CTI With Older Adults & Case Presentations

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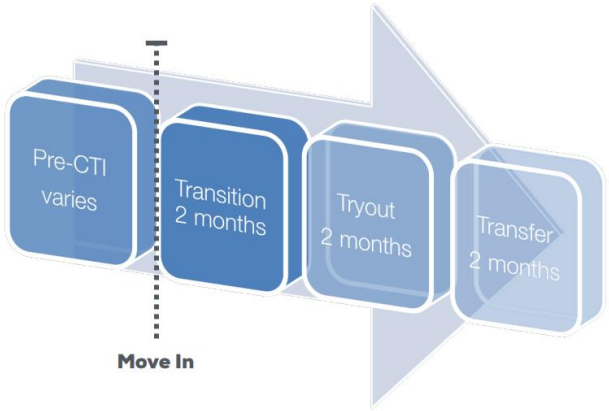
Housing Transitions QUERI

CTI Among Older Adults

- CTI uses a person-centered approach
- It provides a framework for case management practice but can look different from one Veteran to the next
- **CTI is <u>not</u> only suitable for younger veterans or Veterans with low acuity**
- Applying CTI with older Veterans may feel very different, which is to be expected



Aging in Place

- Many older adults want to stay in their homes as they age, but experience concerns with safety, mobility and other daily activities
- Goals are to maximize safety, which may include things like installing grab bars and reducing fall hazards
- Mobility goals can include low-cost transportation or securing a walker or cane
- In home service goals can include establishing care for housing related activities (cleaning, groceries, and daily hygienic needs) or assistance with at home healthcare needs (medication management, etc.)

Cognitive Impairment

- Cognitive impairments, including Alzheimer's and other types of dementia, are common concerns when working with older Veterans
- Linkages to services that can screen for and evaluate memory concerns, and ability to live independently (e.g., navigate activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are critical
- CMs can establish goals around potential safety issues, and linkages to medical, legal and financial supports to prevent housing loss or safety concerns related to cognitive impairment

Identifying Appropriate Housing

- Sometimes in home supports may not be enough and the Veteran requires a higher level of care (skilled nursing facility (SNF), adult residential facility/board & care)
- Recovery goals may shift to a focus on identifying, securing and/or transitioning to a facility that provides a higher level of care
- In emergency situations, where the Veteran's safety is threatened by living alone at home, it is appropriate to take the Veteran to the Emergency Department
- If it is not an emergency, but there are ongoing concerns, the CM should feel empowered to reach out to primary care (e.g., PACT RN care manager) to discuss concerns

Resources

- Eldercare Locator (acl.gov)
- Aging Life Care Association Home
- Community Residential Care (CRC) – for Veterans who do not need hospital or nursing home care but cannot live alone because of medical or psychiatric conditions
- Geriatric Evaluation - Geriatrics and Extended Care
- Occupational Therapy - Rehabilitation and Prosthetic Services (va.gov) (Some VA mental health and homeless service programs also have embedded OT services)
- VA In-Home and Support Services - VA Caregiver Support Program

Older Veteran Case Presentation

- Mr. Sanders is a 68 yo male Veteran who used a transitional housing program at your agency several years ago.
- He has been housed for nearly 4 years and reached out to the agency looking for assistance with rent payments. He lost his job during the height of the pandemic, there was an eviction moratorium which allowed him to keep his housing. Now that the eviction moratorium has ended, Mr. Sanders is behind 3 months in rent and is at imminent risk of losing his housing.
- In Phase 1, you focus on two recovery goals:
  - Increasing finances, including securing funds to pay the arrears owed and increasing Mr. Sanders monthly income (via a budgeting plan and increasing his benefits)
  - Linking him to primary care for a routine check up since it had been several years since he has seen one and he has some knee pain

Phase 1 Action Steps

- Action steps for Phase 1:
  - In a weekly home visit, you and Mr. Sanders submit an application to the COVID-19 Tenant Relief Act
  - In a separate visit, you accompany Mr. Sanders to an SSI/SSDI Outreach, Access, and Recovery (SOAR) benefits specialist
  - You take the bus route with Mr. Sanders to his HPACT primary care appointment and back, and attend the appointment to identify key contacts and engage in a warm handoff
  - You set up a meeting with the landlord to discuss a payment plan for the rent debt

Older Veteran in Phase 2

- Though Mr. Sanders said he was ready to attend his HPACT follow-up appointment on his own in Phase 2, he missed his appointment because he couldn’t remember which bus to take.
- In a bimonthly visit, you attend the HPACT follow-up appointment with him, reviewing the bus route and providing written instructions for his future appointments. He’ll be able to test it out on his own in a few weeks.
- A few days after your visit, Mr. Sanders shows up at the agency. He appears disheveled, stating that he has slept on the streets the last few nights and needs help getting housing. He is having trouble moving one of his arms. He does not remember that you met with him a few days ago and you know his landlord did not evict him. You take Mr. Sanders to the Emergency Department to evaluate him for his altered mental status.

Older Veteran in Phase 2

- You wait in the ED and speak to an ED physician about his degree of cognitive impairment. Mr. Sanders is diagnosed with “vascular dementia” or cognitive impairments that happen after a stroke or other neurological event. He is admitted to the hospital.

- The inpatient social worker works with the medical team and occupational therapy, and collaboratively they decide that he cannot live independently due to difficulties with ADLs and IADLs. The social worker informs you that the assisted living facility (Adult Residential Facility) has a waitlist of several months but that there is a place he can stay on VA grounds until that time.

- Mr. Sanders is less than thrilled about going to the assisted living. He gets angry every time you bring it up. He has been keeping up with his appointments with HPACT while on VA grounds and you and the HPACT social worker have established regular check ins.

Case presentation Discussion

- Phase 3
  - What does Phase 3 look like for Mr. Sanders?
  - Goals?
  - Resources and supports?
  - Transferring independent living skills?
  - What about his resistance to entering an Adult Residential Facility?

Next steps

- **(Optional) Drop-in Hour: February 22th, 2023**

  11-12am AKST/ 12am-1pm PST / 1-2pm MST / 2-3pm CST / 3-4pm EST

  - Stop by if you have questions, would like to discuss a case, or have a burning desire to learn more about CTI!

- **Next CoP: March 1st, 2023**

  10-11am AKST/ 11am-12pm PST / 12-1pm MST / 1-2pm CST / 2-3pm EST

  - Guest Speaker – Jillian Weber (HPACT)