC+ waiver and benefits it may offer to this population, and training and screening tools for 911 operators.
5. Utilization of adult day/clubhouse programs (dementia-friendly) as respite options for caregivers and socialization/activity options for individuals with dementia.
6. Expansion of PACE (Program of All-Inclusive Care for the Elderly) eligibility.
7. Support for a study to explore how Auxiliary Grant (AG) rates for assisted living facilities could be increased, in order to further incentivize community-based resources

for individuals with dementia. The current rate ($1562 per month in most part of Virginia; $1796 in Northern Virginia) does not fund the cost of memory care services.

8. The workgroup held multiple discussions regarding whether dementia should continue to meet the definition of mental illness for the purposes of psychiatric temporary detention orders (TDOs). The workgroup recommends that this topic be reconsidered when more crisis and diversion resources are in place that will serve as a resource and safety net for individuals with dementia who are experiencing a behavioral crisis.

Appendices

Appendix A: Workgroup Participants

Workgroup Chair: Dr. Suzanne Mayo, Director of Community Integration, DBHDS

Organization	Name
Alzheimer's Association	Josh Myers
	Katie McDonough
Department of Behavioral Health and Developmental Services	Commissioner Alison Land
	Alex Harris
	Dr. Alexis Aplasca
	Dr. Emma Lowry
	Heidi Dix
	Jaime Elzie
	Natima Jones
Department of Medical Assistance Services	Barbara Seymour
Department of Social Services	Tara Ragland
Department for Aging and Rehabilitative Services	Commissioner Kathy Hayfield
	Catherine Harrison
	George Worthington
	Nicole Medina
DisAbility Law Center of Virginia	Colleen Miller
Leading Age Virginia	Dana Parsons
Mount Rogers CSB	Sandy Bryant
Office of the Secretary of Health and Human Services	Deputy Secretary Catherine Finley
Region 2	Jean Post
RAFT Northern VA	Alice Straker
	Kristen Johnson
Virginia Academy of Elder Law Attorneys	Rhona Levine
Virginia Assisted Living Association	Jennie Haden
	Judy Hackler
Virginia Association of Area Agencies on Aging	Molly Blakenship
Virginia Association of Community Services Boards	Jennifer Faison
Virginia Center on Aging	Erica Wood
	Dr. Paul Aravich
Virginia College of Emergency Room Physicians	Aimee Perron Seibert
Virginia General Assembly - Senate Finance Committee	Susan Massart
Virginia Health Care Association	April Payne
Virginia Hospital and Healthcare Association	Mark Smallacombe
Virginia Municipal League	Janet Areson

Western Tidewater CSB	Brandon Rogers
	Demetrios Peratsakis
	Latril Mariano

Appendix B: Dementia State Plan, 2020-2024

Virginia's Dementia State Plan 2020-2024 (https://vda.virginia.gov/downloads/2020-2024%20VA%20Dementia%20State%20Plan%20Final_Accessible%20with%20bookmarks.pdf) is the Commonwealth's blueprint for a fully dementia-capable state that is ready to meet the challenge of rising numbers of citizens living with dementia or caring for individuals living with dementia. The Plan is developed by the Alzheimer's Disease and Related Disorders Commission, an advisory body to the Governor and General Assembly that was formed in 1982. The Commission updates the Plan every four years and advocates for its implementation.

The Plan contains five broad goals that have remained constant since the first Plan was developed in 2011. These goals are listed in the table below, together with the specific recommendations that tie in with the recommendations of the Dementia Services Workgroup. The Workgroup itself falls broadly under the Plan's recommendation 1.C.2: Partner with the Department for Aging and Rehabilitative Services (DARS) Adult Protective Services Division, the Virginia League of Social Service Executives, Virginia's Area Agencies on Aging, the Virginia Department of Behavioral Health and Developmental Services (DBHDS), Community Services Boards, and the Geriatric Mental Health Partnership (GMHP) to identify solutions and promote best practices for providing crisis stabilization for individuals living with dementia who are experiencing challenging dementia-related behaviors.

Dementia State Plan Goals, and Recommendations Relevant to the Dementia Services Workgroup	**Workgroup Recommendation**
Goal 1: Coordinate quality dementia services in the Commonwealth to ensure dementia capability	
C. Review all state-funded services to ensure dementia-capable approaches and policies based on principles derived from the Person-Centered Care and Culture Change movements 2. Partner with the Department for Aging and Rehabilitative Services (DARS) Adult Protective Services Division, the Virginia League of Social Service Executives, Virginia's Area Agencies on Aging, the Virginia Department of Behavioral Health and Developmental Services (DBHDS), Community Services Boards, and the Geriatric Mental Health Partnership (GMHP) to identify solutions and promote best practices for providing crisis stabilization for individuals living with dementia who are experiencing challenging dementia-related behaviors.	Workgroup mandate
Goal 2: Use dementia-related data to improve public health outcomes	

Dementia State Plan Goals, and Recommendations Relevant to the Dementia Services Workgroup	Workgroup Recommendation
A. Collect and monitor data related to dementia's impact on the people of the Commonwealth. 2. Coordinate with state licensing agencies to collect data on dementia prevalence, trends, and the characteristics of professions, facilities and providers.	Recommendation 2 Recommendation 3d
B. Collaborate with related public health efforts and encourage possible risk-reduction strategies.	Recommendation 3d
Goal 3: Increase awareness and create dementia-specific training	
A. Provide standardized dementia-specific training to individuals in the medical, health and social services fields and require demonstrated competency. 1. Develop or collect and deliver dementia-specific, evidence-based trainings that include an emphasis on the differences between dementias and their disease trajectories, management of co-morbid conditions, dementia-related behaviors, referral protocols and resources, non-pharmacological interventions, care planning and advance directives, and the needs of and supports for family and informal care partners, among others 3. Develop or catalog and deliver a portable certification program for direct-care staff with standardized content designed to enhance their understanding of memory impairment and their performance in caring for individuals living with Alzheimer's disease or related dementias. This content should include evidence-based, non-pharmacological strategies for addressing dementia-related behaviors	Recommendations 2b, 2c Recommendation 3 Recommendation 4b
B. Provide dementia specific training to professional first responders (police, fire, EMS and search and rescue personnel), financial services personnel, and the legal profession.	Recommendations 3a, 3b, 3e
C. Support care partners, family members and people living with dementia by providing educational information about dementia and available resources and services.	Recommendation 3a Recommendation 3c

Dementia State Plan Goals, and Recommendations Relevant to the Dementia Services Workgroup	Workgroup Recommendation
2. In partnership with the Alzheimer's Association and other state agencies and their contractors, train and link informal or family care partners to information and education about dementia and the caregiving process, including staying healthy, coordinating legal and financial issues, and locating and using respite care services, among other topics. 4. With appropriate stakeholders, develop or collect and implement an evidence-based protocol for appropriate interaction with individuals living with dementia, with specific information on dementia-related behaviors. 5. Develop or collect and deliver person-centered training for family care partners that incorporates evidence-based strategies for addressing dementia-related behaviors. These strategies often include understanding that the behavior is an attempt at communication, identifying the cause of the behavior, and using knowledge of the person to deliver individualized support.	
Goal 4: Provide access to quality coordinated care for individuals living with dementia in the most integrated setting	
A. Create a statewide network of interdisciplinary memory assessment centers with specialized, dementia-capable services for individuals living with dementia and their care partners from assessment and diagnosis through end-of-life. 3. Within the interdisciplinary memory assessment centers and community partners, establish and fund dementia coordination centers that are staffed by credentialed patient navigators who can help persons living with dementia and their care partners and offer such services as:	Recommendation 1
B. Provide a system of services that are integrated, coordinated and diverse to meet the varied needs of individuals living with dementia and care partners during the disease trajectory. 6. In coordination with Area Agencies on Aging and Community Services Boards, establish cross-setting teams and provide supports to long-term care facilities and family care partners to respond to changed behaviors in a safe and appropriate manner.	Recommendation 1

Dementia State Plan Goals, and Recommendations Relevant to the Dementia Services Workgroup	Workgroup Recommendation
8. Promote geriatric emergency departments in hospitals that include trained staff and a thorough evaluation of adults presenting with possible delirium or dementia to assure safety and best outcomes for individuals.	Recommendation 3f
Goal 5: Expand resources for dementia-specific translational research and evidence-based practices	
No recommendations relevant to this workgroup.	