FAMILY SUPPORT AND MULTIPLE CHRONIC CONDITIONS

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DEDICATION
CAREGIVING STATISTICS

- Approximately 43.5 million unpaid caregivers [National Alliance for Caregiving and AARP. (2015). Caregiving in the U.S.]
- At $470 billion the value of unpaid caregiving
  - Exceeded the value of paid home care and total Medicaid spending in the same year,
- 65% of care recipients are female, with an average age of 69.4
- 75% of all caregivers are female, 50% more time providing care than males. [Institute on Aging. (2016). Read How IOA Views Aging in America.]
AGE OF CAREGIVERS

Bar chart showing the average hours of care provided each week by caregivers of different age groups.

- Age 75+ provided 34.5 hours.
- Age 65-74 provided 30.7 hours.
- Age 55-64 provided 25.3 hours.
- Age 45-54 provided 25.8 hours.
- Age 25-44 provided 19.3 hours.
- Age 15-24 provided 14.8 hours.

The x-axis represents the average hours of care provided each week, while the y-axis represents the age groups of caregivers.
UNIQUE CONSIDERATIONS IN WORKING WITH OLDER ADULT PATIENTS & CAREGIVERS

- Understand *resistance* as a defensive function
- Respect *fears of dependency*
- Older adults often have interrelated *economic, social* and personal concern
- Addressing older adult directly
- *While* maintaining a family focus
UNIQUE CARE COMPLEXITIES

Acute
- Stroke
- Heart Attack

Chronic
- Vascular Dementia
- CAD
GENERAL KEYS OF A PROACTIVE APPROACH

- Move from *reactivity to proactivity*
- Have a plan in place *before* the need arises
- Understanding predictable risks
  - Cognitive, behavioral & functional changes
  - Safety risks
  - Care transitions & care support needs
- This approach can help to
  - Decrease anticipatory anxiety
  - Prevent rather than react to caregiver burden & stress
PROACTIVE CARE PLANNING

- 8 general areas addressed:
  - Lifestyle suggestions
  - Functional & role changes
  - Expanding care support network
  - Legal/Financial planning
  - Proactive use of respite
  - Planning for unexpected
  - Planned living transitions
  - Capacity & competence
LIFESTYLE CHANGES

- Choose good nutrition
- High blood cholesterol
- Lower high blood pressure
- Be physically active every day
- Aim for a healthy weight
- Manage diabetes
- Reduce stress
- Limit alcohol
FUNCTIONAL & ROLE CHANGES

- Health crises & functional changes require role adaptations
- Sudden changes in health makes this adaptation more difficult
- Delegation of tasks & roles is critical
  - Start with tasks that others can do easily
  - Move toward more complex tasks
- Delegate based on geography
EXPAND CARE SUPPORT NETWORK

- Expanding the social support network
  - Identify all potential care providers at first visit
  - All caregivers should be adequately educated
- Encourage adequate socialization
  - Couples often do not actively communicate
- Assure supervision needs are adequate
- Delegate “difficult conversations”
- Set-up formal structured support schedule
- Maintain the caregiver’s social engagements
SUPPORT NETWORK DIAGRAM

Formal Supports

Informal Supports

Kin
LEGAL & FINANCIAL PLANNING

- Understanding & developing a financial plan for care
  - Medicare & Medicaid
  - LTC insurance
  - Hospice
- Maximal use of services at each care level
  - Home health is less expensive than facility care
- Completion of appropriate legal documents
  - Advanced health care directive
  - Durable power of attorney for finances
PROACTIVE USE OF RESPITE

- Proactive use of respite
  - Structured family rotations
  - Adult day services
  - Weekend respite trips
  - Assisted living respite
- Several dedicated blocks of time every week
- Allows caregiver to schedule activities
- If caregiver is worried the whole time then they are not getting a break
- Psychological/emotional stress is ranked higher than physical stress among caregivers
PLANNING FOR UNEXPECTED

- Planning for unexpected changes in caregiver’s abilities
  - Short-term plan
  - Permanent plan
- Planning changes in environmental fit
  - Short-term plan
  - Permanent plan
PLANNED LIVING TRANSITIONS

- What are the disease specific red flags?
  - Physical barriers
  - Social barriers
  - Cognitive changes
- Reduce reactive moves
- Location that meets needs across the disease span
  - Care continuum communities
CAPACITY

• Functional & decisional capacity of patient & primary caregiver
  – Decision making & planning
  – What is the capacity of the spouse/caregivers?
  – Is the couple guardians of adult children with capacity issues?

• Capacity of care team
  – Geographical proximity
  – Historic relational connection or discord
    • Between patient & family, & between family members
  – Willingness & availability
GOALS OF CARE CONVERSATIONS

- Explain key differences between durable power of attorney, advanced health care directive, POLST forms
- Early, in-depth conversations with patient, spouse & family
- *Family meetings to discuss wishes helps decrease conflicts & confusion*
- Assure that after decisions are made these are documented
  - Copies of directives to family, PCP, specialists, nursing home or AL
- Reassess & update!
  - Perspectives on quality of life changes as disease changes
- Each decision should support *patient’s* primary goals of care
  - Each decision should answer “to what end?”
CARE TRANSITIONS

● About 1 in 6 Medicare patients was re-hospitalized within 30 days in 2009
  ◆ *heart attack, heart failure, surgery*, hip fractures or pneumonia
● Most likely – *heart failure* 21.2%
  ◆ *Socioeconomic status*
  ◆ *Demographic factors*
  ◆ *Access to social supports*
● Care transition models
  ◆ Enhanced Discharged Planning (Bridge) Model
  ◆ Coleman’s Care Transitions Model
Financial coverage for services is the primary driving care planning consideration.

Medicare covers rehabilitative care:
- PT, OT, ST,
- Rehabilitation stays

Medicare does not cover supportive care for chronic conditions:
- Personal care agency
- Adult day centers
- AL or SNF

Medicaid covers some in home supportive care & SNF

Veteran’s Affairs has a variety of care support programs for those who qualify
Mental Health
MENTAL HEALTH ISSUES

- Depression is an independent risk factor for the a wide range of CVD
  - Van der Kooy et. al. (2007)
    - Persons with late life depression are likely to have a more chronic course of illness
- 20% of older adults experience symptoms of depression
  - Approximately 6 million seniors in America suffer with depression
  - Only 10% receive treatment
  - The recovery rate for those who receive treatment is estimated at 80%
SUICIDE STATISTICS

- Older adult (males) remain high risk
  - 65 – 74 = 15.6
  - 75 – 84 = 17.5
  - 85 + = 19.3
  - National average = 13.4
- Across the lifespan
  - 15 – 24 = 11.6
  - 45 – 64 = 19.5
  - 65 + = 16.6
- Mountain Region high rates in US (19.8)
CHANGES IN SUICIDE RATES
UNIQUE RISK FACTORS OF OLDER ADULTS

- Undiagnosed depression
- Chronic/terminal health conditions
- Social isolation/loneliness
- Loss (physical/functional, relational (spouse/friends), meaning, purpose, dignity)
- Family discord
- Hopelessness
- Later life perspective
- Changes in substance use
- Access to lethal means (67% use firearms, 2x > under 60)
- White males = 24.1 (3x higher than African Americans)
RISK ASSESSMENT & TREATMENT

- Risks Assessment
  - Routine screening
    - PHQ9, GDS,
  - Follow-up questions
    - Past suicide attempts
    - Suicidal plan
    - Probability
    - Preventative factors

- Educational Interventions

- Assessment in Primary Care is critical!

- Evidence-based treatments with older adults
  - Behavioral Therapy
  - Cognitive-Behavioral Therapy
  - Cognitive Bibliotherapy
  - Problem Solving Therapy
  - Brief Psychodynamic Therapy
  - Reminiscence Therapy
REFERENCES

• National Alliance for Caregiving and AARP. (2015). Caregiving in the U.S.
• Institute on Aging. (2016). Read How IOA Views Aging in America