EVERGREEN HEALTH

GERIATRIC REGIONAL ASSESSMENT TEAM

Karin E. Taifour, LMHC GMHS
Evergreen’s Behavioral Health Services

Four programs
• Geriatric Crisis Services: a specialized crisis intervention and stabilization service available to older adults anywhere in King County (except in SNF or hospital)
• Family Caregiver Counseling Services: up to 6 free visits
• Substance Abuse Services: in-home counseling
• Consultation Services: private-pay assessments, professional case consults, training and education

For questions on eligibility or to make a referral, call 425.899.6300.

Serving the community for over 20 years
GRAT’s Crisis Service

• Has licensed counselors, geriatric mental health specialists, chemical dependency professionals, social workers, a nurse, an on-call occupational therapist, and a consulting geriatric psychiatrist.

• Works collaboratively to provide in-home assessments of mental health, substance abuse, medical status, safety, psychosocial and functioning abilities for people age 60 and older who meet the criteria for eligibility.

• Charges no fees for crisis visits, thanks to funding from the King County Mental Health and Chemical Dependency Department.

• Sees individuals within three business days of referral (or next business day if requested by first responders).
GRAT commonly sees cases where:

- Medical concerns are prominent:
  - Highly acute issue, need to go to the ED immediately
  - Acute issue, need to get to primary care dr tomorrow
  - Chronic issue not appropriately managed, need to get follow-up care
- Mental health and/or substance abuse concerns are prominent
  - Diagnosed vs. undiagnosed
  - Acute vs. chronic, adjustment disorder vs. other
  - Complex comorbidities
- Cases with neglect and financial exploitation by family members/caregivers, or self-neglect (abuse less common)
- Cases with DPOA or guardians have not been able to get the person to accept needed care and support to stay healthy and safe (self-neglect)
Perspectives on...

- Aging: It’s Complicated
- Aging + Mental Health
- Aging + Alcohol and/or Substance Abuse
- Clinical considerations
- I’m not often able to be involved in ongoing care transition or case management support. But some of the key factors in crisis work with older adults transfer to working with any patients/clients.
Thinking about aging

NORMAL AGING

Cognitive Impairment

INABILITY TO CARE FOR SELF (SELF-NEGLECT)
Seniors and mental health

- Over 20% have a mental health disorder not related to aging
- Over 15% meet criteria for depression
- More likely to report physical symptoms than psychological ones
- Primary care providers see them the most but unfortunately may lack training/experience to identify issues
- Effects:
  - Isolation
  - Sleep/appetite changes increase risk for functional/cognitive impairment and health issues
  - Visit doctor and ER more often, use more medications, incur higher outpatient charges, stay longer in hospital
  - Highest suicide rate of any age group

EvergreenHealth
Everyone and mental health

• Actually, EVERYONE has mental health “issues” – questions are:
  • how bad is it / how much do they impact us, and
  • how well are we are handling them?
• “Every patient is a mental health patient”
  • All patients require assessment of their mental health and appropriate action if needed.
• However, people with mental health issues are more likely to have other issues vs. people without mental health issues:
  • Higher rates of chronic general medical conditions
  • Higher frequency of multiple general medical conditions
  • Higher rate of premature mortality resulting from these conditions
Mental & physical health

• These general medical comorbidities have a detrimental effect on their mental health, compounding already high levels of functional impairment.
  • Also, general medical conditions in this population are frequently missed, so the problem is greater than data shows.
• Why?
  • Socioeconomic disadvantage, lack of insurance, system gaps
  • Substance abuse comorbidity
  • Medication side effects
  • Neglect of self-care, other unhealthy behaviors
  • Perceived barriers, stigma
  • Reports that providers dismiss their somatic complaints
Back to Seniors: The Three D’s

- Dementia, depression, and delirium
  - Can co-exist
  - One can cause / exacerbate the other
  - Symptoms overlap
  - Differential diagnosis can be difficult
Dementia

• Chronic, irreversible decline – typically progressive
  • Dx: Memory impairment plus at least one cognitive disturbance
• Alzheimer’s: 60-80% of cases, considered to be a 3-stage disease that begins well before symptoms appear
• Vascular: 10% of cases, was known as multi-infarct or post-stroke, more stair-step decline after a cerebrovascular event
• Lewy Body: 10-25% of cases, abnormal microscopic protein deposits
• Frontal-Temporal: 10-15% of cases, includes behavioral variant, Pick’s, primary progressive aphasia, progressive supranuclear palsy. Personality and behavior changes prominent, typically earlier onset (around age 60). Very common to present as depression.
• Other types / causes:
  • Parkinson’s, Huntington’s, Alcohol-Induced Persisting Dementia, Wernicke-Korsakoff Syndrome (B-1 deficiency)
• Mixed dementia: combination of types
Depression

• Dx: Depressed mood or a loss of interest or pleasure in daily activities
  • for more than two weeks
  • that affects functioning
  • with specific symptoms present nearly every day
• Can be caused by medical illnesses or medication side effect
• Dysthymia = melancholy state
• Mild to moderate depression = can still be quite functional
• Major depression = significantly affects function
  • Can have psychotic features, suicidality, FTT
• Persistent depressive disorder = 2 years or more
• Post-partum depression = 10-15% of women after birth
• Anxiety symptoms often accompany depression
Delirium

• Acute confusional state, reversible if treated
• Presents as:
  • In typical younger adults: disruptive behavior, hallucinations, delusions
  • In elders: more frequently somatic features such as incontinence
• Causes:
  • Infections (UTI), drug-related, electrolyte imbalances
  • Polypharmacy – taking multiple meds, Rx & over-the-counter medications
• If delirium is not reversed, it may evolve into a permanent dementia (55% occurrence).
Differentiating between the D’s

- Thorough history of symptoms, onset, premorbid functioning
- Medical workup and physical exam
- Diagnostic clarity is important for appropriate treatment
- Higher risk of suicide:
  - White men age 85+ have highest suicide rate in U.S.
  - Most had depression that their doctors were not aware of
  - Many had visited their doctors within 1 month of their deaths
- Seniors have more medical conditions such as heart disease, stroke, or cancer, which may cause depressive symptoms
- Vascular depression, aka arteriosclerotic depression or subcortical ischemic depression, occurs when blood vessels harden with age and prevent normal blood flow to organs and brain. May co-occur or raise risk for heart disease or stroke.
Seniors and Medications

• 2/3 of people over age 65 take THREE or more Rx meds

• Nearly every drug class can cause either drug-induced delirium or dementia in older persons

• More than half of hospitalizations of older adults result from adverse drug reactions.

• One CT program found more than 75% of medication discrepancies occurred in patients age 65+, with 7.4% of all discrepancies involving high-risk medications.
Seniors and Medications

• Besides the pharmacy bottles:
  • Over-the-counter medications
  • OTC pain medications (30%)
  • Alternative / naturopathic / herbal (24%)
  • Alcohol and substance use/abuse
• Non-medical use of prescription drugs:
  • 44% of women, 23% of men.
  • 10% misuse prescription drugs with serious abuse potential
  • Most often: anti-anxiety benzodiazepines like Klonopin, sleeping pills like Ambien, opiate painkillers like Oxycodone.
Seniors, Medications, and Alcohol

- Physiological changes in older adults can render alcohol and medications harmful at doses lower than those used by younger people.
  - Many older adults are unaware of this fact.
- National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommends no more than one alcoholic beverage a day for men over 65 and somewhat less than that for older women.
Seniors and Alcohol

- While moderate alcohol use has been shown to protect against dementia, higher rates of consumption increase the chances of getting it. But,
  - One news article defined “moderate” use as “up to four glasses of wine per day” (!)
  - Another article defined “binge drinking” as 4+ drinks, which 8.3% of seniors reported having
  - And 2% reported “heavy drinking” – whatever that is...
- Drinking too much alcohol over time can cause medical problems
- Risk of problems caused by mixing alcohol with some medicines
Substance Use Increasing in Elders

- 6.3% in 2011, up from 2.7% in 2002
- Rates of drug abuse to double by 2020
- Most common are opiates, cocaine and marijuana
  - ...but remember those prescription medications
- Elders are less likely to recognize substance use as problematic or to use treatment services
So...

MENTAL HEALTH

ALCOHOL

MEDS ETC.

DRUGS

PHYSICAL CONDITIONS
Risk Factors for Abuse/Neglect

- Dementia puts elders at high risk of abuse:
  - Nearly 50% experience some kind of abuse.
  - 47% are mistreated by their caregivers.
- Mental illness and/or substance disorder often affects perpetrators.
- Self-neglectors have mental health or cognitive problems.
- Most frequent types of APS cases:
  - Neglect = 36% of all reports to APS.
    - Self-neglect = 60% of all neglect cases.
  - Self-neglect occurs 3x more than caregiver neglect/abuse.
- Abused have triple the mortality rates of those not abused.
- Self-neglectors are twice as likely to die.
Capacity & Cognition

• The processes involved in cognitive processing are often viewed in a hierarchical way, with the more basic abilities as building blocks for the more complex.

• **Executive functioning** is what enables us to perform IADL’s:
  - Shopping, meal prep
  - Housekeeping
  - Transportation
  - Telephone
  - Managing finances and medical care
Understanding health info

• These cognitive processes align with the tasks involved in managing one’s health care
• Where cognition weakens, ability to manage health declines

- Executive functions
  - Decisions about care

- Abstraction and symbolic abilities
  - Understanding how diet affects health/meds

- Short-term memory, learning
  - Taking medications

- Perception, attention, processing
  - Identifying symptoms
Implications for care transitions

• Educate patients and their caregivers about the transition process before the transitions happen – preferably at a time of lower stress, so they can process the information.

• Include printed materials so they don’t have to remember everything you said.

• In terms of making those improvements, there are so many tools already out there – I think it’s important for programs to not reinvent the wheel, but look at the best practices, the most appropriate things that you can use that have already been created and tested by others with probably more experience and expertise than any of us have.

  • The Center for Healthcare Research and Transformation report on best practices, done in January of this year, is very helpful and summarized the research up to that time.
Don’t reinvent the wheel

• There are so many tools already out there that have already been created and tested by others with probably more experience and expertise than any of us have.

• Whatever model you are working within, you can still incorporate other tools and strategies to support your work.

• Look at best practices, adopt the most appropriate things that fit your needs.
  • The Center for Healthcare Research and Transformation report on best practices, done in January of this year, summarized research up to that point.
But, watch for missing parts

- Mental health is left out or only touched on in many models:
  - In the WSHA Reducing Readmissions: Care Transitions Toolkit triage and checklist, mental health isn’t mentioned anywhere in the flow chart. It’s included in the social/resources assessment (addressed in 3-4 of 20 items). On the forms sampled from various hospitals, none of them address mental health or cognitive concerns directly.
  - In Society of Hospital Medicine’s BOOST program, their model does not include mental health practitioners or psychiatrists as team members.
“Customize your ride”

• C-TraC: Designed for patients who are 65 years old and either live alone or were hospitalized in the last 12 months; OR have a history of dementia, delirium, or cognitive impairment.
  • VA & UW put together C-TraC Toolkit with detailed protocols.

• Other possibilities for implementation compromises:
  • Optimizing Patient Transfers, Impacting Medical Quality and Improving Symptoms: Transforming Institutional Care, known as OPTIMISTIC
  • The Healthy Aging Brain Center
Tools for the toolbox

• The WNYCCP individual service plan is great – it includes a lot of WRAP (Wellness Recovery Action plan) items in creating a crisis and self-care plan.

• CTI provides “coach questions” – examples of language usage to better elicit information from patients to assess their understanding of their health situation and treatment.

• Washington’s AAA had Qualis Health develop a toolkit which includes activation tips, goals and measures, and troubleshooting guides for various situations e.g. patient resistant to writing health record.

• Re-Engineered Discharge (RED) has a tool to assess and enhance caregiver roles.

• NTOCC provides great patient forms, caregiver tips and info, and other helpful materials.
Health literacy

• Health literacy:
  • How much does the person understand what we consider to be basic health terminology, let alone specialized lingo?
  • Do they know how to take their temperature and at what point to get concerned, and what to do then?
  • Do they have the fundamental knowledge about body systems to be able to identify and report their symptoms?

• Some good resources are available for assessing patients’ health literacy and providing health information in a way that is appropriate and accessible for them.
  • Person-Centered Thinking Resource Guide
Cultural competence

• Studies showed that better use of interpreters led to more depression screening, and potential reduction in readmissions for non-English-speaking patients
• Even if the person speaks English, is there anything impacting how they will take in, understand, and process information?
• What are their values and beliefs around health care, about their role to their providers, about how to communicate with them?
• Part of being able to assess this about your client/patient, you need to be aware of your own cultural background and how that affects how you see and interact with others.
• Another part of being culturally competent is remembering that whatever you know about one ethnic or cultural group does not necessarily apply to the person in front of you.
CT mental health factors

- Best practices point to particular areas for providers to focus on for people with mental health issues:
  - Patient and family engagement
  - Medication management
  - Comprehensive transition planning and support
  - Transition communication
  - Self-care: nutrition, exercise, activities, coping skills
  - Crisis management plan
  - Coordination of and assistance with follow-up appointments
  - Transition plans written for patients at their levels of health literacy
Clinical considerations

• Study in 2013 looked at what CT clinicians saw as strategies to ensure good transition from acute care to rehab – 3 themes:
  • communicating more effectively
  • being vigilant around the patients’ readiness for transfer and care needs
  • documenting more accurately and completely in the patient transfer record.

• Assessment is not enough – another study found that even though patients were identified as having mental health needs, they aren’t necessarily connected with treatment/services or appropriate support.
Clinical considerations

• Clinicians need to be proficient in documenting cases, as medical documentation has legal and forensic implications on top of the clinical applications.

• Documentation of activities, observations, and recommendations, with details, is crucial. 
  
  “If it isn’t in writing, it didn’t happen!”

• Much of GRAT’s work involves “building a case” – documenting information to support the justification of intervention down the road.
Case example: Ms. H

- 76yo divorced Native female, living in public housing with her son (who is not on lease). After a fall last year, she was in hospital and got diagnosis of lung cancer but never went back in to have it evaluated or learn any treatment options.
- She has diabetes, depression, cognitive impairment, is bedbound with limited mobility, history of alcohol abuse, and smokes.
- She says she is “drinking because I’m upset about my son’s drinking.”
- Son is alcoholic with history of violence, DV, violating protection orders, assaulting officers, etc.
- Son was arrested for stealing from client’s account using her ATM card, client refused to press charges.
Ms. H, continued

• ADS CM involved for financial exploitation, referred to GRAT.
• Client admits she can’t trust her son to help her but feels she has no other options: Client’s daughter is disabled, lives an hour away, and is scared to be involved due to client’s son. COPES caregivers discontinued due to safety issues (re: son).
• After GRAT visit, client's daughter called ADS CM saying son told her that client had open bedsores. ADS CM called 911, client agreed to go to hospital but wasn’t happy about it... but hospital did x-rays, labs, etc., which did not show lung cancer.
• Problems:
  • GRAT couldn’t get HH/IHMH involved as Medicare requires primary care physician to see client in prior 30 days.
  • ADS CM referred for GRAT psych eval, which showed client still had ability to make her own decisions.
Ms. H, continued

- Interventions / action taken:
  - ADS CM got Harborview Palliative Care and Supportive Services program involved with client, so primary care physician can see her at home, order HH/IHMH, etc.
  - ADS CM was getting COPES services restarted.
  - Financial situations and son’s presence are still problems.
- Other possibilities:
  - Involve case mgmt. / resources for adult children
    - allow them to move toward independence
    - relieve elder’s anxiety / resistance
  - But, Ms. H’s son refused any assistance
Case Example: Mr. A & Mr. B

- Two gentlemen who had lived together for 40+ years
  - Condition of home had deteriorated to “hazmat”
  - Hadn’t seen their doctors in months or years
  - GRAT diagnosed both with significant dementia
  - Families unclear about relationship status
- Convinced Mr. A to go see his doctor, who then sent him to ED where he was admitted for significant medical issues
- Convinced Mr. B to go see his partner, got him seen in ED, then he was admitted as well
- Advocated with hospital SW, they got to be in same room
- Family communicated to them both that they were supportive of their relationship
- They ended up being placed in care together
What made these cases work?

• Clinicians were able to spend time:
  • Building rapport and trust with clients
  • Exploring with clients what they wanted, not agenda
  • Connecting with family members
  • Communicating and coordinating with medical providers
  • Following up to ensure clients’ information wasn’t lost

• Outside-the-box approaches to complex situations

• Cross-agency communication and partnership
COLLABORATE

• To effectively analyze situations, develop options for intervention, and take appropriate action, agencies must work together.

• Successful collaborations depend on the relationships and commitment of the individuals involved.
  • Often agencies have competing mandates/goals or conflicting procedures.
  • Catch-22 situations are common.
    • Example: client has to have seen their primary care doc within the past 30 days to get home health services, but client isn’t capable of getting out of their home.
What else can we do?

• Support more research, particularly into best practices and innovative approaches

• Advocate for funding and resources:
  • Federal, State, County, Local, Agency

• Be prepared for a long road with multiple setbacks on the way to positive change

• Take care of yourself, or you’re no good to anybody!
Ask your customers for feedback

• While we’re all here talking about how to support patients through care transitions, we professionals often exclude those very patients from the process. We design systems and models without the input of patients/clients, who are our customers – the people who our systems and models are supposed to be serving.

• Beyond simply surveying patient satisfaction, organizations need to look at how to involve their users in the process of making improvements.

• It’s never too late to start involving people – on a regular basis, ask the people you’re serving for feedback on how your systems could be better for them.
Keep a holistic perspective

- Emotional
- Environmental
- Financial
- Intellectual
- Social
- Spiritual
- Physical
- Occupational

Source: Adapted from Swarbrick, M. (2006) in SAMHSA, Eight Dimensions of Wellness
Resources

• Communicating for Person-Centered Relationship Oriented Counseling: http://www.adrc-tae.acl.gov/tiki-download_file.php?fileId=32477

• Healthy Aging Brain Center: http://www.eskenazihealth.edu/our-services/senior-care/healthy-aging-brain-center

• National Transitions of Care Coalition: http://www.ntocc.com

• OPTIMISTIC - Optimizing Patient Transfers, Impacting Medical Quality, and Improving Symptoms, Transforming Institutional Care: http://www.optimistic-indy.com/index.html


• RARE: Reducing Avoidable Readmissions Effectively – Mental Health resources page: http://www.rarereadmissions.org/resources/mental_health.html
Resources

- RARE Recommended Actions for Improved Care Transitions: Mental Health and/or Substance Use Disorders: http://www.rarereadmissions.org/documents/Recommended_Actions_Mental_Health.pdf
- SAMHSA Dimensions of Wellness: www.samhsa.gov/wellness
- Scott & White Healthcare, “A Practical Toolkit Created From A Successful Implementation Of The Care Transitions Intervention®” by Alan B. Stevens, Phd, and Laura L. Morgan RN, MSN, CCRP
- VA Coordinated-Transitional Care (C-TraC) Program Toolkit: http://www.hipxchange.org/download-ctrac
- Western New York Care Coordination Project, Individual Service Plan: www.carecoordination.org/documents/ISP_v1-23-08.doc
Contact:

Geriatric Regional Assessment Team
Phone 425-899-6300, Fax 425-899-6301

Karin Taifour, Crisis Case Manager
Cell 425-785-9042
ketaifour@evergreenhealth.com