

Community Based Adult Services

Case Presentation

CBAS Intervention Modality

- For those with multiple complex conditions ADHC/CBAS is a uniquely powerful intervention that has proven effective in maintaining individuals in the community.
 - Provides integrated comprehensive support in a non-institutional setting.
 - Getting services outside of the home is a key to success because social isolation and caregiver burn-out are risk factors for placement.

Center Overview

- 57% of dual eligible participants have 5 or more chronic conditions
- Most are in their 70's, 80's and 90's
- 83% are managing diabetes
- 50% have depression

CBAS Participant Profile

- Participant with 14 chronic conditions, including severe mental illness, diabetes, hypertension, anemia, severe degenerative joint disease, and chronic renal failure
- 23 medications
- Significant history of psychiatric hospitalization, catatonia, self harming behavior, limited coping skills
- Obese and unwilling to comply with diet

CBAS Related Outcomes

- Despite lack of support and stress at home, no psychiatric hospitalizations for 7 years ptp. has attended CBAS.
- Uses coping strategies taught by SW and psychiatric consultant.
- RN and LVN manage diabetic regimen resulting in # of meds decreasing and weight loss despite limited ability to comply with diet plan
- No longer reclusive, has made friends at Center, is active and engaged, remains responsible for self.

CBAS Related Outcomes

- Psychiatric consultant report notes participant has “blossomed” in program and center involvement “is preventing lengthy and costly inpatient hospital stays, is greatly reducing the risk of client harming self, is providing safety due to daily monitoring of mood and medications and is adding tremendously to the client’s quality of life.”

Community Based Health Home
Case presentation:
Complex Medical and
Behavioral Health
Example

Participant Background

- 67 year old
- Medicare/Medi-Cal managed care
- Enrolled in CBAS since 3-3-11
- Enrolled in CBHH in Sept 2013
- Currently 3 days/week

Social History

- Retired professional
- Lives in apartment with husband who is primary care giver. He gave up job to care for her and is now IHSS worker.
- 3 children with limited ability to assist: 2 are overseas.

Diagnoses

- 1) Paranoid state with delusions
- 2) Osteoarthritis
- 3) Hyperlipidemia
- 4) Type 2 Diabetes
- 5) Esophageal reflux
- 6) Alzheimer's disease alone or in combination with Lewy Body pathology. Visual hallucinations, delirious episodes, and Parkinsonism support that disease.
- 7) Some features support a diagnosis of evolving Progressive Supranuclear Palsy.

Medications

- Ibuprofen 600 mg
 - Lorazepam 2mg 5x/day (anti-anxiety)
 - Omeprazole 20mg (heart burn)
 - Mirtazapine 30mg (antidepressant)
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- Has been on Seroquel and Haldol in the past, but those have been discontinued.
 - Medication compliance has been extremely difficult. For a period of time she would only take white medications.

Current Situation

- History of being anxious, paranoid, delusional, agitated and restless but has had recent increase in severity.
- She has to be reminded to bathe; feeds herself but is always hungry.
- Calls 911 frequently. 14 ER visits from late Oct. 2013 through January 2014.
- Paranoia makes care management extremely difficult for her husband, who is devoted but cannot effectively managing her aggressive outbursts.
- Is currently less agitated at the center than at home due to care planning focused on keeping her calm.

RN-N Interventions

- Participates in IDT planning and IDT meetings.
- Makes frequent in-home and physician visits.
- Set up 6-month follow up at UCSF memory center with neurologist and transportation (husband does not drive).
- RN-N attended appt. with participant and husband.
- Differential diagnosis continues to challenge MDs who are now questioning Lewy Body pathology
- UCSF continuing to follow up with RN-N and husband to improve situation.
- RN-N plays essential role in helping caregiver understand medical situation and communicating info from MD visit to IDT.
- Work with husband to ID trigger behaviors for aggression

Ongoing and Future Concerns

- Husband wishes to continue caring for wife at home with continued CBAS attendance.
- CBAS and RN-N support are essential for couple's well being and safety given severity of symptoms.
- RN will continue to provide medication management and education/support for husband to improve home situation.
- RN-N will continue to assist in coordinating specialist care and primary care, which has been a critical issue due to complexity.