Measuring Outcomes of an APS-Geriatrics Collaboration: Virtual Capacity Evaluations

Cleveland Clinic

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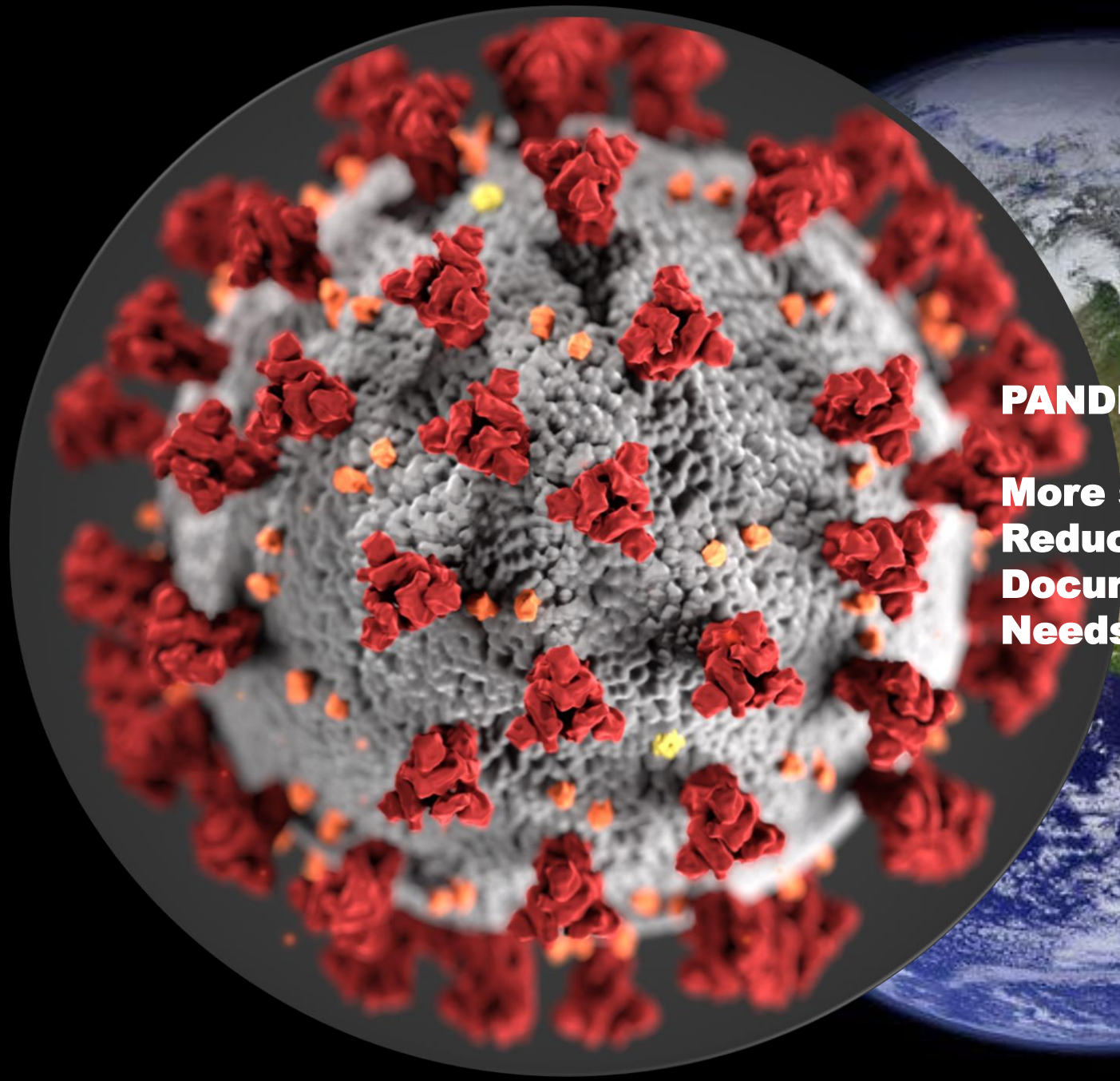

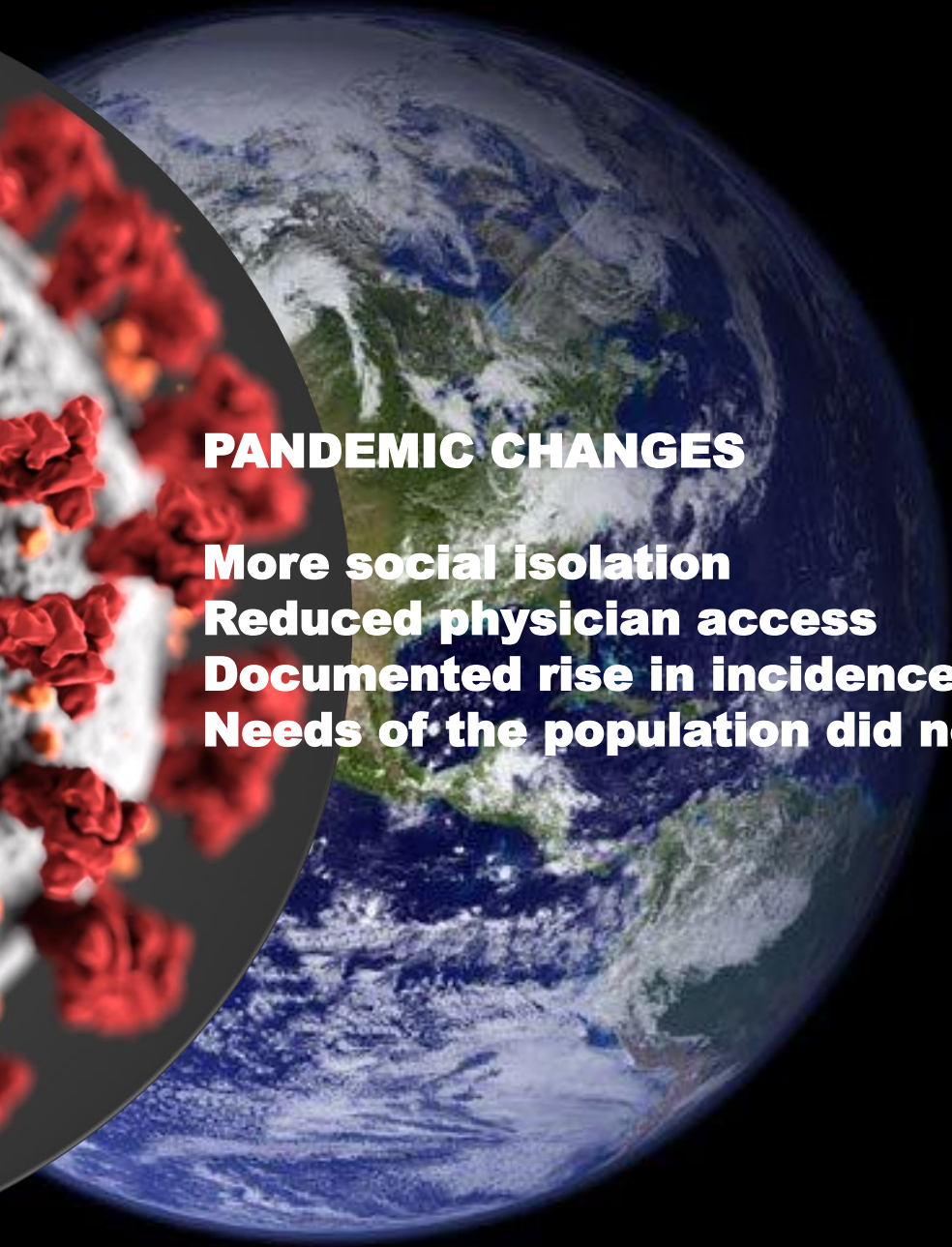

PANDEMIC CHANGES

More social isolation
Reduced physician access
Documented rise in incidence of elder abuse
Needs of the population did not change

Routledge
Taylor & Francis Group

Journal of Elder Abuse & Neglect

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Capacity evaluations for adult protective services: videoconference or in-person interviews

John M. Halphen, Carmel B. Dyer, Jessica L. Lee, Carlos A. Reyes-Ortiz, Cristina C. Murdock, Julia A. Hiner & Jason Burnett

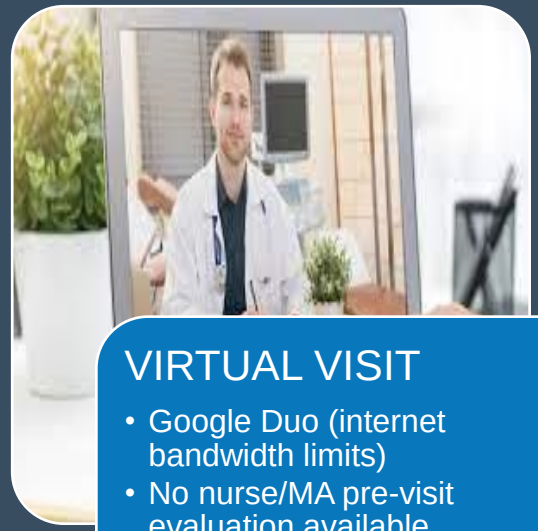
Triggers for Virtual Geriatric Assessment

- APS visit observes the following:
  - Moderate-severe confusion with risk behaviors and lack of supports
    - At risk behaviors: wandering, going to casinos, driving, active exploitation from scams
  - Confusion compounded by medical non-compliance and neglect
  - Combativeness with caregivers
- PCP contacted and cannot perform evaluation
- In person visit cannot be performed
  - No supports for transport
  - No appointments
  - Client refuses to leave the home
- Urgency of need for evaluation

Referral and Evaluation Process

INITIAL REFERRAL

- Contact physician office – APS nurse
  - Set up 1 hour visit (new patient)
- APS provides background information for referral (sent via e-mail)
  - Reason for APS referral
  - Consent for release (should be scanned into system)



VIRTUAL VISIT

- Google Duo (internet bandwidth limits)
- No nurse/MA pre-visit evaluation available
- Components: vitals, cognitive testing, virtual physical examination, medication review (if possible – helps identify comorbid medical problems)

DE-BRIEF

- Results of cognitive testing – PDF sent to physician
- Additional collateral information
- Final recommendations regarding assessment
- Follow-up – if appropriate

Obtaining Collateral from APS

- Police, EMS reports – abuse, domestic violence, physical abuse, wandering
- Community reports – concerns about neglect, abuse, exploitation
- Pill counts – can be conducted in patients home by APS
- Bills – paid or unpaid
- Environment – food in the home, clutter in areas of egress, physical condition of residence, hoarding, vermin
- *Collateral from family often NOT present or reliable in these cases
- *Can consider sending request for release of records (virtual visit – no signature, but can place request for continuity of care)

Pre-visit Information and Set Up

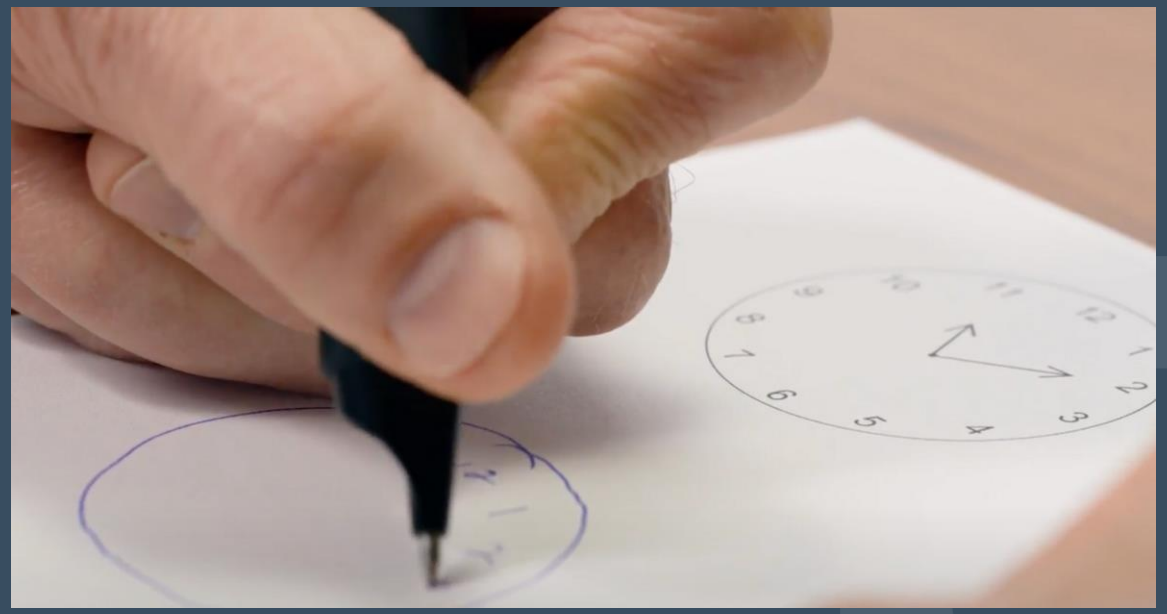
- Is the client available during the time?
- Wi Fi or Hot Spot?
- Vitals including weight
- Medication review and medication list
- Safety concerns…
- Challenges…

Medical Evaluation of Cognitive Impairment

- Known medical/mental illness contributing
  - Chronic illness effects/exacerbation
  - Acute illness - delirium
- Medications – expected and side effects
- Undiagnosed medical problems
- Undiagnosed mood disorder
- Undiagnosed cognitive disorder

Cognitive Testing Used During Virtual Capacity Evaluation

- Saint Louis University Mental Status Exam (SLUMS)*
- Geriatric Depression Scale (short form)
- CLOX test
- Trails A and B*



Interview Questions

- Who is their usual doctor?
- Functional Status: BADLs and IADLs – what does the individual believe they are doing independently
- Geriatric issues:
  - Does the person think they have any memory problems? Do they think that the memory problems affect function? (insight)
  - Any depression?
  - Any weight loss?
  - Any dementia related experiences?
  - Any falls, emergency department visits, hospitalizations?

UNDERSTANDING, APPRECIATION

Interview Questions

- More details:
  - Medications: what, how many, why?
  - Finances: what bills, how often paid?
  - Groceries: what is bought at store, how often do you go?
  - Meal preparation: what did you eat for dinner last night, this last week?
- Identifying trusted decision maker
- Future planning: (judgment)
  - Safety questions
  - Acceptance of assistance in the home
  - Alternative living arrangements

UNDERSTANDING, REASON

Putting Things Together

- Is there functional impairment?
- Is there cognitive impairment?
- Is functional impairment due (at least partially) to cognitive impairment?

Putting Things Together

UNDERSTANDING:

- Does the individual understand that there are functional impairments?
- Does the individual understand that there is cognitive impairment?
- Does the individual give explanation for why functional impairment exists?
- Does the individual give explanation for why they need assistance for function (whether or not they recognize that functional impairment exists)?

APPRECIATION:

- Does the individual give explanation for why functional impairment exists?

Putting Things Together

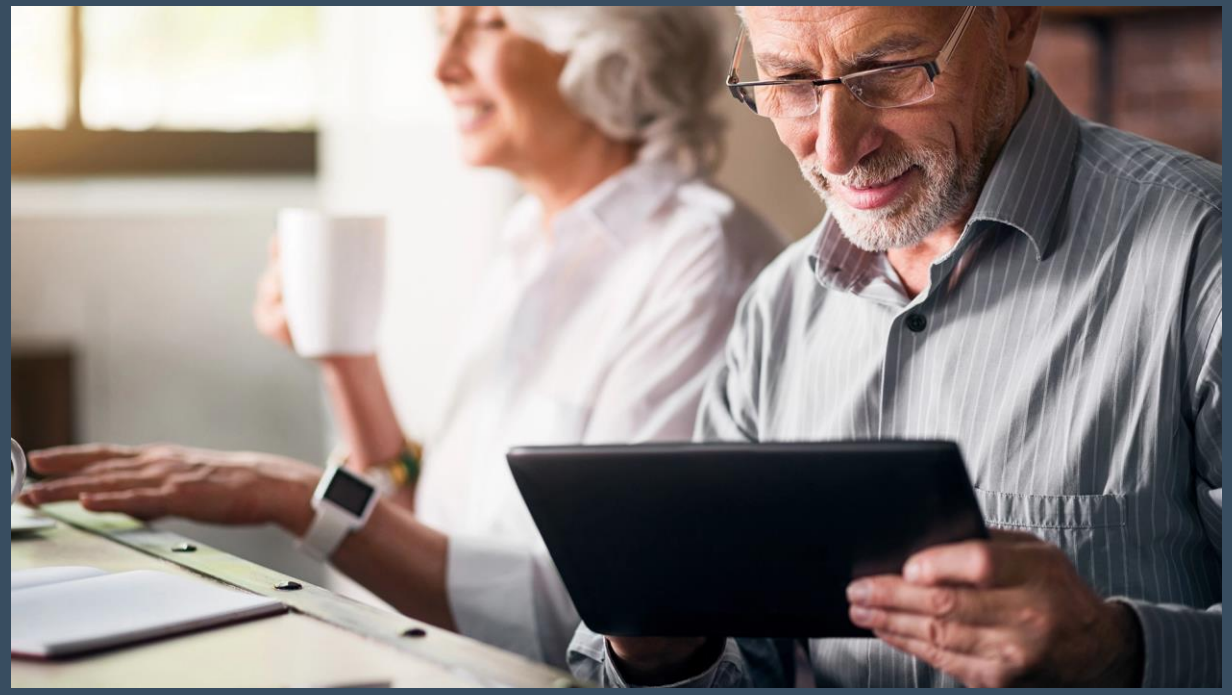
REASON:

- Does the individual give explanation for why they need assistance for function (whether or not they recognize that functional impairment exists)?
- Would the individual accept assistance in the future if care needs decline? If not, what is their explanation?
- Does the individual consider alternative living situation if home is no longer the proper place for them to reside?

COMMUNICATION:

- Can the individual understand questions asked?
  - Can the individual effectively articulate answers to the above questions?

Virtual Physical Examination



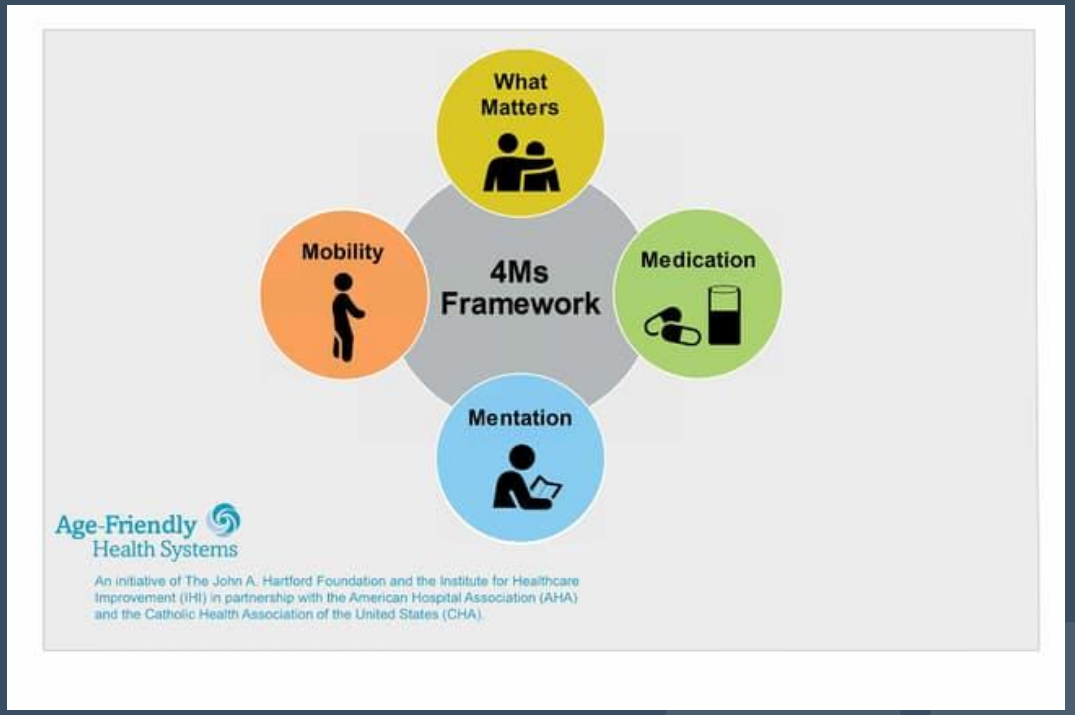
- Vitals
- Observation of…
  - Breathing
  - Speech
  - Eye movements
  - Movements of arms
- Active neurological examination
- Evaluation of walking
- Brief assessment of environment (obstacles for falls)

Debrief

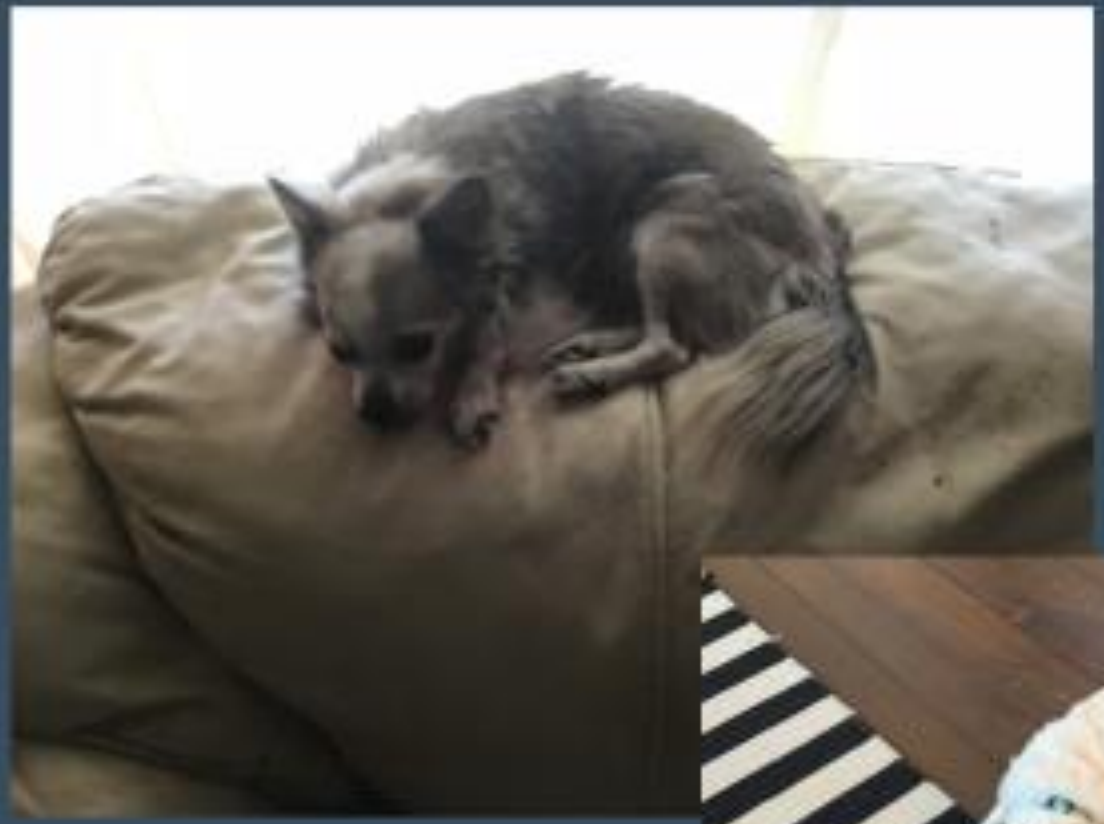
- Comparison of data
  - Collateral and collected information vs. information from the individual
  - Any recommendations for medical testing
  - Connection to follow-up primary care
  - Completion of Statement of Expert Evaluation

Medical Framework of Evaluation – 4Ms

- Mentation:
  - Cognitive evaluation
  - Capacity evaluation
  - Recommendations for medical workup of cognitive impairment
- Mobility:
  - Assessment of gait and mobility
  - Identification of environmental risk factors for falls
- Medication:
  - Medication reconciliation
  - Identification of adherence issues
  - Identification of potentially uncontrolled chronic medical issues
  - Identification of acute medical problems (rare)
- What Matters Most: independence
  - Collaborative plan of care
  - Offering of community services
  - Reconnection to medical care
  - Decisions considering the best interests of the individual being evaluated



Collateral Damage



19 lbs Yorkie!

Collateral Damage

Pilot Program Background

- Conducted: May 2020-September 2021 N: 54
- Data collected retrospectively:
  - Age
  - Gender
  - Whether or not client was receiving routine medical care prior to evaluation
  - Was there a diagnosis of dementia prior to evaluation
  - Whether or not statement of expert evaluation was completed
  - Achievement of the following:
    - Completion of statement of expert evaluation (SEE)
    - Assignment of guardian or conservator
    - Recommendation and acceptance of services to support the individual
    - Ability of individual to remain at current residence
    - Placement in a more supervised setting
    - Connection/reconnection to medical care after evaluation completed
    - Type/types of abuse alleged

Demographic Information

- Average Age: 79
  - Men: 19 (35%)
  - Women: 35 (65%)

Demographics and Outcomes

Statement of Expert Evaluation Completed	yes	no
	38	16
men	11	8
women	27	8
average age	79.07895	78.4375
Guardian assigned	28	0
Conservator assigned	3	2
Prior Primary Care Available	16	7
Connected to Primary Care After Evaluation	33	11
Dementia Diagnosis Prior to Evaluation	13	4

Services and Placement P1

services offered	SEE	No SEE	guardian assigned	no guardian assigned	
Yes	33	15			
No	5	1	1	4	Higher fraction of individuals not offered services were not assigned guardian (4/5) - ?reasons
services offered	33	15			
Yes (accepted)	12	3	9	3	Slightly higher fraction of individuals who accept services are not assigned a guardian (3/12)
No (refused)	21	12	18	3	Higher fraction of individuals who refuse services are assigned a guardian (18/21)
accepted and stayed home	7	3	5	2	Higher fraction of individuals accepting services stay home (7/12) compared to those who refuse (7/21)
accepted and placed	4	0	4	0	Reason for acceptance then placement?
refused and stayed home	7	12	5	2	higher fraction of individuals who refuse services are placed (13/21) vs. staying home (7/21)
refused and placed	13	0	12	1	Slightly higher fraction of individuals who accept services are not assigned a guardian (3/12)

The Rest

- No Services Offered (5)
  - 1- stayed home
  - 1- placed
  - Others (3) – moved in with family or moved out of state

Services and Placement P2

services offered	SEE	No SEE	guardian assigned	no guardian assigned	
total staying home	15	16	10	5	
total placed	18	0	17	1	compared to individuals who are not assigned a guardian, persons assigned guardian are more likely to be placed
other	5	0	1	4	

Dementia and Medical Care

	prior dementia diagnosis	no prior dementia diagnosis	primary care prior to eval	no primary care prior to eval
	17	37	23	31
SEE completed (38)	13	25	16	22
Guardian assigned (28)	8	20	11	17
Stayed at home (31)	11	20	16	15
Placement (18)	5	13	5	13

Conclusions:

- Higher fraction of individuals with no prior diagnosis of dementia are likely to
  - Have guardian assigned (20/37 vs. 8/17)
  - Placed (13/37 vs. 5/17)
- Higher fraction of individuals with no primary care prior to evaluation are likely to
  - Have guardian assigned (17/31 vs. 11/23)
  - Be placed (13/31 vs. 5/23)
- Persons connected to primary care prior to evaluation are more likely to stay home (16/23 vs. 15/31)

Abuse Types Encountered

	prior dementia diagnosis	no prior dementia diagnosis	
	17	37	
Single Abuse Type(s) Alleged			
Neglect (N)	1	2	
Self Neglect (SN)	8	19	No diagnosis – no medical care?
Financial Exploitation (FE)	2	7	No diagnosis – isolated - ?no one watching
Physical Abuse (PA)	0	0	
Verbal Abuse (VA)	0	1	
Multiple Abuse Types Alleged			
N-FE	2	2	persons with prior diagnosis of dementia seem to be more likely victims of multiple types of abuse
SN-FE	2	3	MULTIPLE combinations with FE
VA-FE	0	0	
PA-FE	0	1	
N-SN	2	2	

Additional Opportunities to Evaluate

- Medication review
  - Helpful? Effective?
  - Are practice issues identified: administration (drops, injections for diabetes), adherence
- Falls: environmental risks, clutter
- Identification of sensory impairment: hearing, vision (impacts assessment)
- Identification of hoarding
- Problems with animals, pets
- Infestations: cockroaches, bedbugs
- Housing issues: toilets working, lights working, home in disrepair
- Nutrition issues: missing food? Expired/spoiled food?
- Access to emergency services: recalls “911”, access to phone, panic button
- Technology issues: limited bandwidth for virtual visit (impacts assessment)
- Safety issues for APS: Need for protective service order, police escort
- Study of candidates selected for virtual capacity evaluation vs. those who are not - ?impact on outcomes

More Opportunities

- Is there any difference that is noticed by Probate Court Judges? Physicians involved in the evaluations?
- Are there any challenges to implementation identified by APS?
- Security and privacy issues: How is privacy preserved? How is security of the virtual assessment maintained? Are these real threats?
- Technology challenges: How can these barriers affect implementation and availability of these resources? How do you implement this in rural areas? Areas with low bandwidth?

Future Directions

- Differences in outcomes vs. usual pathways
- Does virtual capacity evaluation result in FASTER interventions vs. usual care/usual pathway
- How has acceptable has this intervention been to agency staff
- How has availability of this resource changed practice?
- Ohio practice: compare outcomes to other counties that DO NOT have virtual evaluations available
- National practice: compare outcomes to other parts of the country that DO have such services – how do you measure outcomes and differences?

Practice and Policy Implications

- Sustainability: How can this resource be maintained? How do you recruit, train, and retain physicians to do these evaluations
- Advocacy: Can lawmakers help advocate for or champion this services? How can you provide fixed financial support beyond current funding (county APS budget only)
- Purpose of research: share experiences, observations, and knowledge to help other practitioners encountering similar situations and offer them solutions and insights

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100 YEARS

EST. 1921

THE FUTURE OF HEALTHCARE SINCE 1921