SOCIAL WORK CONSIDERATIONS for Ensuring Coordinated Care Transitions with Patients Presenting With Physical and Behavioral Symptoms Related to Neurological or Behavioral Health Diagnoses

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Providing social work services to the aging population offers the profession a unique opportunity to support clients who present with a wide range of complex issues. The aging population is growing; therefore, practitioners are exploring methods of providing adequate assistance to aging patients who display behavioral disturbances. Important assessment issues include whether the patient has a change in behavior or decline in cognitive function that can be attributed to a neurological condition, behavioral health disorder, or a mix of illnesses related to acute or chronic conditions. It can be tricky to pinpoint the direct cause of the behavioral change, and as these issues are being addressed, the patient can be shuffled from one agency to the next, with social workers trying to find services based on a mix of behavioral health symptoms. Such shuffling may contribute to a lower level of functioning for the patient. This article will explore the complexity of distinguishing between acute care and outpatient community service admission, acute or outpatient psychiatry, or neurology in caring for patients with dementia and/or behavioral health diagnoses.

THE PROBLEM

The American Psychological Association recently reported that the "growing mental and behavioral health concerns facing older Americans" are alarming. Emerging issues for the aging population include "mental health concerns," "depression and suicide," "chronic illness," "Alzheimer's disease and dementia," and the need for more aging-related mental health professionals (American Psychological Association, 2018). According to the Alzheimer's Association, 5.7 million Americans are living with Alzheimer's disease (www.alz.org/alzheimers-dementia/facts-figures), and this number is projected to rise to nearly 14 million by 2050.

STATE OF AFFAIRS ON ASSESSMENT

The acute care admission process for symptomatic patients consists of a comprehensive diagnostic assessment that entails numerous medical and behavioral health methods of information gathering. This assessment often begins with an evaluation and continues with a diagnostic process that requires extensive probing, medical history review, consultation, and keen analytical approaches to accurately diagnose reported symptoms, arrange necessary consultations, and determine appropriate specialty-service assignment and treatment. In some instances, this process may occur over the phone via consultation with one or more primary care physicians or through direct report from family members or caregivers.

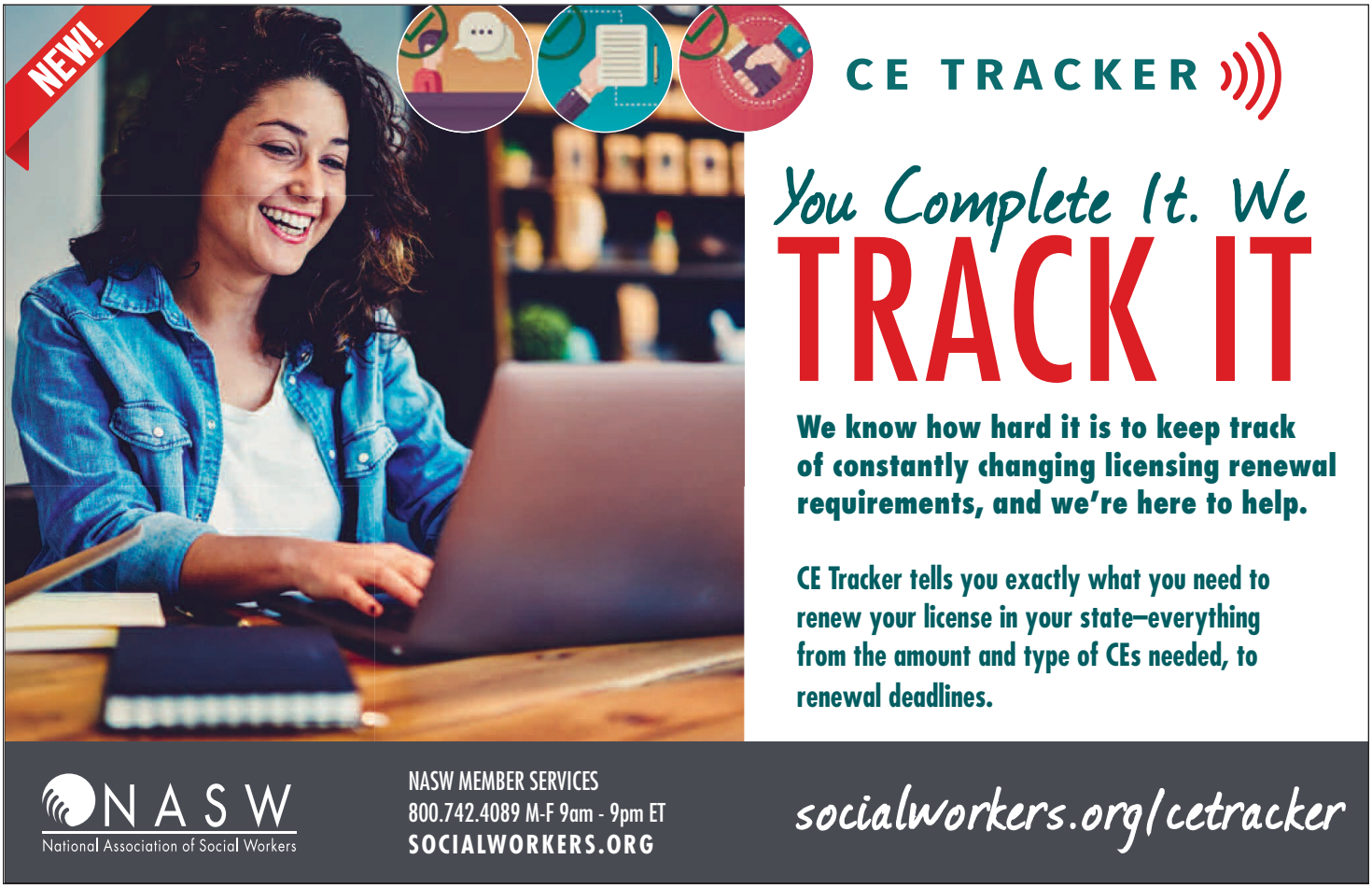
In hospital settings, attending or emergency physicians admit aging patients into acute care centers for observation or for a general inpatient stay after an initial assessment and screening in a primary or specialty care provider's office. In the community, a patient's clinical assessment report may derive from a team of first responders, employees from a supervised living environment or long-term care facility, and/or primary caregivers in home-based settings. In determining the most suitable approach to treatment, a mini mental exam is often administered to quickly access cognitive coherence and competence. Another important step is to determine if the patient has a durable power of attorney for health care or if there is a next of kin who will act as primary health care decision maker during the admission and treatment phases.

RECOMMENDATIONS

Social workers who are charged with identifying and coordinating services for aging patients are most effective when they have accurate information about the patient's health and functioning capacity. In a person-centered practice environment, self-reporting should not be dismissed; however, aging patients with the potential onset of a neurological condition or a behavioral health disorder may require a more accurate integrated reporting system. Consistently engaging caregivers and those who can report on the daily functioning of the patient is essential. The inclusion of community-based care providers in this assessment is recommended as a vital component of historical fact gathering.

Further, research suggests that "promoting a home-based" multidisciplinary team of medical professionals and care managers is also necessary for all aspects of care to align and to lessen avoidable hospitalizations (Arai H1, 2012). The referral process is most effective when it is based on a widely utilized set of standards that account for the essentials of culturally appropriate health care. As social workers navigate these systems on behalf of patients, delayed responsiveness by providers may result in lack of care continuity. Therefore, outreach and advocacy for patients may be a vital aspect to building coalitions of support and engaging in essential planning discussion for developing continuity of care with aging patients.

Another solution to consider is the use of technology. Technology can track care



coordination, monitor patient safety, and educate patients and caregivers while providing alerts and reminders for medication and disease management. According to recent statistics from the Pew Institute 59 percent of seniors access the internet (Smith, 2014). Although some patients may have physical limitations that inhibit them for using technology (Smith, 2014), there are devices that can be worn by the patients as monitors and/or cameras. Also, online technology can be accessed by the aging patient and caregivers, thus allowing accommodations for physical limitations. A Center for Technology and Aging report has outlined a comprehensive toolkit to encourage integration of technology that includes "fall monitors," "caregiver platforms," and a "formal care platform" (Ghosh, Lindeman, David, Ratan, & Steinmetz, 2014). The report also suggests that smart tool technology has already contributed to a reduction of health services utilization and improved health care delivery (Ghosh et al., 2014). It is safe to assume that as technology advances, the aging community's use of smart tools will increase. Social work professionals can be on the front lines of educating, coordinating, and advocating for aging patients to have the most advanced technology. This can potentially lead to enhanced accuracy of diagnoses, early prevention, appropriate treatment approaches, and increased monitoring of patients with a variety of neurological and/or behavioral health symptoms in acute care and community-based settings.

Finally, to prepare for an expansion of the aging population presenting with symptomology related to either neurological or behavioral health disorders, a population-specific organizational policy is needed. In many communities, local and state aging and disability agencies are the first service entry points for aging patients who have a variety of symptoms; in other places, full-service behavioral health agencies are tasked with providing care. The 2016–2017 Massachusetts Department of Public Health's Alzheimer's and Related Dementias Acute Care Advisory committee report is one example of advanced state agency planning for the treatment of patients with neurological related symptoms (Massachusetts DPH, 2017). The committee published the following recommendations for hospitals:

- Adopt an operational plan available to the public to identify dementia and/or delirium in the emergency department or inpatient setting and create a care plan specific to the population.
- Commit to engage caregivers in the hospital and discharge planning processes for patients diagnosed with dementia.
- Develop quality-assurance performance improvement measures and processes for public access to include comprehensive and inclusive staff education (Massachusetts DPH, 2017).

To provide care continuity and standardized practices, community-based organizations may adopt a similar model for managing the needs of patients living with dementia or delirium in outpatient, long-term care, and home-based/custodial care settings.

In conclusion, strategic planning for the aging community's anticipated growth, increased life expectancy, and projected complex physical and behavioral health needs must include innovative, solutions-oriented approaches that combine all available resources. A few social work practice considerations include: (1) applying evidenced-based research to the treatment process; (2) developing a standardized assessment training and plan implemented by a multidisciplinary team; (3) accessing smart tool technology as an information source for tracking and data sharing, with all options tailored to provide person-centered care to an evolving aging community; and (4) adoption of organizational policies and practices that support quality care.

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