Opening Doors... Enabling Choice

Amanda Masterson, MSW, RSW, **Kim Sheppard,** RegN, LTCM, **Louise Carrier,** MD FRCPC, **Linda Gobessi,** MD FRCPC, **Jessica Lam,** OT Reg.(Ont.)

Case Management in Community Geriatric Psychiatry

Learning Objectives

1. Identify attributes and skills which open doors to support clients in their home through case management, home visit model
2. Learn practices that allow for the delivery of client centered geriatric psychiatry service to a high volume of referrals with limited operational resources, and
3. Recognize key ingredients needed for collaboration with seniors and their support networks that build capacity towards their transition to discharge.

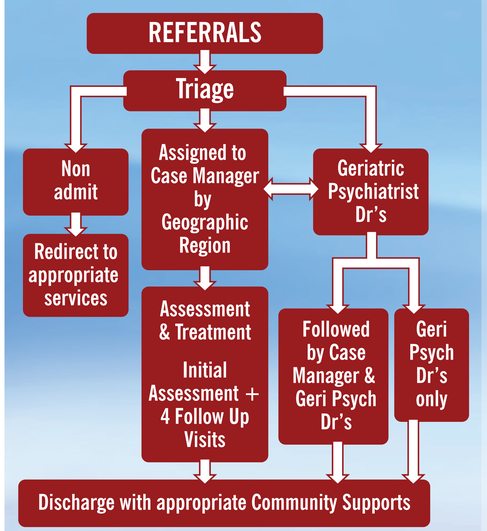
Serving the Hard to Serve

Through home visits, Geriatric Psychiatry Community Services of Ottawa (GPCSO) provides services to clients over the age of 65 (or under 65 with a confirmed diagnosis of Alzheimer Disease or Frontal Temporal Dementia) who experience behavioural and psychological symptoms of dementia (BPSD).

Many of these clients are isolated and vulnerable – marginalized by lack of education, low income, ageism, or mental illness.

We use a collaborative practice model with clients, their informal / formal support network, and allied health professionals working with specialists (geriatric psychiatrists) and primary care (general practitioners).

GPCSO Care Pathway



The Case of Determined Betty

Referral to GPCSO from Geriatric Emergency Management (GEM) Nurse for:

- 83 year old female; cognitive impairment identified during a visit to the Emergency Dept. for distressing hallucinations
- Lives alone in subsidized housing
- Sees people in her apt. at night, fearful, frequent calls to daughter every evening, noted decrease in self care and weight loss
- Daughter having trouble coping with both the decline in her mother and her increased demands

Attributes Needed to Open the Door

- Non-threatening
- Interested, curious
- Non-judgmental
- Empathetic
- Accepting of client's reality
- Appreciative of the unique behaviours and limitations associated with cognitive impairment
- Being a knowledge expert
- Patience and understanding
- Supportive

Skilled Assessment Putting the P.I.E.C.E.S.™ Together

Physical
- Disease
- Drugs
- Delirium
- Allergies
- Allergies
- Disability
- Discomfort
- Sensory
- Addictions
- Specialists

Intellectual
- Cognition
- Symptoms of Dementia

Capabilities
- Activities of Daily Living (ADL's)
- Instrumental ADL's

Emotional
- Depression
- Anxiety
- Delusions
- Suicidal
- Psychosis
- Psych History

Social
- Life Story
- Social network
- Cultural heritage
- Ethnicity
- Gender Identification

Environment

In own home, Residential, Supportive care, Living conditions, Care Staff

Hamilton, P., Harris, D., Le Clair, K., Collins, J. Putting the P.I.E.C.E.S Together (6th Edition Revised)

Clinical Skills

- Use of standardized screening tools for dementia
- Interpretation of results from tools
- Assess insight / ability to make treatment decisions
- Problem Solving Therapy
- Cognitive Behavioural Therapy
- Mindfulness
- Behavioural Activation
- Anxiety Management
- Clinical reasoning
- Appropriate management of resources

Clinical Case Manager Skills

Communicator

- Deliver education to client, family, formal and informal supports
- Liaison with care partners, community support services
- Motivational interviewing
- Active listening

Dementia Expert

- Knowledge expert
- Determine needs vs priorities
- Understand balance between autonomy vs. safety
- Understand BPSD and develop treatment interventions based on the bio-psycho-social assessment
- Knowledge of community resources

Advocate

- With client , family, formal/informal supports
- For systemic change

Identified Needs

Betty wants:
- to stay in her apartment
- to no longer be afraid of the people who she sees in the evening
- her daughter to be more patient with her

Daughter wants:
- mother to stop calling +++
- stop mom's weight loss
- to understand and know what to do for mom's strange behaviour

Case Manager identifies that Betty:
- has no formal diagnosis
- is isolated and lonely
- is disturbed by hallucinations
- has poor nutrition and hygiene
- wants to stay in apartment.
- mis-manages medications
- has no future plan
- daughter stressed

Betty's Treatment Plan

(In collaboration with client, daughter, GPCSO team, GP)

1. Request GP initiate dementia workup
2. Refer client to Geriatric Psychiatrist for diagnosis and treatment
3. Forward preliminary medication suggestions for paranoia and hallucinations from Geriatric Psychiatrist to the GP. Case Manager to assist in monitoring response.
4. Provide Betty and daughter with strategies to cope with fear from the hallucinations
5. Identify supports required to maintain Betty in her home
6. Address Betty's: weight loss, poor hygiene, medication mis-management and social isolation
7. Provide caregiver support and education
8. Provide information on future supportive housing options

Betty's Plan into Action

Referrals & Collaborative Tasks:
- Community Care Access Centre (CCAC) re Personal Support Services (PSS) assistance with hygiene, Adult Day Away Program and Dietician
- Telephone programs - social & reassurance
- Link to Aging in Place program in Betty's Apt Building for social programs
- Meal delivery service
- Pharmacy – implement a unit dose dispensing medication system
- Alzheimer Society (education / information)

Visit #1 Collaborating with Betty

Discuss:
- outcomes of referrals made
- accessing help when afraid at night i.e. provision of Distress Line phone number
- ways to self soothe when afraid:
  - Use of posted written cues (turn on favourite music, listen to reassurance message from daughter, "It's Ok mom, take 3 deep breaths, sing your favourite song, You are my Sunshine")
  - Teach & practice deep breathing techniques

Visit #2 Collaborating with Daughter

Acknowledge caregiver stress and build capacity to care for mother:
- review outcomes of referrals, response to medication and coping strategies provided to mom
- educate on how to look for the meaning behind the behaviour to address the emotional need
- show & practice appropriate responses to mom's emotional reactions
- build strategies to reduce frequency of phone calls i.e.: place a reassurance message on answering machine and / or a short video
- recognize that mother has declining capacity but still has the right to live at some risk

Visit #3 Collaborating with Betty & Daughter

Evaluate:
- outcomes of suggested strategies
- changes in mood / behaviour

Consolidate learning

Provide information:
- future supportive living options
- when to follow up with Case Manager pending consultation with Geriatric Psychiatrist

Prepare for Discharge
- determine necessity of 1-2 more visits

Visit #4 Saying Good Bye to Betty

Post Geriatric Psychiatrist's consultation:
- Formal diagnosis of Mixed Dementia
- Review and support recommendations i.e.: added non-pharmacological approaches
- Medication recommendations

Evaluate:
- Response to medication
- Results of interventions

Enabling Betty's Choice:
- Betty remains at home; GP, daughter & friends to monitor
- Community supports in place: meal delivery service, phone reassurance, ↓ social isolation, PSS for personal care, medications in unit dose pkg, info and support from the Alzheimer Society
- ↓caregiver stress: daughter has↑ understanding, knowledge & compassion
- Revise plan / interventions as needed
- Provide procedure for program re-admission
- Educate Betty and daughter on warning signs / changes that would warrant re-admission to program

Conclusion

Betty was engaged in her treatment plan through a process of short treatment interventions that required collaboration with her, her daughter, and her formal and informal supports.

This was achieved by: clear identification of wants and needs, a well developed plan of action and realistic treatment goals.

These combined actions resulted in Betty's ability to:
- Continue to live in her own home with additional supports at minimal risk
- Prevent repeat trips to the Emergency Department as a result of her distressing hallucinations
- Be discharged from GPCSO services allowing the program to serve additional clients in need

References

1. Smetanin, P., Kobak, P., Briante, C., Stiff, D., Sherman, G., and Ahmad, S. Rising Tide: The Impact of Dementia in Canada 2008 to 2038. Risk Analytica, 2009. http://www.alzheimer.ca/~/media/Files/national/Advocacy/ASC_Rising_Tide_Full_Report_e.pdf
2. Mental Health Commission of Canada: Guidelines for Comprehensive Mental Health Services for Older Adults in Canada http://www.mentalhealthcommission.ca/sites/default/files/mhcc_seniors_guidelines_1.pdf
3. Hamilton, P., Harris, D., Le Clair, K., Collins, J. Putting the P.I.E.C.E.S Together (6th Edition Revised). www.piecescanada.com

Acknowledgements

- Betty is not a specific individual but a composite representation of many clients who we serve
- Thank you to our clients, their families and informal support networks who trust and allow us to participate in their challenging journey
- Thank you to all of the health care professionals, service providers and agencies in the Champlain Region for the care and support of the population we serve

GPCSO SCGPO