

# Supporting Informal Care Providers in a Home Based Setting

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# Goals

- GEMM Care Program
- Why Treat the Caregiver?
  - What we know
  - What we learned
- Our in-the-Home Techniques
- Data Support
- What's next?

# Our Goal...

*“To deliver integrated physical and mental health assessment and treatment to homebound and mobility-challenged older adults.”*

# The “GEMM Care Program”

“Geriatric Medical and Mental Health Care”

- **Jewish Senior Life Physician House Calls Program**  
(home-based primary care: MDs, RN)
- **Jewish Family Service** (community-based counseling, care management: MSW, Ph.D)
- **U of Rochester Geriatric Psychiatry Program**  
(continuum of mental health services: Psych NPs, MD, Ph.D)

# GEMM Care Protocol

- **RN conducts first phone screen & ongoing contact**
  - Gather demographics, patient info
  - Families contact RN frequently
- **MD conducts first medical home visit (~ 90 min)**
  - Review prior records
  - Determine safety
  - Obtain comprehensive hx from patients & caregivers
  - Conduct physical exam
  - Conduct initial mental health screens
  - Develop tentative list of medical & mental health probs

# GEMM Care Protocol - 2

- **If indicated, GEMM Care Advocate (SW) or psych NP makes 2nd visit (about 90 min contact)**
  - Complete mental health and caregiver burden assessments
  - Assure that patient/caregivers understand nature of service
- **GEMM Care Advocate also provides:**
  - Counseling, problem-solving therapy if indicated
  - In-person or phone-based case management (about 30 hrs for each pt who screens positive)
  - Caregiver support (about 15 hrs for each pt who screens positive)
- **Interdisciplinary team meetings twice monthly**
  - Review initial visit/screening results of ALL new cases
  - Discuss ongoing treatment issues

# Screening Tools

- PHQ-2: Depression screen (f/u with PHQ-9)
- GAD-2: Anxiety screen (f/u with GAD-7)
- Mini-Cog: Cognitive functioning
- Audit C: Alcohol Abuse
- Zarit Caregiver Burden Interview

# Initial Plan Revised

- We will treat patients within 4 visits, then refer to “traditional” therapy settings.
- Ongoing mental health tx will take place in the home.
- Case management needs, when identified, will be referred to community partners.
- Case management will be provided by GEMM Care Advocate, RN, and others as needed and appropriate.
- All care givers will be screened with Zarit Burden Inventory. Caregivers experiencing burden will be referred to community partners.
- We will conduct screenings, provide support and encourage referrals to the greatest extent possible.

# Why Treat the Caregiver?

## What we Know

- Caregiving = increased depression, anxiety, physical pain, financial stress, death
- Caregiving = decreased physical health and well-being
- Caregiving = increased aging-in-place (preference, value)
- Depressed caregivers may be the main reason for nursing home placement \*
- 1:3 caregivers experience depression (+ caregivers of pts w/dementia)
- Caregiver burden = decreased perception of patient's functional abilities
- Caregiver burden negatively impacts health and well-being of the patient

# Why Treat the Caregiver?

## What we Learned

### Caregivers

- Impact our process significantly
- Make frequent calls regarding patient care
- Impact our ability to communicate with and treat patients
- Often determine whether or not medical advice is followed
- Are a source of joy and concern for our patients

# Supporting Caregivers: Challenges

- Time
- Privacy
- Motivation
- Stigma
- \$

# Supporting Caregivers: Strengths

- OMH Support—Thank you!!!
- Supportive/Mental-health-sensitive (and savvy) team
- On-site expertise
- Practice size
- Captive audience

# Supporting Caregivers: Solutions

- Incorporate into home visit
- Creatively seek opportunities for privacy
- Provide brief/informal respite
- Provide Education
- Family Meetings
- Connection with Resources

# The Case of Sylvia and Tom

- S & T have lived in Rochester all their lives (3 adult children in town)
- Sylvia had dementia and was wheelchair bound. She had been a well-organized housekeeper, fantastic cook, and skilled decorator
- Tom had impaired gait and increasing joint pain. He was cognitively intact and attended to Sylvia's physical needs. He was a WWII veteran
- Adult children provided social connectedness, but no tangible assistance or respite for father
- Tom became increasingly frustrated with Sylvia's cognitive impairment. He scored high on Zarit screen but refused referrals
- Team supported the entire family as Sylvia's decline quickened
- Home hospice was established and Sylvia died in her home surrounded by family

# GEMM Care Roles - 1

## Geriatrician/ PCP

### **Patient Care**

- Conducted brief mental health screening as part of medical visit; then involved psych NP, SW
- Worked closely with patient, husband and family as care needs increased
- Assisted with Sylvia's transition to hospice care

### Psychiatric NP

- Psychopharm evaluation and treatment recommendations (antidepressant for Sylvia)

### **Caregiver Support**

- Educated patient and family re: care needs
- Supported Tom and family as Sylvia's health deteriorated
- Contact with Tom to explain recommendations

# GEMM Care Roles-2

## GEMM Care Advocate (SW)

### Patient Care

- Provided support and therapy for Sylvia as she grieved her former functioning level
- Provided case management to develop community connections (church calls)
- Sylvia's physical health and cognitive functioning deteriorated
- 4 adult offspring had strong & conflicting ideas about Mom's situation (nursing care, hospice care, in or out of home)

### Caregiver Support

- Developed relationship and trust w/Tom upon arrival, exit, ph calls
- Set up piano "gigs" for Tom
- Encouraged Tom to take walks, pick up needed items during weekly visits
- Set up brief companion care
- Encouraged empathy and development of new patterns
- Had 2 family meetings to provide ed and support to Tom and family and to encourage communication

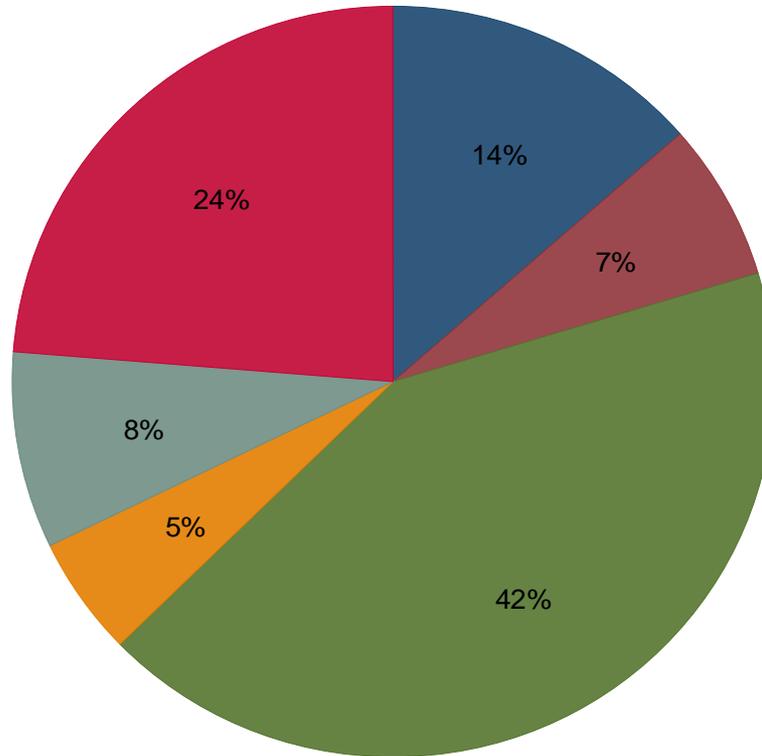
# Sylvia & Tom: Outcomes

- Family-centered care supported *Sylvia and her caregivers* so that she could remain at home as was her wish
- Responsive, integrated care prevented emergency room visits and hospitalizations

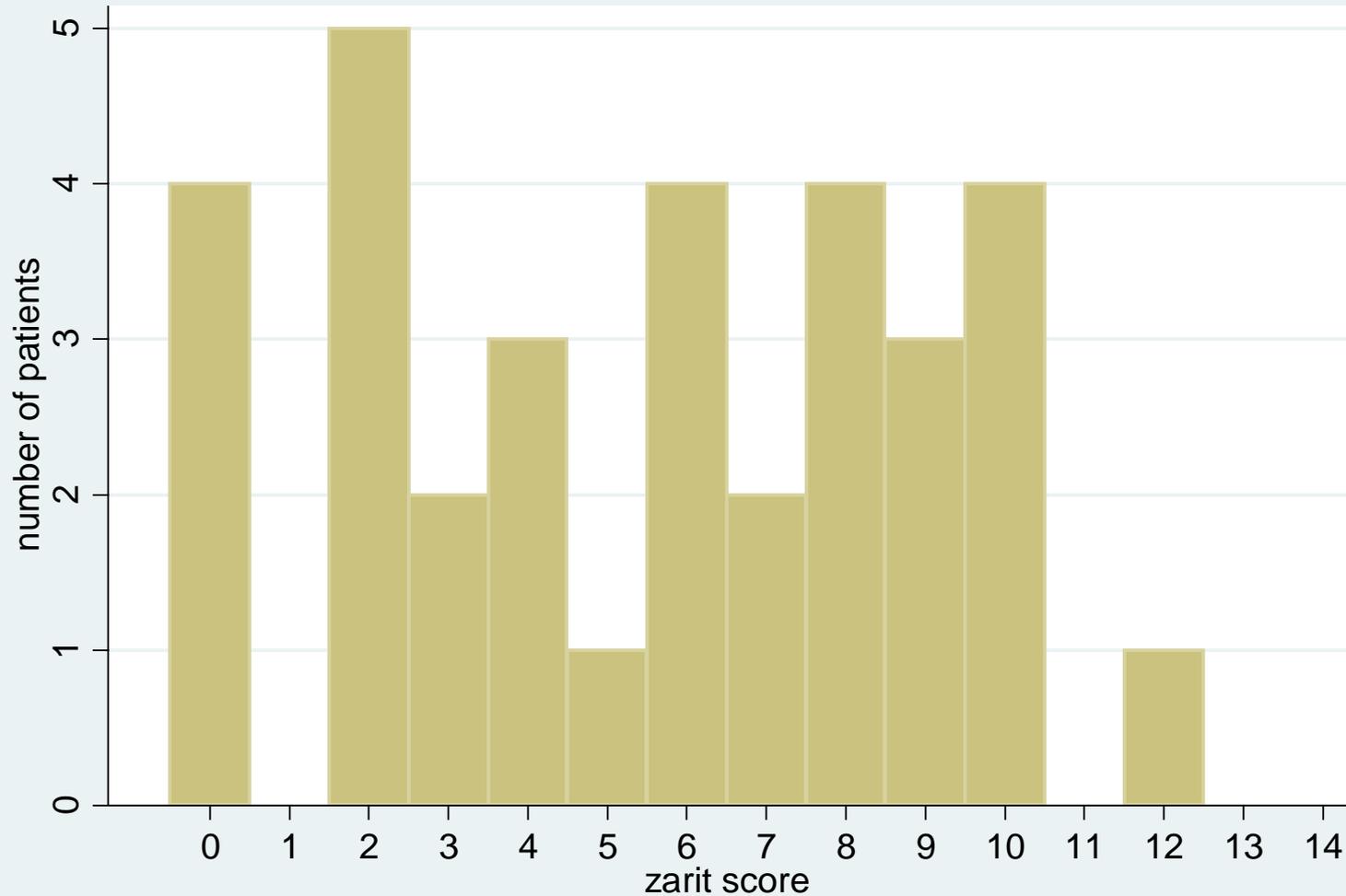
## Of 146 GEMM patients cared for so far...

- 54 (37%) identified as having clinically significant mental health problems
- 47 (32%) identified as having clinically significant cognitive problems
- Diagnoses (not mutually exclusive):  
depression (31, 21%), anxiety d/o (26, 18%),  
dementia (15, 10%), adjustment d/o (14, 10%)

# Most patients have multiple problems...

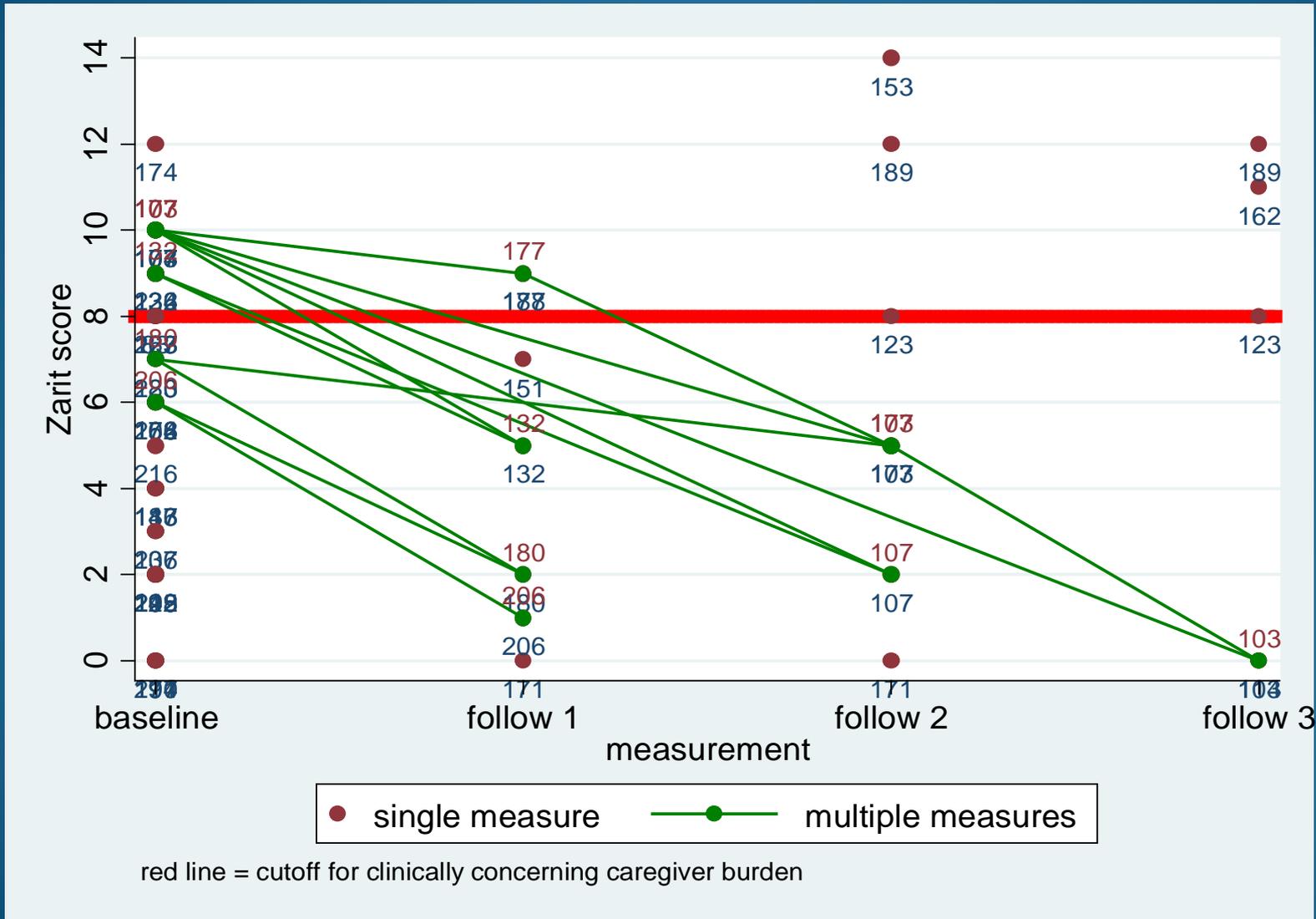


# 36% of those assessed have significant caregiver burden...



N=33

# Caregiver burden decreases over time..



# Findings so far...

- Patients and family members value GEMM model & accept mental health treatment.
- Geriatrician colleagues now use standardized screening tools including caregiver burden assessment routinely as part of integrated care program.
- There are high rates of co-morbid physical, mental health & cognitive problems in this population, complexity of care needs adds to burden risk.
- End-of-life issues abound: How to capture the “value” of helping patients die at home vs. in hospital?
- Family-centered care is critical. Caregivers are consumers of GEMM services although not original focus of protocol

# What's Next?

- Ongoing efforts to sustain and expand program
- Lack of reimbursement for family-centered care that involves caregiver support and case management
- Lack of reimbursement for invaluable, interdisciplinary team time
- Increased focus on data tracking of caregiver experience
- Increased efforts to bill for services
- Demonstrate overall health cost savings by reduced hospitalizations, ER visits & NH placements to support enhanced reimbursement for in-home medical care

# Strategies for sustainability

- Begin billing for psych NP services: In process of empaneling, establishing practice structure for nurses
- Explore expansion to include GEMM Care-PC: Screening & psych NP f/u in PCP practice (“We should be doing depression screening- It’s best practice but we haven’t found the time to deal with it.”)
- Demonstrate overall health cost savings by reduced hospitalizations, ER visits & NH placements to support enhanced reimbursement for in-home medical care

# Thank you!

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