People experiencing homelessness with cognitive impairment

Interdepartmental and cross-organizational collaboration in transitions of care

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Whole Person Integrated Care

Agenda

- Background
- Challenges
- Considerations
- Framework
- Case work

Background: What is cognitive impairment

Mild cognitive impairment

- Presence of memory difficulty greater than expected for age
- Objective memory impairment
- Preserved ability to function in daily life

Background: What is cognitive impairment

Major neurocognitive disorder (Dementia) DSM V criteria

Significant cognitive impairment in at least one of the following cognitive domains:

- Learning and memory
- Language
- Executive function
- Complex attention
- Perceptual-motor function
- Social cognition

Background: What is cognitive impairment

Dementia DSM V criteria *(continued)*

- The impairment must be acquired and represent a significant decline from a previous level of functioning
- The cognitive deficits must interfere with independence in everyday activities
- The disturbances are not occurring exclusively during the course of delirium
- The disturbances are not better accounted for by another mental disorder (e.g., major depressive disorder, schizophrenia)

Background: common causes of dementia

- Alzheimer disease (AD)
- Vascular Dementia
- Parkinson Disease Dementia
- Frontotemporal lobar degeneration
- Lewy body disease
- HIV infection
- Huntington disease
- Prion disease
- Substance and or medication use
- Traumatic brain injury

Background: Risk factors

- **Age:** Half of American population of people experiencing homelessness (PEH) is over 50
- **Family history**
- **Chronic health conditions:** Diabetes, high blood pressure, or high cholesterol

Background: Risk factors

- **Smoking/substance use**
- **Traumatic brain injury:** Even a single head injury increases the likelihood that you'll get **dementia** later in life. The more head injuries you have, the greater your risk.

Background: Dementia in PEH

Do cognitive disorders contribute to homelessness?

Do comorbidities of homelessness contribute to cognitive decline?

- Higher incidence of Traumatic Brain Injury (TBI) (2-7x general population)
- Higher incidence of substance use and alcohol use disorders
- Less engagement in chronic care management of chronic disease

Background: MORE AND AT A YOUNGER AGE

- Compared to general population PEH aged 50 years and older have higher rates of cognitive impairments
- Individuals from homeless shelters in Boston, USA, with a mean age of 56 years: 24% had cognitive impairment
- PEH acquire age-related functional impairments substantially earlier than do members of the general population

Background: Consequences of impaired cognition

- Loss of ability to communicate
- Loss of ability to care for oneself
- Memory loss
- Inability to recognize loved ones
- Increased mobility issues
- Increased risk of infections
- Decreased lifespan

Challenges: Navigating Recuperative care

- General resources and recommendations
- Wandering
- Memory: Unable to remember existing resources
- Custodial needs: (Help with ADL, IADL)

General: Preventing further decline

1) Healthy food and healthy weight
2) Smoking cessation
3) Manage blood pressure, diabetes and other chronic medical conditions
4) Stay (or become) physically active
5) Create an environment that promotes quality sleep
6) Create an environment of social network
7) Adjunctive medical care and monitoring for infections, bed sores etc.
8) Harm reduction for alcohol and substance use

General Recommendations: Medical care

1) Treatment directed at underlying cognitive disorder
2) Lifestyle: (exercise, healthy weight and diet, sleep hygeine)
3) Quit smoking
4) Keep blood pressure under control
5) Manage diabetes
6) Harm reduction for alcohol and substance use

Challenges: Wandering precautions

1) Testing in hospital/community/shelter for bed location
2) Guiding throughout the facility
3) Placing bed in front and entry with known possessions such as blanket, clothes, etc.
4) Signs at bedside/color tape on floor
5) Wrist bands with name, location and number of facility

Challenges: Wandering precautions

1) Staff education and training to redirect those at risk for wandering
2) Promoting sleep hygiene through out the facility with lights out and minimization of noises for restful sleep
3) Sending out BOLO (Be on the lookout) to community partners, community paramedics and departmental staff

Challenges: Memory: losing benefits card, forgetting family/loved ones

1) Request records to identify prior emergency contacts and obtain collateral
2) Record collateral information in medical record/sign out for others to access
3) Maintain routines: Continue at the same clinic, same payee, same providers
4) Hold important documents at risk of being lost with client consent

Challenges: Social: losing benefits card, forgetting family/loved ones

1) DPOA:
    1) Has capacity
    2) Person voluntarily signs over legal matters
2) Conservatorship:
    1) Lacks capacity
    2) appointed representative despite someone's wishes

Challenges: Support in ADLs/nursing needs

1) Assess for medical comorbidities (DM or UTI causing incontinence)
2) Simplify continence regimen: bedside urinal, incontinence supply
3) Timer or staff to remind (for meals or toileting etc.)
4) DOT
5) Nursing assistants/Patient care assistants for clinic level of care ADL support

Resources: adjunctive

1) Adult day care
2) In Home Supportive Services (IHSS)
3) Health at Home (HAH) PT/OT

Considerations for transitions of care

1) Current memory and ability to navigate a new environment and return to ongoing care resources
2) Trajectory: Cause of cognitive impairment can inform
    - Was this TBI and expected to be stable?
    - Is this Alzheimers and expected to progress?
3) Current medical needs
4) Current custodial needs (ADL support)

Transitions in care: Independent living (PSH)

Benefits:

- Autonomy
- May be easier access or shorter wait time
- May be only option for PEH with Substance use disorder who are unable to maintain abstinence

Risks:

- Decline may occur and go unrecognized
- IHSS worker may theoretically but not in reality meet needs

Transitions in care: Independent living

May be Augmented by:

- IHSS
- HAH *(initial home safety evaluation and need for supportive devices for reasonable accommodations)*
- CalAIM Enhanced Care Management (ECM)/Intensive Care Management (ICM)
- CalAIM Community Supports (CS)

Transitions in care: Assisted living

Non-medical custodial care (ADLs)

Residential care homes are licensed for six or fewer residents housed in a private residential home setting

- Benefits: become familiar with small staff
- Cons: limited programs/groups

Assisted living facilities: complexes or specialty facilities generally built to care for elderly people

Transitions in care: Assisted living

Provision and oversight of personal and supportive services

- Assist with self-administration of medication
- Provide three meals per day plus snacks
- Housekeeping and laundry
- Transportation or arrangement of transportation
- Activities
- Skilled nursing services as needed

Transitions in care: Assisted living

Benefits:

- Can provide assistance with all daily living activities, such as bathing, dressing, toileting, urinary or bowel incontinency care.
- In general ½ cost of nursing home

Cons:

- Limited skilled nursing services (injections, catheters/colostomy care) unless there is a credentialed RN or LVN in the home)
- More expensive than public benefits and not covered by medical insurance
- Potentially long wait list

Transitions in care: Assisted living waiver

- Medi-Cal and Medi-Care do not pay for assisted living as it is considered a non medical facility
- Assisted living waiver created under California Department of Health Care Services (DHCS) to pay for assisted living
- Currently, the Assisted Living Waiver (ALW) is available in 15 counties and the current five-year waiver term is approved for March 1, 2024 – February 28, 2029.

Transitions in care: Assisted living waiver eligibility

- Age 21 or older
- Have full-scope Medi-Cal eligibility with zero share of cost
- Have care needs equal to those of Medi-Cal-funded residents living and receiving care in nursing facilities
- Willing to live in assisted living as an alternative to SNF
- Able to reside safely in an assisted living facility or public subsidized housing
- Willing to live in an assisted living setting located in one of the 15 counties

Transitions in care: Skilled Nursing Facility (SNF)

1) Skilled nursing
2) People who require 24-hour care
3) Daily skilled nursing (acute care needs like IV antibiotics, tube feeds)
4) chronic care needs such as custodial care
5) Daily supervision for safety and elopement behavior secondary to dementia-related
6) Cognitive limitations requiring a secure unit
7) Physical Therapy 5 times/week and additional rehabilitation services

Transitions in care: Skilled Nursing Facility

Pros:

High level of care including nursing needs for most vulnerable

24 hour care

High level of safety

Cons:

Strict qualifying criteria

curfew

low tolerance for substance use

Framework: Patient Centered Approach

- Level of cognition
- Trajectory of cognition
- Medical needs
- Capacity for decision making vs autonomy
    - DPOA and conservatorship
- Substance use and mental health history
    - SB 43
- Custodial care needs
    - Ability to perform ADLs and IADLs

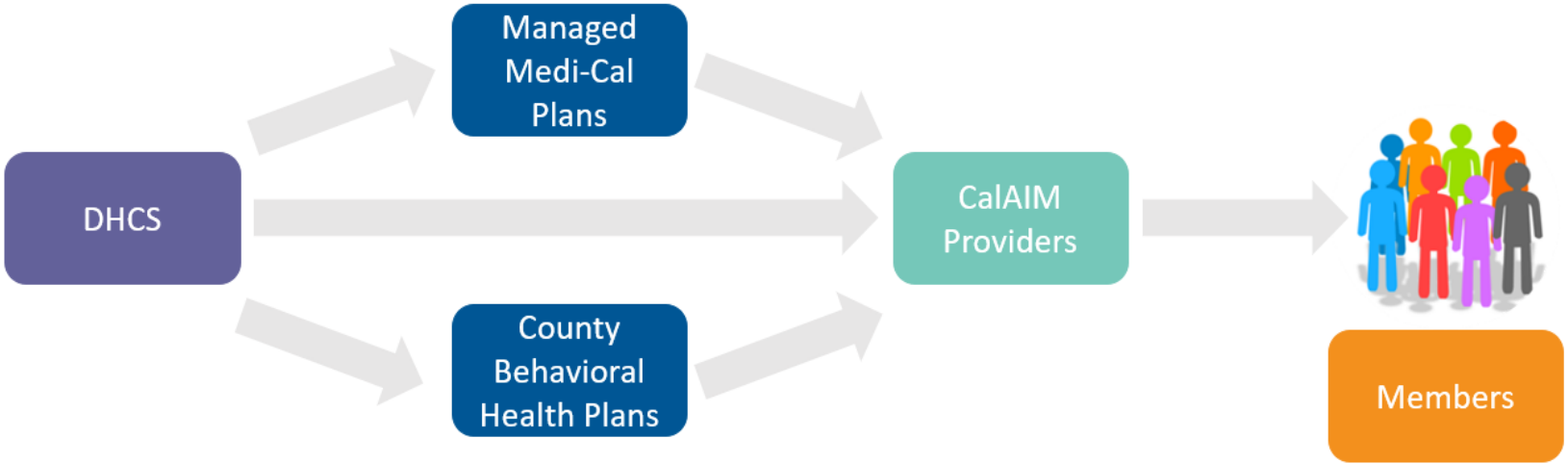
CalAIM Overview

- A statewide transformation of Medi-Cal with the goal to provide more **coordinated, person-centered, equitable** health care, addressing the medical, mental, dental, and **health-related social needs** of the state's most vulnerable.
- CalAIM strives to **standardize, simplify, and streamline** how members across the state access health care by working to better integrate and coordinate care for members.
- **No matter where members seek care** – at the doctor, with a social worker, or at a community center – they'll be connected to the quality of care they need.

CalAIM Populations of Focus

- **Individuals experiencing homelessness**
- **Individuals with Serious Mental Illness (SMI) or Substance Use Disorder (SUD)**
- Individuals with high utilization of care
- Individuals transitioning to the community from incarceration
- Foster youth
- Individuals at risk of institutionalization
- Black, American Indian or Alaska Native, or Pacific Islander individuals who are pregnant or postpartum

CalAIM Structure



CalAIM Community Supports (CS)

A menu of 14 community-based, **medically appropriate and cost-effective** alternatives that:

- address health-related social needs
- can substitute for and decrease utilization of hospital care, nursing facility care, visits to the emergency department, or other costly services
- are optional for Medi-Cal Managed Care Plans (MCPs) to offer and for beneficiaries to use

SFDPH CS Implementation

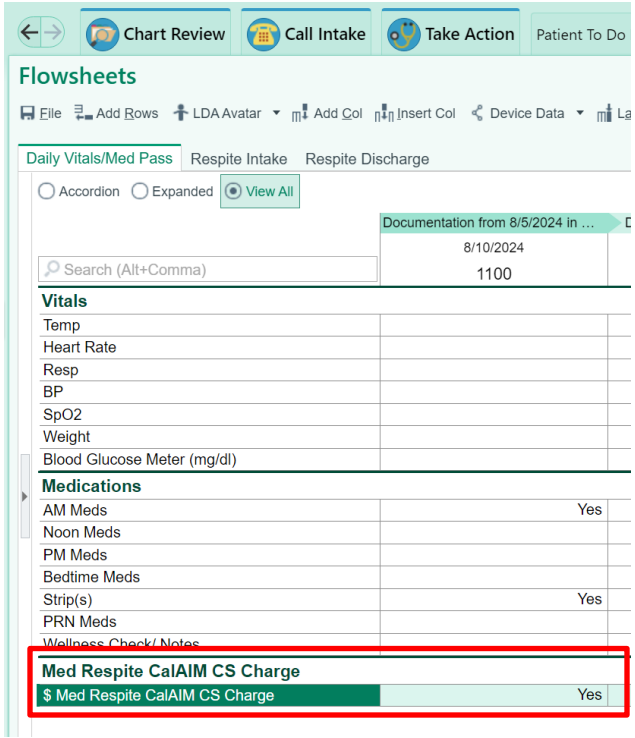
- SFDPH has coordinated with the San Francisco MCPs (San Francisco Health Plan and Anthem) to identify SFDPH programs, such as Medical Respite, that align with CalAIM Community Supports.
- 1/1/2022 implementation of Medical Respite as a SFDPH CalAIM Community Support provides an innovative Medi-Cal funding stream to support current programs and potential expansion.

CS	*CS Program*
Recuperative Care (Medical Respite)	Medical Respite
	Managed Alcohol Program (MAP)
Sobering Center	Sobering Center (alcohol)
	SoMa RISE (drug)

SFDPH Medical Respite CS Successes

Implementation of Medical Respite as a CalAIM CS was designed to have minimal impact on front line workflows

- Simple front-end process and minimal impact for front line staff to bill
- Revenue generation



CalAIM Community Supports Continuity of Care

40-year-old person with developmental delay, alcohol use disorder, bipolar disorder, and diabetes. Has had many emergency department visits and blood sugars >500. Resides in permanent supportive housing site.

ECM Lead Care Manager supported linkage to PCP, connected client to medically tailored meals, provided diabetes education, and provided meds in bubble packs resulting in improved diabetes control.

Facilitated a safety transfer to a permanent supportive housing building with more on-site nursing services, and supported client in attending court to press charges for interpersonal violence.

Helped with linkage to Intensive Case Management for mental health support.

Case 1

R.T. is a 68 year old admitted to Respite on 5/1/2018

PMH: R thalamic hemorrhage (CVA), L-sided hemiparesis, HTN, CKD Stage II.

Referred from Winter Shelter presenting with significant physical and cognitive defects: wheelchair bound, not independent in ADLs, and vulnerable with limited survival skills and decision-making capacity.

What further evaluation is needed? Where does he go on discharge?

Case 1

Per Neuropsych evaluation found to lack capacity including medical decision making and recommended for conservatorship.

Conserved on 12/17/2020. Referral to long-term placement followed conservatorship. Client DCed to Long Term Care facility 2/25/21

Case 2

M.N. is a 66 year old admitted to Medical Respite from Shelter

PMH aortic dissection, HTN, poor memory/dementia, and h/o ETOH dependence.

Client was struggling with frequent ED and hospital admissions due to med adherence, cognitive impairment and heavy EtOH use.

Found to have significant memory defects. Would get lost frequently and require periodic re-orienting.

What further evaluation is needed? Where does he go on discharge?

Case 2

Neuropsych indicated pt lacked capacity.

SW initiated conservatorship with Pt's brother on 3/21.

Team struggled with finding safe, appropriate placement given pt's alcohol use and were unable to identify an RCFE that was suitable to his level of need, but where he could also continue to drink. Staff helped client gradually reduce his drinking over the course of several months, and client was discharged to Assisted Living on 9/28/22.

Case 3

XD is a 73 y.o. male with PMH of moderate/severe cognitive impairment (Korsakoff syndrome), AUD, compensated cirrhosis referred from the hospital.

Client had lived outside for many decades and struggled with being in an indoor congregate facility, and would try to leave frequently.

Case 3

We purchased single instant coffee packets, as coffee was identified as a way to redirect client when he wished to leave, and placed client next to our CBO staff desk to ease frequent orienting.

Despite our efforts, this client did wander away from the facility a few times, we would put out a BOLO and then he would be returned to us. Client was discharged from Respite after a 28 day stay, after not returning for several days. Eventually, after multiple ED visits he was placed at RCFE.

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