LET'S TEST YOUR KNOWLEDGE..

- By the time 2050 arrive, what will be the percentage of the world's population over 60 years old?
  - A: 15%
  - B: 17%
  - C: 20%
  - D: 22%

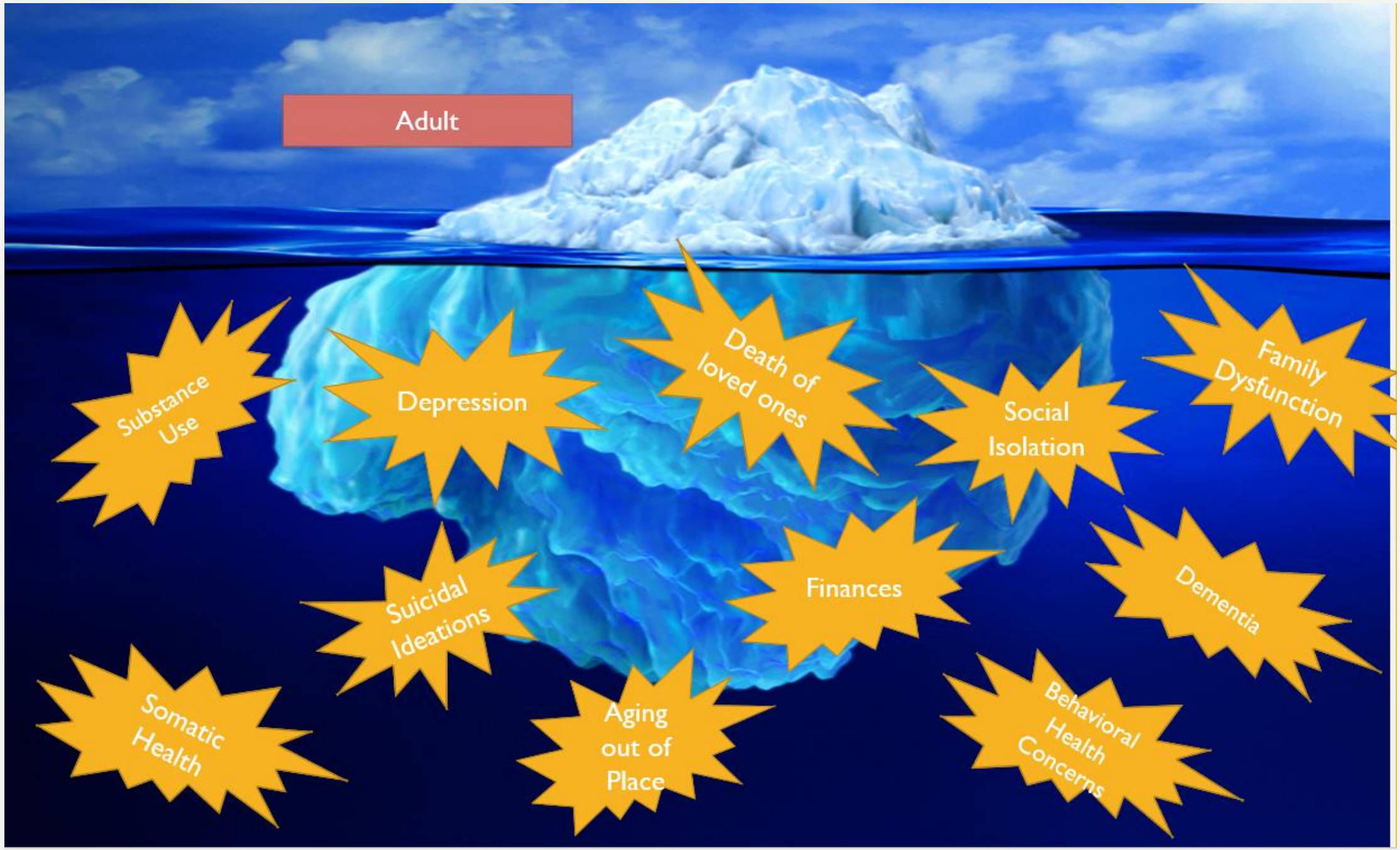
- What percentage of adults aged 85 or older, need help with ADLs?
  - A: 20%
  - B: 40%
  - C: 60%
  - D: 70%

LET'S TEST YOUR KNOWLEDGE..

- Among adults, 50 years and older, how many of these individuals experience homelessness for the first time?
  - A: 25%
  - B: 35%
  - C: 44%
  - D: 50%

According to CDC, what percentage of Older Adults (50 and over) are diagnosed with a Mental Health Disorder?

- A: 15%
- B: 20%
- C: 25%
- D: 30%


Adult
Substance Use
Depression
Death of loved ones
Social Isolation
Family Dysfunction
Suicidal Ideations
Finances
Dementia
Somatic Health
Aging out of Place
Behavioral Health Concerns

A STORM IS BREWING….

- **Nearly 1 in 25** (10 million) adults live with a serious mental illness
- **Lack of Studies that examine extent of Guardianship program**
  - The Center for Social Gerontology had reported to the U.S. Administration on Aging in 1992. It stated, "the numbers are impossible to quantify because individual states themselves do not know how many aging adults they have agreed to "protect."
- **Lack of finances and placement options**
  - Leading to more Adults at risk for homelessness
- **Lack of services**
  - Underserved population with limited resources available

THE STORM IS HERE….

- According to the World Health Organization (WHO), the total number of people worldwide living with Dementia is projected to increase to **82 million by 2030**. 152 million individuals by 2050
- According to the American Foundation for Suicide Prevention, the Suicide Rate for individuals 85 years and older was the second highest rate of any age group.
  - The highest rate reported was for individuals age 45-54
- 70% of older adults in the US with a prevalent Mood and Anxiety disorders did not utilize any services

NEUROCOGNITIVE PREVALENCE IN SMI

Prevalence of Diagnosed Dementia	By age 66	By age 80
Without Schizophrenia	1.9%	11.3%
With Schizophrenia	27.9&	70.2%

Prevalence of Alzheimer's Disease	By age 66	By Age 80
Without Schizophrenia	.04%	5.1%
With Schizophrenia	8.2%	37.2%

CHALLENGES

General shortage of mental health providers

Lack of training opportunities

- Few opportunities for specialization in Geriatrics Exist

Lack of incentives for entering the Geriatric Provider Workforce

Silo Work

Lack of Support for caregivers and community supporters

WHERE DOES AN INDIVIDUAL AGE IN THE COMMUNITY?

- Very few programs exist to cover the costs of an Assisted Living Facility

- Programs
  - Assisted Living Subsidy
    - This is monitored by Department of Aging
    - Many counties do have a waitlist, PLEASE put clients on waitlist
    - Requirements
      - Individual must be 62 years or old
      - Meet financial criteria
  - Home and Community Based Services Waiver
    - Tries to prevent individuals from entering Nursing Facilities by providing services in the community

HOW DO I ACCESS HCBS?

Requirements:

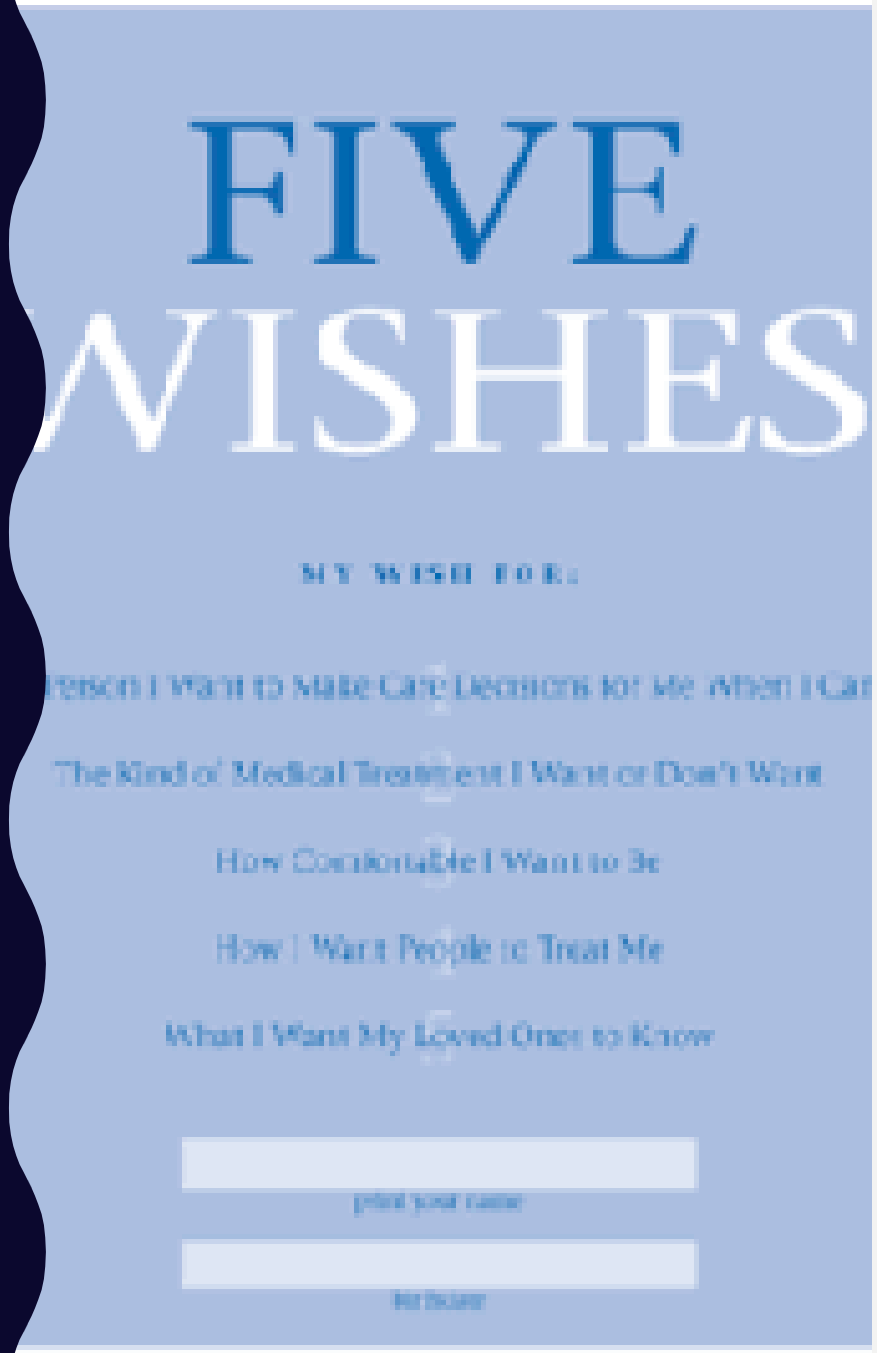
- 18 and over
- Meet a Nursing Home Level of Care
  - This will be determined when an individual is invited to apply
- An individual's income and assets are reviewed to determine financial eligibility for community Medicaid

How to apply:

- Contact local Maryland Access Point (MAP)
- Ask for individual to be put on the HCBS Registry
  - Ideally any individual over the age of 50 should be put on this registry
  - Based on what information you provide to the intake assessor, that automatically populates a Priority Level (Level 1-6)
    - The more needs an individual has, the higher priority ranking they get. It is very important to speak towards ADL impairment, hospitalization history, how their Behavioral Health diagnosis impacts their ability in the community
  - Once the individual's name "comes up", the individual will be officially invited to apply

WHY PLAN FOR THE FUTURE?

- Planning is what empowers people with Mental Illness to make the decisions they choose, rather than have decisions made for them.
  - Planning needs to be undertaken when the consumer is relatively well and able to make such decisions
- People at increased risk of relapse also need emergency or crisis plans, detailing what needs to be done if they become acutely unwell.
- During an acute episode, the ability of someone to make decisions is often taken away from them. It is essential, therefore, for consumers to be proactive and make these decisions when they are well.
- Decisions regarding the care of children and pets can be particularly distressing for people experiencing an acute episode but planning for such emergencies can help ensure that the decisions of consumers themselves are upheld, rather than what a service provider might deem appropriate or practical at the time.



IMPORTANCE OF ADVANCE DIRECTIVES

- Helps loved ones, and medical personnel make important decisions during a crisis.
- Having an advance directive in place ensures that your wishes regarding your health care are carried out, even when you're unable to make your wishes known
- What type of decisions, the individual will need to decide about:
  - CPR (cardiopulmonary resuscitation)
  - Ventilator use
  - Artificial nutrition (tube feeding) and artificial hydration (IV, or intravenous, fluids)
  - Comfort care

PSYCHIATRIC ADVANCE DIRECTIVES

- Allows a person living with Mental Illness to state their preferences for treatment in advance of a crisis.
- It can serve to protect a person's autonomy and ability to self-direct care.
- They are similar to living wills and other medical advance planning documents used in palliative care

PSYCHIATRIC ADVANCE DIRECTIVES (CON'T)

- In general, a Psychiatric Advance Directives (PAD) have two parts: an advance instruction and a health care power of attorney. A person who wishes to develop a PAD can use one or both parts. The advance instruction can detail preferences for treatment, give consent for admission and consent for contact in advance. It can detail preferred medications and treatment modalities.

- The health care power of attorney can be used for medical or psychiatric emergencies. It allows the person to appoint a trusted individual to serve as health care agent with decision making authority during times that a person is unable to make decisions due to incapacity. The health care power of attorney forms may also describe wishes for end-of-life care and other instructions and can be used as a stand-alone document if the person chooses


Questions are the path to learning

DO YOU NEED HELP WITH A CLIENT?

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Older Adults & Brain Injury

Anastasia Edmonston MS CRC, TBI Partner Project

June 4, 2021

Quick video

Jordan Grafman PH. D Rehab Institute of Chicago
https://youtu.be/8h0bJGvHCjM

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Agenda- what do those working in programs that support older adults need to know promote person-centered approaches

- What is Brain Injury
- What are common signs and symptoms
- Where do brain injury and aging intersect
  - Why are older adults vulnerable to brain injury
  - What are the implications of a brain injury incurred later in life?
  - What might it mean to age with a history of brain injury
- What is considered a person centered approach?
- Tips, tools and strategies
- Suggestions for prevention

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Introduction

Why is it important for those who work with older adults to have a understanding of brain injury?

Professionals who serve older adults and their families are seeing people who present with emerging functional issues due to a recent or remote TBI that may be contributing to difficulties that the older adult is experiencing around general health, behavioral health, and cognitive functioning

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"To Love What is"

"Finally, the 911 operator comes back on the line to report that he's sent out the highest, most serious alarm, a Number 10. I'm perplexed. Scott is talking okay, and I don't see any blood. 'Why a Number 10?'"

"An elderly man falls nine or 10 feet and loses consciousness? That's a Number 10 if anything is."

"Elderly? The word takes me by surprise. It applies to one's parents, not one's husband. Whenever our children have shown that they consider us old, we've balked or laughed. Scott, whom I fell for when he was 20 and I 17, is timeless to me, not elderly. Maybe that's why we fell in love a second time, after 34 years apart: in each other's eyes, we were still the (by then mythical) youths we'd been in 1950, the summer of our first romance."

Source: *Alix Kates Shulman's 2008 memoir, "to Love WHAT is, a Marriage Transformed"*
http://www.brainline.org/content/2009/08/to-love-what-is_pageall.html

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Adults-65 and Older, a growing population

Older Adults and Traumatic Brain Injury

- Four in five (81%) TBI-related ED visits in older adults aged 65 years and older were caused by falls
- Falls are the leading cause of death for persons 65 years of age

Sources: *(https://aoa.acl.gov/Aging_Statistics/index.aspx , https://gardner.utah.edu/wp-content/uploads/State-of-Utah-Demographic-Profile-2010-2018.pdf & https://www.nytimes.com/2017/01/28/opinion/sunday/a-housing-crisis-for-seniors.html*

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“Despite this high incidence, older adults may be less likely to seek medical attention for TBI and are also less likely to be accurately diagnosed even when medical attention is sought”

Source: *Journal of Neurotrauma (2018)*

Considering behavior and circumstances through a brain injury informed lens means you are better able to proactively and productively engage with others…to do so, ask people whenever possible to *Tell Me Your Story…*

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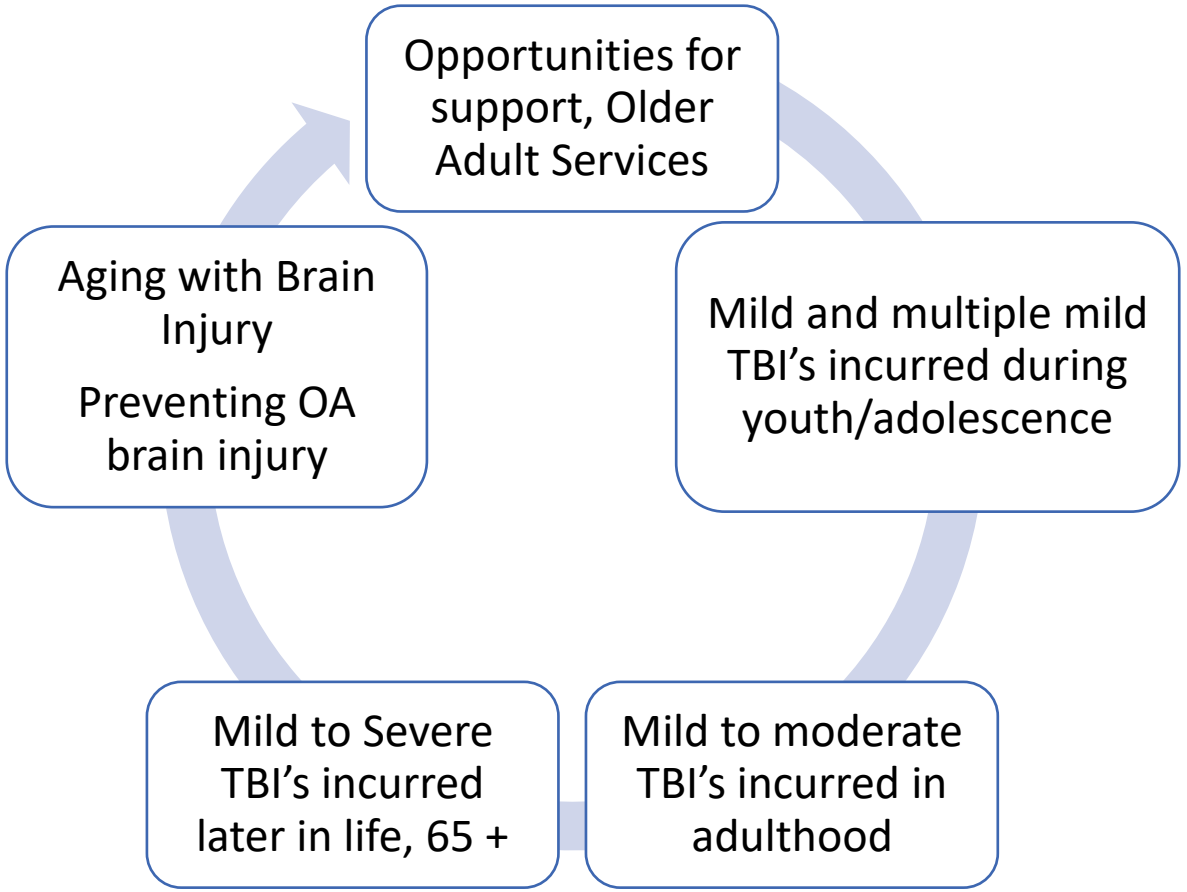
Brain injury through the Life Span-Older Adults



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What *is* a Brain Injury?

An Acquired Brain Injury (ABI) occurs *After* Birth

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Types of Acquired Brain Injury

Traumatic Brain Injury (TBI)- Defined

TBI is an insult to the brain caused by an external physical force, such as a: fall, motor vehicle accident, assault, sports related incident, or improvised explosive device (IED) exposure

Acquired Brain Injury (ABI) Defined

ABI is an insult to the brain that has occurred after birth, such as: TBI, stroke, near suffocation, infections in the brain, anoxia, and overdose(s)

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Continuum of Traumatic Brain Injury (TBI) Severity

Mild Traumatic Brain Injury (mTBI). **mTBI is also referred to as a concussion**	80% of all TBI's are mild	This means brief or NO loss of consciousness and/or post traumatic amnesia
Moderate Traumatic	10–13% of TBI's are moderate	Loss of Consciousness between 30 minutes to 24 hours, post traumatic amnesia of 1 to 24 hours
Severe Traumatic Brain Injury	7–10% of TBI's are severe	LOC >24 hours, PTA >24 hours

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Age related differences in mechanisms of injury

- Because the majority of TBI's experienced by older adults are attributed to low-level or same-level falls from a standing height or less, older adults will incur "mass lesions such as subdural hemorrhage, while…
- ….the motor vehicle accident-related TBIs experienced by teens and younger adults more commonly result in diffuse axonal injury"

Source: Gardner RC, Dams-O'Connor K, Morrissey MR, Manley GT. Geriatric Traumatic Brain Injury: Epidemiology, Outcomes, Knowledge Gaps, and Future Directions. *J Neurotrauma*. 2018;35(7):889-906. doi:10.1089/neu.2017.5371

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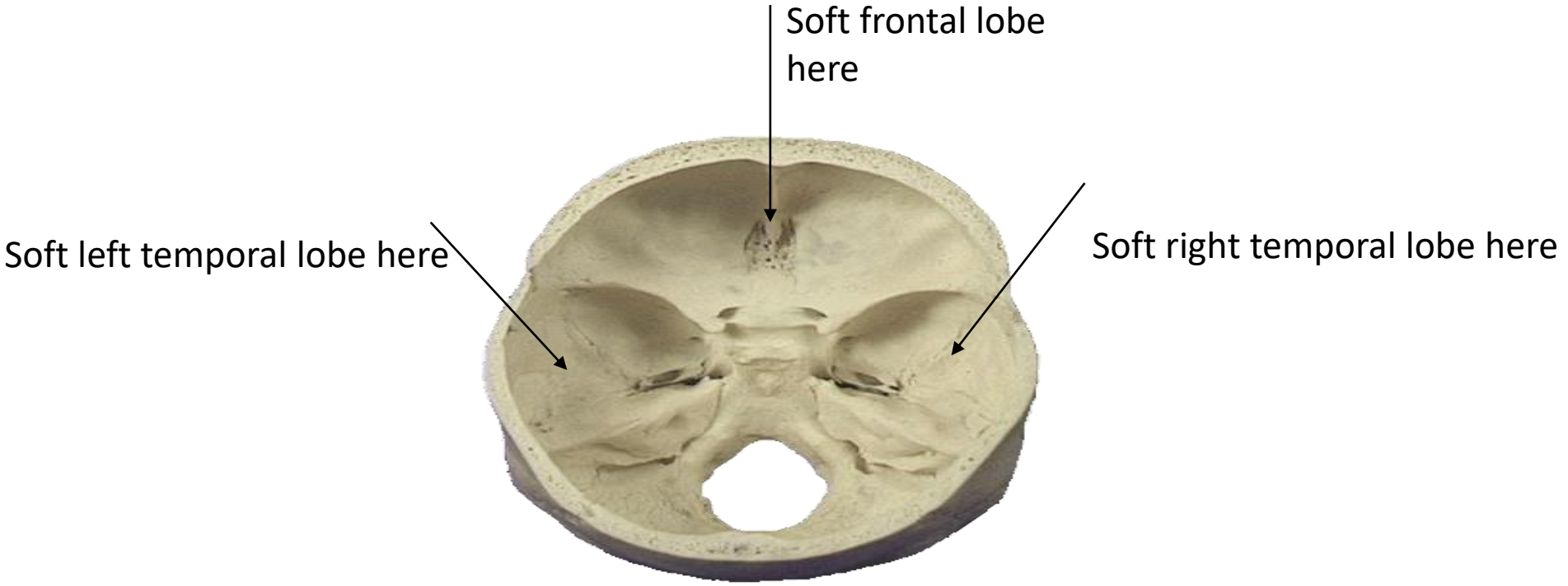
Why the Frontal & Temporal Lobes are so vulnerable to injury



The brain is the consistency of overcooked cauliflower. When excessive outside force is applied, the brain can be shaken within the skull, where it comes against the hard bony ridges located in the underside of the skull

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Risks of Brain Injury Specific to Older Adults

Low force = substantial injury

- Adults age 65 and older are at a greater risk of being hit by a car as a pedestrian than are children, many older adults cannot navigate crossing the street at a crosswalk at the expected rate of four feet per second
- Older adults are active! This is a good thing, but it does come with sports related risks for those 55-64 years of age those risks include; skiing-related TBI and bicycle-related, commonly occurring while mounting or dismounting the bike

Source: *New Jersey Institute for Successful Aging, lecture by Anthony J. DiPasquale, OD* http://www.youtube.com/watch?v=5K67IAjEiag ., Gardner RC, Dams-O'Connor K, Morrissey MR, Manley GT. Geriatric Traumatic Brain Injury: Epidemiology, Outcomes, Knowledge Gaps, and Future Directions. *J Neurotrauma*. 2018;35(7):889-906. doi:10.1089/neu.2017.5371

Why is the older brain so vulnerable to brain injury?

- Physiologic age-related changes
  - Balance, vision and hearing, physical strength, gait, dexterity and cognitive skills
  - Shrinkage of certain parts of the brain, reduced communication between nerve cells, decreased blood flow and inflammation
- Presence of co-morbidities
  - Cardiovascular disease, cancer, arthritis, depression, diabetes, chronic kidney condition, chronic obstructive pulmonary disorder, prior history of TBI
- Polypharmacy-simultaneous use of multiple medications
  - Anticoagulants, psychotropics, and sedatives that increase the risk of dizziness, hypotension, arrhythmias, and decreased level of consciousness

Sources: Fu WW, Fu TS, Jing R, McFaull SR, Cusimano MD. Predictors of falls and mortality among elderly adults with traumatic brain injury: A nationwide, population-based study. *PLoS One*. 2017;12(4):e0175868. Published 2017 Apr 21. doi:10.1371/journal.pone.0175868., Paliwal Y, Slattum PW, Ratliff SM. Chronic Health Conditions as a Risk Factor for Falls among the Community-Dwelling US Older Adults: A Zero-Inflated Regression Modeling Approach. *Biomed Res Int*. 2017;2017:5146378. doi:10.1155/2017/5146378., https://www.nia.nih.gov/health/how-aging-brain-affects-thinking

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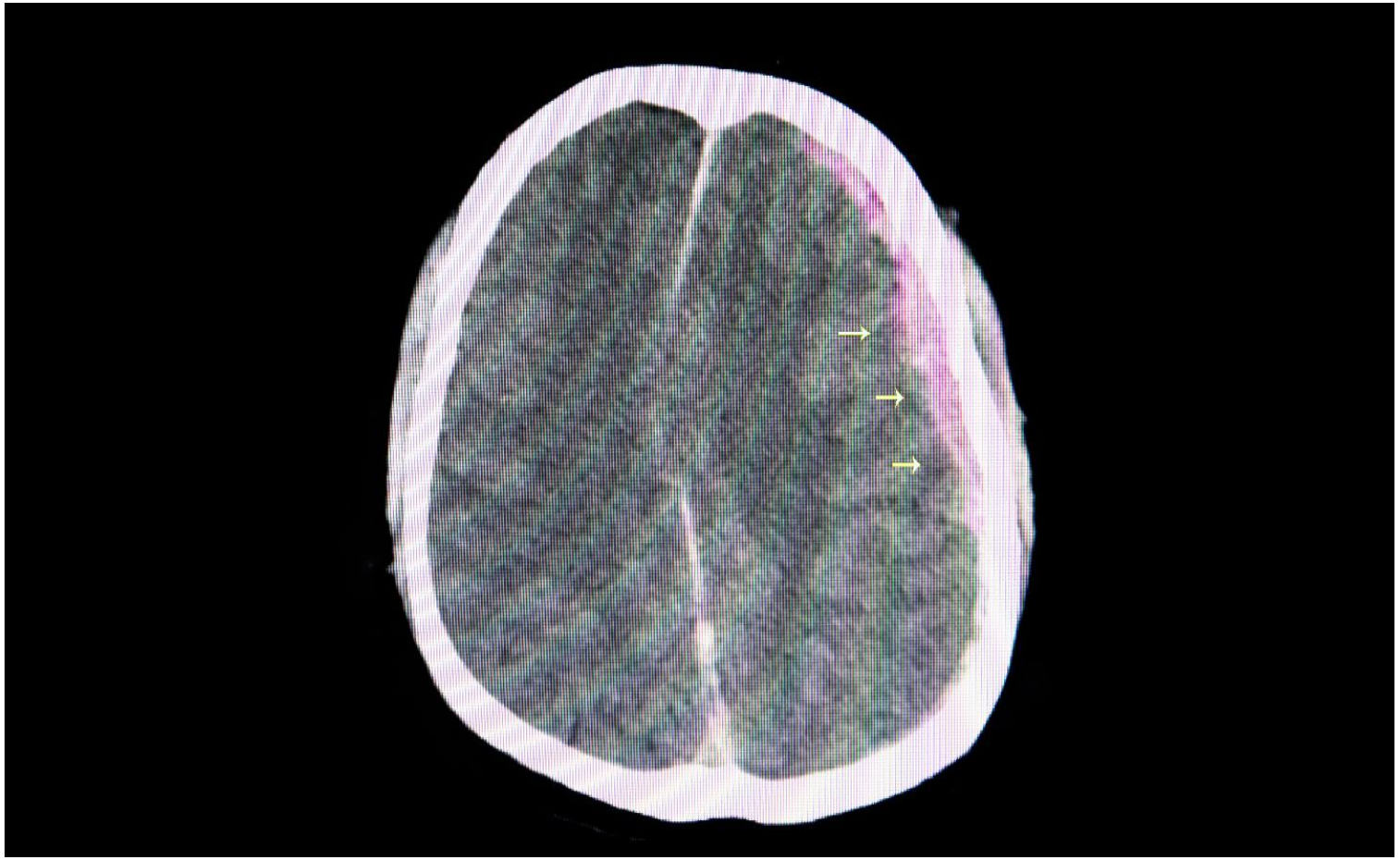
Chronic Subdural Hematomas-a vulnerability unique to the older adult brain



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Aging and TBI

"Subdural hematomas can also occur after a very mild head injury, especially in the elderly. These may go unnoticed for many weeks, and are called "chronic" subdural hematomas. With any subdural hematoma, tiny veins between the surface of the brain and its outer covering (the dura) stretch and tear, allowing blood to collect. In the elderly, the veins are often already stretched because of brain atrophy and are more easily injured."

Source: *www.nlm.nih.gov/medlinieplus/ency/article/000713.htm*

Aging and TBI **Clues that may suggest a person has incurred a subdural hematoma/TBI and should be seen by a medical professional:**

- Low-grade headache that won't go away
- Having more trouble than usual remembering things, paying attention or concentrating, organizing daily tasks, or making decisions and solving problems
- Blurred vision or eyes that tire easily
- Loss of sense of taste or smell
- Ringing in the ears
- Change in sexual drive
- Slowness in thinking, speaking, acting, or reading
- Getting lost or easily confused
- Feeling tired all of the time, lack of energy or motivation
- Change in sleep pattern—sleeping much longer than before, having trouble sleeping
- Loss of balance, feeling light-headed or dizzy
- Increased sensitivity to sounds, lights, distractions
- Mood changes like feeling sad, anxious, or listless, or becoming easily irritated or angry for little or no reason

Sources: https://my.clevelandclinic.org/health/diseases/21183-subdural-hematoma
https://well.blogs.nytimes.com/2015/04/06/for-older-adults-a-rising-risk-of-subdural-hematoma/

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Rehabilitation

Researchers in New Jersey found that after mild TBI, “functional outcome is good to excellent for both elderly and younger patients. Older patients required more inpatient rehabilitation and lagged behind their younger counterparts but continued to **recover and improve** after discharge.”

Observing and engaging: Looking for clues of a history of brain injury

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Observing: Physical Clues of a possible history of Brain Injury

- Walks with a limp/seems to be paralyzed on one side of body
- Scars are visible on forehead, temple, neck
- Arms/hands are shaky
- Uses a cane, walker or wheelchair
- One arm is in a sling or is held close to the body
- Wears an eye patch
- Can’t track an object with their eyes
- Doesn’t make eye contact
- One of their eye glass lens appears to be cut like a diamond or prism
- Appears to have difficulty forming words
- Speech is slurred
- Is wearing a medical alert bracelet or necklace

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Observing: Thinking/Cognitive Clues of a Possible Brain Injury

- Blank facial expression in response to a question or request
- Seems unable to relay basic personal information such as where they are coming from, where they are going, what is their current address
- Responses are disorganized
- Responses include information that was not requested (e.g. after stating their name and adding extraneous information such as who they were named after)
- Repeats responses
- Responses are not factual given the situation/known facts

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Engaging in a Person Centered and Brain Injury Informed Way-1

Ask questions based on observations of physical clues

- “Hey, I see you are walking with a limp, have you hurt your leg?”
- “Sir, are you able to see me okay?”
- “If it is okay with you, I am going to repeat back what I think you have said so I can be sure I am understanding you”
- “I am wondering if you have ever hurt your head, maybe in an accident like a fall or car crash, or if you have had a stroke?”

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Engaging in a Person Centered and Brain Injury Informed Way-2

Ask questions/take actions based on observations of clues of behavioral health issues

- Make and maintain eye contact
- Speak in short, simple sentences with a neural tone
- When possible, give the person a “heads up” regarding what to expect during your interaction
- Redirect
- Focus on what matters
- Be mindful of non-verbal clues
- Focus on positive and don’t attend to negative behavior for example,

“ I like how you are sitting here with me”

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Brain Injury Informed and Person Centered approaches may include:

Careful examination of medical, educational, employment and any involvement with the criminal justice system

- Has this individual been exposed to a possible TBI or ABI
  - Motor vehicle/motorcycle/all terrain vehicle accidents/related emergency department or hospitalization
  - Did the individual play organized sports or engage in potentially risky recreational activities
  - Is there evidence of childhood abuse or neglect
  - Medical records that indicate history of traumatic brain injury or an acquired brain injury from lead poisoning, a stroke, brain tumor, epilepsy, meningitis or encephalitis
  - History of overdose or overdoses from opioids and other substances

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You are looking for a cut point in the individual's life trajectory-remote history of brain injury

- If a suspected insult to the brain happened in childhood, are there any reports from parents, caregivers, teachers, pediatricians around developmental impacts around not achieving expected benchmarks
- If the suspected insult to the brain happened in adolescence/young adulthood, are there any reports around initiation into drug or alcohol use, did the individual's academic performance diminish, were they experiencing depression, anxiety, were they diagnosed with conduct disorder, attention deficit hyperactivity disorder? Criminal justice involvement at any point in time?
- Did the individual have a history of behavioral health challenges, mental

health of substance use disorder, is there a fairly obvious before and after

regarding when these challenges began?

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Older Adults, TBI and Veteran's Status

- Rates of comorbid Post Traumatic Stress Disorder (PTSD) and mild TBI are estimated to be about 30 percent of all those who screen positive for TBI
- Veterans with a confirmed diagnosis of TBI likely to be diagnosed with PTSD and other anxiety and adjustment disorder—they may also may experience longer symptom duration and greater cognitive difficulties post-TBI
- A prospective study of World War II vets with a history of moderate to severe TBI had a two to four-fold increase of dementia than controls
- Some studies suggest there is a increase risk of dementia for those with PTSD

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TBI: A Chronic Condition-1

Suspected factors in development of dementia if aging with TBI include:

- The injury is incurred later in life, with the impact worsening as the person ages
- The injury is more severe
- There are repeated injuries
- There are genetic markers (ApoE4 genotype)
- The person is a male

Source: *adapted from TBI Research Brief, Western Oregon University, July 2012*

TBI: A Chronic Condition-2

Source: Galveston Brain Injury Conference 2010

As more individuals thankfully survive brain injury, research is looking at the potential implications of aging with a history of brain injury.

> "Injury to the brain can evolve into a lifelong health condition termed chronic brain injury (CBI). CBI impairs the brain and other organ systems and may persist or progress over an individual's life span."

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Ask about existing strategies the person uses and build upon them

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Incorporating Structure

- With the individual establish a regular appointment time and day
- Address any possible barriers and formulate plans to address them e.g. transportation, internet connection and a private place to talk remotely/by phone
- With the individual, determine the preferred way to track topics and

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Incorporating Structure

- Strategies are individualized for each individual
- If fatigue is an issue, build in 1-2 minute stretch breaks during meetings/sessions
- Summarize main points at intervals throughout meetings/sessions
- Determine together, the preferred way to track topics and issues discussed, e.g. via journal, phone app etc.
- Review the information at the end, underscore the major takeaways and,
- Record next steps, these can be tasks to do between meetings/sessions as well as reminders of what will be discussed at later appointments

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Accommodating Brain Injury related barriers

- Encourage the use of a journal and/or calendar in whatever format or formats work for them
- Encourage the creation of a daily schedule with built in reminders
- Use a digital recorder
- Encourage use of rest and low activity periods-strategic naps
- Use of a high lighter when reading text when appropriate
- Use of templates for routine tasks at home and work
- Encourage liberal use of labels (kitchen drawers, files etc.)

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Final Tips

- Repetition of information and practice of strategies is key to eventual internalization of that information and those strategies
- If appropriate and with the individual (and/or their permission), when referring to community services, provide a summary of what works best for that person when engaging in services. These strategies are universally applicable across all settings

- Don’t take at face value someone that someone "gets it”, they may sincerely believe they are good with say, a change in appointment time, but follow that up with supportive strategies such as a follow up phone call/email/text

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In Season 5 of Netflix's series *Grace & Frankie*, demonstrations held by a group of Older Adults supporting an increase of the "Walk" time allocated at the crosswalk to get the local senior center was capped by Ms. Fonda's regal stroll across the street.
https://youtu.be/XuCXMckDeSo?t=115

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Resources & Information

- ER-case study with CAT scan of an older adult following a fall, underscores how even the seemingly mild of brain injuries need to be evaluated in older adults. https://youtu.be/64fcupSbbgs
- PsychiatricTimes on-line journal article, “TBI in Older Adults: A Growing Epidemic”
- The Center for Disease Control and Prevention’s “Still Going Strong” on-line resource has information on fall/TBI prevention at: https://www.cdc.gov/stillgoingstrong/index.html

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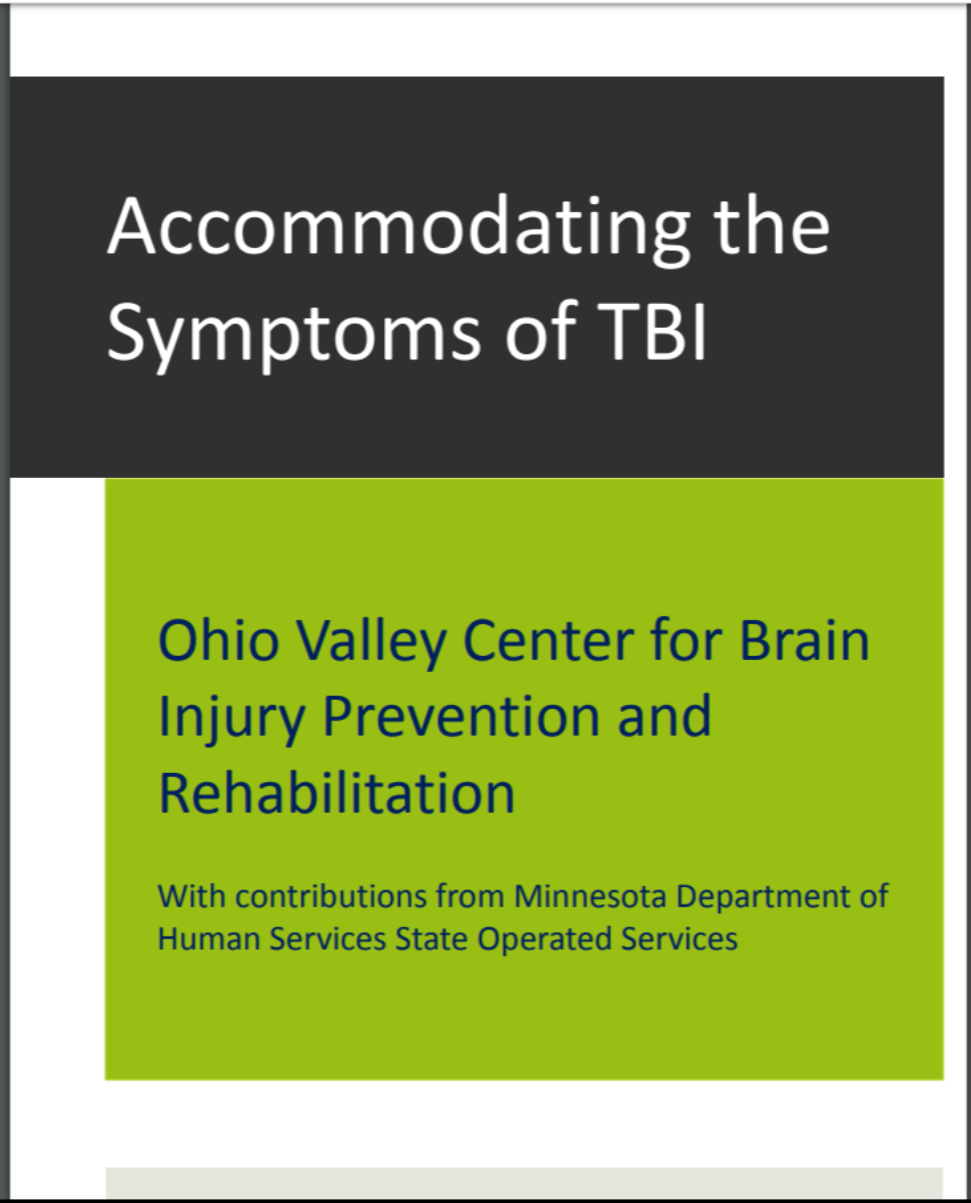
Brain Injury Association Of Minnesota 27th Annual Conference Changing Their Minds - Google Chrome

heller.brandeis.edu/ibh/pdfs/accommodating-tbi-booklet-1-14.pdf

To view on-line go to:

https://heller.brandeis.edu/ibh/pdfs/accommodating-tbi-booklet-1-14.pdf



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2021

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NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Falls Prevention & Incontinence Management

June 4th 2021

Caitlin Synovec, OTD, OTR/L, BCMH

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Why falls and incontinence?

Both affect older adults

Are considered a normal part of aging – but are NOT

- However, often impact many individuals who are aging

People with serious mental illness age earlier than the general population

- Things like falls and incontinence may be more prevalent and occur earlier

Both can result in unnecessary and early transition to long-term care

Both are preventable or can be addressed in a person's home and community.

Falls and Falls Prevention

What are falls?

A fall is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.

Fall-related injuries may be fatal or non-fatal.

1 out of 5 falls can cause serious injury such as a broken bone or head injury

1 out of 4 Americans aged 65 or older fall at least once each year

(World Health Organization, 2021; Centers for Disease Control, 2017)

Importance of Falls Prevention

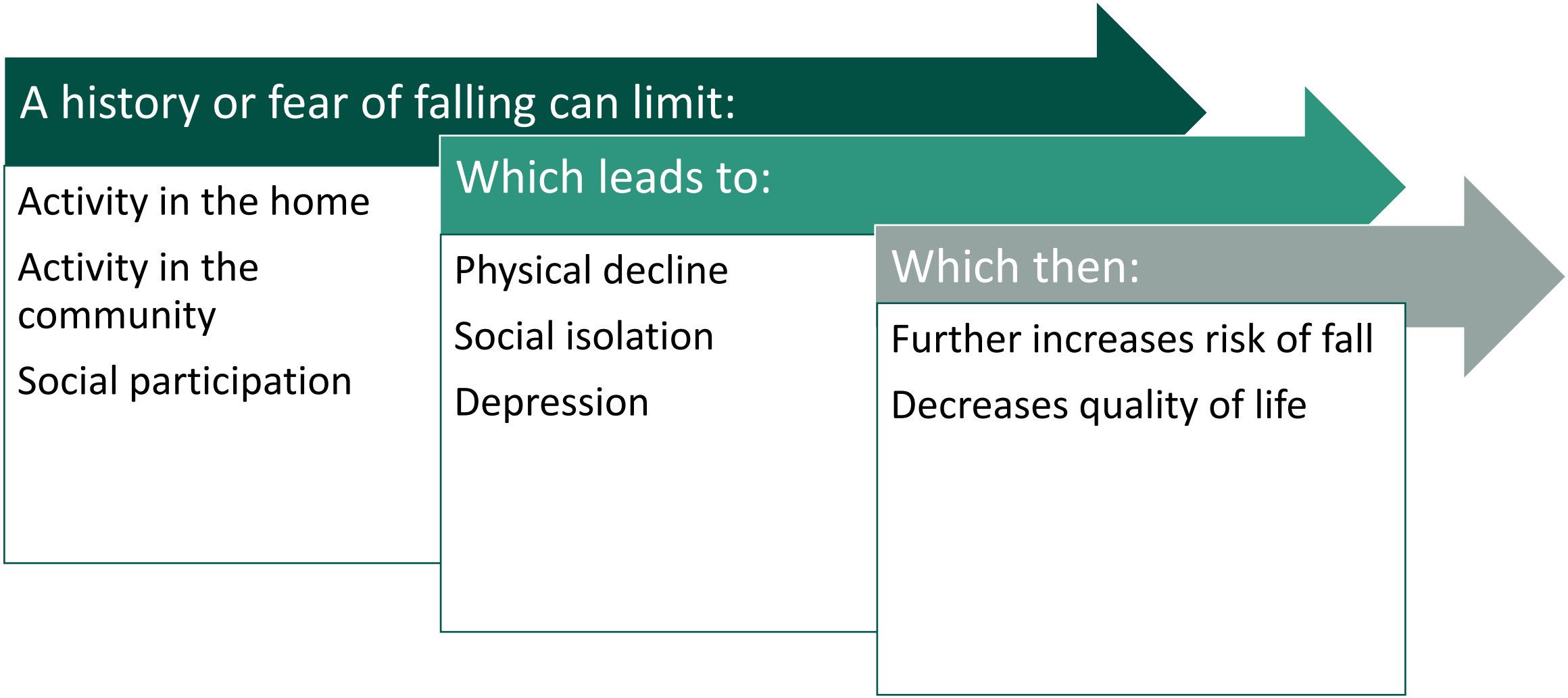
Falls are a leading cause of fatal injury, hospital admissions, and ER visits for older adults

Having one fall increases the risk of subsequent falls

Those who experience falls, especially multiple falls, often enter long-term care earlier than those who have not had a fall

(Centers for Disease Control, 2017, 2020)

Importance of Falls Prevention



(Centers for Disease Control, 2017, 2020)

Causes of Falls

- Decreased balance
- Medication interactions
- Medication side effects such as dizziness
- Low vision
- Decreased cognition
- Lower body weakness

(Centers for Disease Control, 2017)

Factors Increasing Risk of Falls

Low-income	Living in low-income or less resourced areas	Lack of access to exercise spaces
Lack of access to health care	Decreased nutrition and food intake	Hazards within the home
Foot pain or not having proper footwear	Decreased sleep	Chronic medical conditions

(Centers for Disease Control, 2017)

Impact of Serious Mental Illness on Falls

What do we know from research?

- Risk of falling may be exacerbated by mental health symptoms and conditions, especially depression, mania, and anxiety.
- Risk of falling may be increased by medications used to treat mental health symptoms.
- Adults with SMI have higher rates of conditions that increase risk of falls.

(Bartels et al., 2017; Bunn et al., 2014)

Impact of Serious Mental Illness on Falls

More likely to be prescribed medications that impact balance

- Side effects such as dizziness or drowsiness
- Side effects that impact movement or gait

Increased anxiety can increase risk of falls

- Having a fall then increases anxiety of further falls

(Bunn et al., 2014; Iaboni & Flint, 2013)

Impact of Serious Mental Illness on Falls

Presence of mania or manic symptoms can increase speed of movement or impulsivity that might result in a fall

Depression is a high risk factor for falls

- Medications may have side effects
- Low activity related to depression may decrease strength and balance and overall activity
- May impact cognitive factors that would also impact falls

(Bunn et al., 2014; Iaboni & Flint, 2013)

Impact of Serious Mental Illness on Falls

People with SMI are also at increased risk of chronic and geriatric conditions at an early age

Individuals with SMI may have less access to health care and specialty care that would address risk factors

Individuals with SMI may have less access and resources to address environmental fall risk

(Bartels et al., 2017; Bunn et al., 2014; Chippendale & Bear-Lehman, 2011; Viron & Stern, 2010)

Importance of Addressing Falls in Community Housing Settings

- Falls can increase risk of early institutionalization, especially with individuals with serious mental illness
- **Falls are preventable**
- Risk of falls can be addressed through several interventions that occur within the home and community
- Falls interventions within the home and community setting can be **low-cost and benefit all residents of the home**

Trauma Informed Approach

Experience of having a fall may be traumatic both emotionally and physically

Experiencing a fall may a person's quality of life

- Feeling safe and vulnerable in the community
- Fear of housing loss
- Fear of moving into long-term care facility
- Minimize engagement with social supports or cause social isolation

Team Approach

- Communication among the team and staff to implement strategies
- Consistency in approaches and strategies
- Coordinating care between primary care and specialty providers

Approach: Addressing the Client

Check Your Risk for Falling

Circle "Yes" or "No" for each statement below			Why it matters
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
Total _____		Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling.	

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. J Safety Res; 2011: 42(6)493-499). Adapted with permission of the authors.

https://www.cdc.gov/steadi/pdf/STEADI-Brochure-StayIndependent-508.pdf

- Using motivational interview and person-centered planning, discuss the person's concerns or frequency of falls
- Bring up concerns or episodes of falling to the person's medical providers

Approach: Addressing the Client

Organize routines to prevent rushing

- Set timers or alarms to start preparing to leave the house

Organize personal belongings to make them easy to find quickly

Organize spaces so that frequently used items are easy to reach

- Prevent reaching over head or bending too low without support

Organize personal areas to ensure clear pathways

- Minimize clutter or items near the edge of the bed

Approach: Addressing the Client

Use supportive footwear

- If the person prefers to wear slippers or socks instead, use those that have a rubber bottom, tread, and are secure to the foot

Exercise

- Engaging in regular exercise can help improve and maintain balance, strength, and mobility
- Recommended exercises include: chair exercise (both cardio and yoga); Tai Chi; Silver Sneakers exercise classes (YMCA); walking; gentle stretching

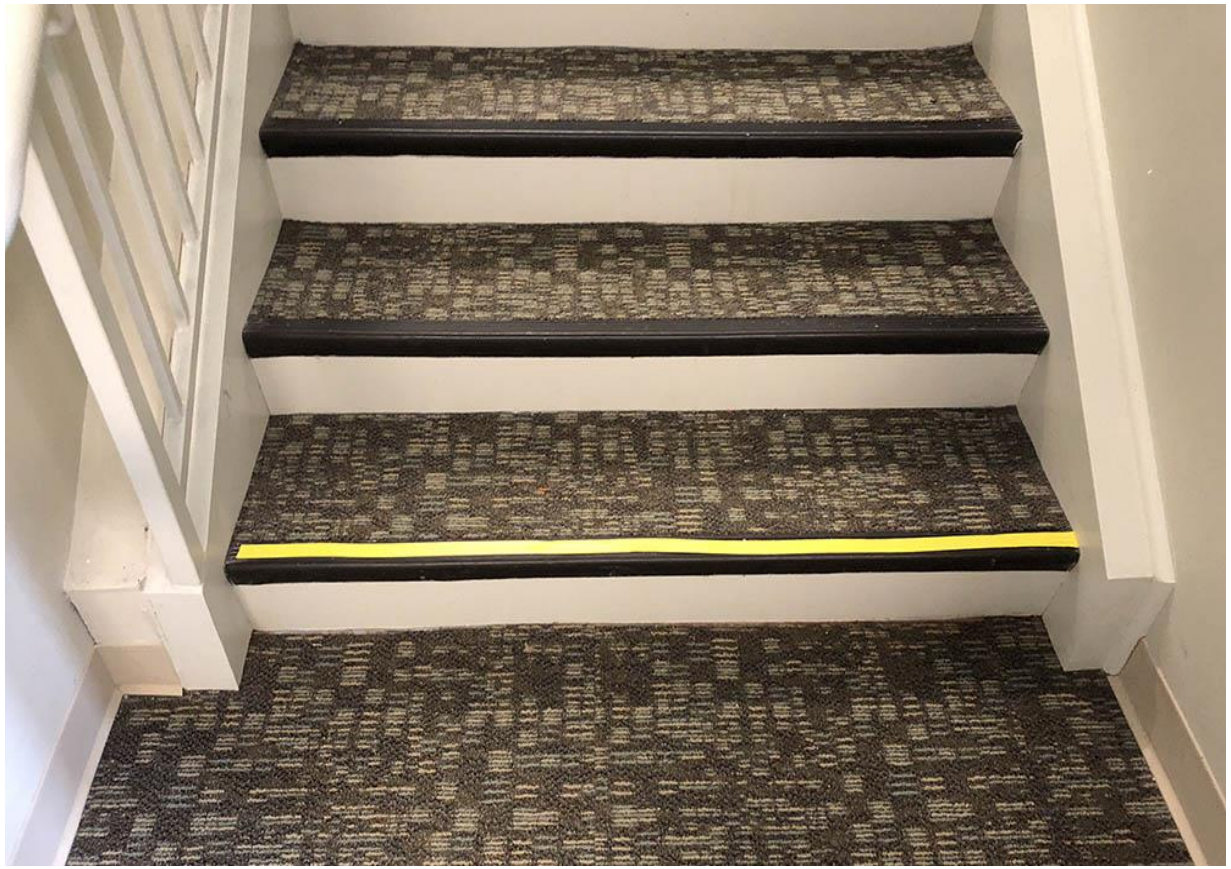
Accessibility of key spaces:

- Is the person required to go up stairs to use the bathroom or kitchen?
- Can the room or space be moved to increase the person's access?

Approach: Modifying the Environment

Install ramps as able to provide an alternative to stairs	Secure handrails at all stairs in and outside	Non-slip tread on stairs	Contrast at edge of stairs and transitions in floors
Non-slip mats or tread in bathrooms and showers	Remove or secure loose rugs	Clear pathways and hallways	Remove cords and other tripping hazards
Add grab bars within the bathroom/shower	Ensure adequate lighting in all rooms	Have sensor detected night-lights in hallways or bathrooms	Change lightbulbs or provide additional light through lamps

Environment Modifications



Contrast at stair edges

Grab bars in shower

Environment Modifications

Non-slip tread in bathtub

Outdoor handrails

Environment Modifications

Non-slip backing to secure floor rug

Sensor night light

Approach: Talking with Providers

- Work with client to identify ways to communicate to providers what is going on
- Help client with tracking occurrences and frequency of falls or near falls
- Advocate for referrals or physical exam
- Medication reconciliation and changes to manage side effects
- Prescription for mobility devices and equipment

Approach: Specialty Referrals

Specialists for Underlying Conditions:

- Optometrist/Ophthalmologist for a vision exam
- Cardiologist to address blood pressure

Physical Therapy

- Strengthening
- Mobility training
- Training for use of devices such as walkers

Occupational Therapy

- Home assessment and recommendations for modifications or devices
- Retraining or modifications to make activities safer due to low vision or changes in mobility

Incontinence and Incontinence Management

What is Incontinence?

Any non-intended loss of urine or stool. The loss may be in large or small quality.

In the US, half of the population of older adults experienced urinary leakage or accidental bowel leakage, and 25% had moderate, severe, or very severe urinary leakage, and 8% had moderate, severe, or very severe bowel leakage (CDC, 2014)

Incontinence

- Physiological
- Caused by:
  - Medical conditions or health
  - Medication and side effects
  - Psychological conditions including trauma
  - Environment and access

vs.

Incontinence Management

- Ability to respond to existence of incontinence
- Acquire and use products
- Implement routines and strategies
- Implement exercises to address pelvic muscles and function
- Engaging with medical provider regarding concerns

Types of Incontinence

Stress Incontinence

- Involuntary loss of urine . May result in leakage of small amounts during physical movement

Urge Incontinence

- Involuntary loss of urine associated with a strong desire to void.
- May result in leakage of large amounts of urine at unexpected times, including during sleep.

Mixed Incontinence

- Combination of urge and stress urinary incontinence.

Overflow Incontinence

- Any voluntary loss of urine associated with the overdistention of the bladder; the bladder becomes so full it simply overflows.

Functional Incontinence

- Urinary leakage associated with inability to toilet because of impairments of cognitive or physical functioning, psychological functioning, or environmental barriers.

Causes of Incontinence: Medical

- Urinary Tract Infection
- Constipation
- Spinal cord injury
- Osteoporosis
- Pelvic injury
- Bladder
- Prostate
- Obesity
- Lack of sensation from neurological conditions
- Diabetes or other endocrine disorders

(Covell-Pierson, 2018; Weissberg, 2016)

Causes of Incontinence: Medication

Medications causing changes in urinary frequency and retention

- Depression
- Psychotic disorders
- Diuretics
- Sleeping medications
- Blood pressure medications

Medications causing constipation

- Pain medications

Medication interactions

(Covell-Pierson, 2018; Weissberg, 2016)

Causes of Incontinence: Physical

- Physical limitations impacting ability to get to the bathroom on time
- Physical limitations impacting ability to undress quickly enough
- Physical limitations impacting ability to open and use disposable underwear
- Mobility limitations
- Positioning and posture
- Decreased cognition
  - Time awareness
  - Body awareness
  - Unable to recall when last used the bathroom

(Covell-Pierson, 2018; Weissberg, 2016)

Causes of Incontinence: Psychological

Trauma

- Recent trauma
- History of trauma – especially sexual and physical

Stress

Anxiety

Substance use

- Alcohol use

Mental health diagnosis may impact hormonal and chemical levels in the brain

Severe or acuity of mental health symptoms

(Covell-Pierson, 2018; von Gontard et al., 2017)

Causes of Incontinence: Environmental

Lack of fiber within the diet	Dehydration	Inconsistency in routines for toileting for need to hold bladder for extended periods of time
Disrupted or inconsistent routines	Not enough time to void bladder effectively	Unable to afford Depends or other disposable clothing and supplies
Accessibility of bathroom spaces	Lack of access to restrooms and continence supplies can lead to an increased prevalence of UTIs	Lack of access to showering/bathing and personal cleaning supplies

(Covell-Pierson, 2018; Weissberg, 2016)

Impact of Incontinence

- Decreased social and community engagement
- Stigma and poorer treatment
- Limitations in routines to avoid being without or away from bathrooms
- Falls
- Sleep disruption
- Dehydration
- Exacerbation of medication side effects
- Skin irritations and infections

(Covell-Pierson, 2018; Weissberg, 2016)

Impact of Serious Mental Illness on Incontinence

What do we know from research?

- Adults with SMI have higher rates of conditions that increase risk of developing incontinence.
- Many prescription medications to address mental health symptoms may also cause intontinence.
- A history of homelessness, housing instability, or trauma can increase risk for incontinence.

(Bartels et al. 2017, Covell-Pierson, 2018)

Importance of Addressing Incontinence in Community Housing Settings

- Incontinence increases fall risks
- Incontinence alone is not necessarily a reason for referral to higher levels of care or long-term care
- **Incontinence can be addressed and treated**, preventing early and unnecessary institutionalization
- Incontinence can increase social isolation

Trauma Informed Approach

History of trauma especially sexual trauma may be present and contributing to incontinence

Understand how difficulty with continence can cause concerns regarding:

- Feeling safe and vulnerable in the community
- Fear of housing loss
- Fear of moving into long-term care facility
- Minimize engagement with social supports or cause social isolation
- Avoidance of structured activities where bathroom breaks are not available
- Safety and legal involvement/arrest

Trauma Informed Approach

All conversations should be private and away from others including staff

Provide clarity and discuss with client who should be involved to address incontinence or implement strategies

- Staff should not approach clients if not consented

Provide private spaces for self-care and toileting

Provide private spaces to discard continence supplies and provide appropriate containers and plastic bags

Team Approach

- Communication among the team
- Consistency in approaches and strategies
- Universal language regarding what is happening
- Ensuring privacy in discussions
- Coordinating care between primary care and specialty providers

Approach: Engaging the Client

Use motivational interviewing to address concerns and identify person's perceptions of issues and need to change.

Questions should be trauma-informed and focus on experience:

- Do you ever have a hard time getting to the bathroom on time?
- When you need to urinate do you feel a strong urge that you need to rush?
- Do you have leakage when you cough or sneeze?
- Do you have what you need to take care of yourself and toileting needs?

Approach: Role of Providers

Behavioral Health

- Motivational interviewing and other strategies to identify concerns
- Strategies to promote and address behavior change

Case Management

- Identify client needs/concerns
- Coordination of referrals for specialists/medical care
- Support to identify resources and supplies
- Support to identify resources to support nutrition needs

CHW/Peer

- Identify client needs/concerns
- Support to identify and access resources and supplies
- Support to address concerns at medical appointments

Approach: Role of Providers

Nursing

- Basic assessment and patient questionnaire
- Identify client needs/concerns
- Support to gather data/needs
- Support to implement strategies
- Assess for dehydration

Primary Care Providers

- Initial exam to identify and address causes
- Referral to appropriate specialists
- Medication changes and reconciliation to minimize side effects

Approach: Individualized Routines and Programs

Tracking continence/incontinence episodes

- Frequency
- Potential triggers
- Time of day

Prompting the person or setting a toileting schedule to avoid incontinence episodes

- Use the diary or tracker to identify times or frequency to pre-emptively go to the bathroom

Setting routines for fluid intake, meals, and medications

- Limit drinks 2 hours prior to bedtime

NATIONAL ASSOCIATION FOR CONTINENCE

BLADDER DIARY

Complete one form for each day for four days before your appointment with a healthcare provider. In order to keep the most accurate diary possible, you'll want to keep it with you at all times and write down the events as they happen. Take the completed forms with you to your appointment.

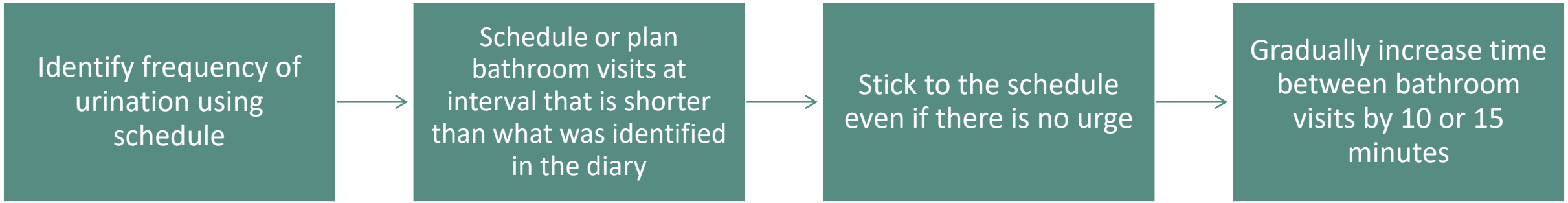
NAME:

DATE:

Time	Fluids		Foods		Did you urinate?		ACCIDENTS			
	What kind?	How much?	What kind?	How much?	How many times?	How much? (sm, med, lg)	Leakage How much? (sm, med, lg)	Did you feel an urge to urinate?		What were you doing at the time? (Sneezing, exercising, etc.)
Sample	Coffee	1 cup	Toast	1 slice	✓✓	med	sm	Yes	(No)	Running
6 a.m. - 7 a.m.								Yes	No	
7 a.m. - 8 a.m.								Yes	No	
8 a.m. - 9 a.m.								Yes	No	
9 a.m. - 10 a.m.								Yes	No	
10 a.m. - 11 a.m.								Yes	No	
11 a.m. - 12 noon								Yes	No	
12 noon - 1 p.m.								Yes	No	
1 p.m. - 2 p.m.								Yes	No	
2 p.m. - 3 p.m.								Yes	No	
3 p.m. - 4 p.m.								Yes	No	
4 p.m. - 5 p.m.								Yes	No	
5 p.m. - 6 p.m.								Yes	No	
6 p.m. - 7 p.m.								Yes	No	
7 p.m. - 8 p.m.								Yes	No	
8 p.m. - 9 p.m.								Yes	No	
9 p.m. - 10 p.m.								Yes	No	
10 p.m. - 11 p.m.								Yes	No	
11 p.m. - 12 mid								Yes	No	
12 mid - 1 a.m.								Yes	No	
1 a.m. - 2 a.m.								Yes	No	
2 a.m. - 3 a.m.								Yes	No	
3 a.m. - 4 a.m.								Yes	No	
4 a.m. - 5 a.m.								Yes	No	
5 a.m. - 6 a.m.								Yes	No	

Provided by the National Association For Continence; visit www.nafc.org for more information, locate a special special, and find support.

Developing a Schedule



Diary identified extreme urgency and episode of incontinence every 90 minutes

Scheduled going to the bathroom every 75 minutes

- Written schedule
- Phone alerts/alarms
- Prompting from providers/staff

Approach: Individualized Routines & Programs

Increase awareness of urge

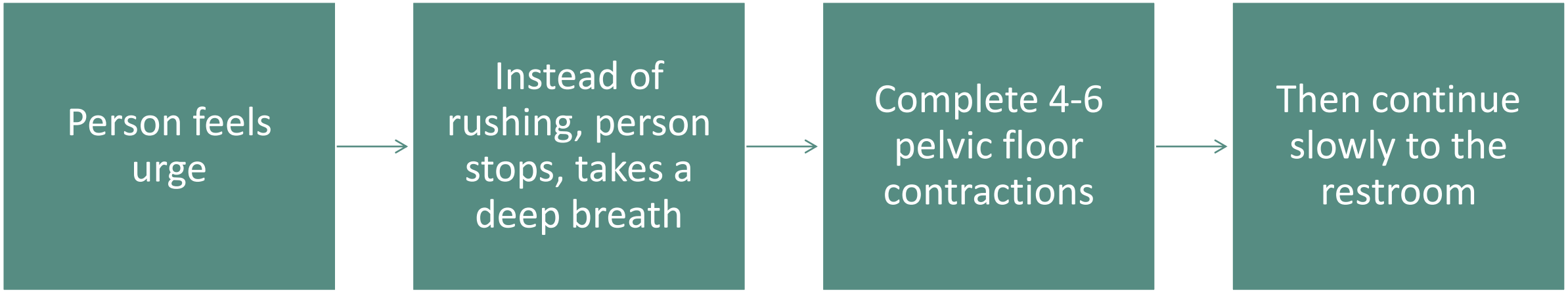
Delay urge

- Use deep breathing and pelvic exercises to slow down versus rush

Double Voiding

- Encourage person to stand up briefly, and then sit back on the toilet to void the bladder again

Delaying Urge



Approach: Setting up the Environment

Bathrooms should be available throughout the day

- A person should not have to hold their urine for more than 4 hours

Facilities should have adequate supplies

- Toilet paper, disposal bags, trash receptacles
- Appropriate incontinence supplies
- A variety of sizes, durability, and absorption for all types of anatomies

Access to laundry facilities and supplies to clean clothing

Approach: Setting up the Environment

Position the person near the bathroom or hallway to the bathroom

Have at least one bathroom or bathroom stall that is accessible

- Room for mobility devices
- Grab bar
- Provide a commode or raised toilet seat

Ensure procedures for disposable of used products and trash receptacle is an adequate size and routinely taken out

Accessible Restroom

Accessible Toilets

- Measure what will fit current facilities
- Install safely and properly

Approach: Diet

Provide a nutritious diet which includes fiber

- Can potentially address constipation which can address urinary incontinence

Support identifying specific food and beverage triggers

- Can be in addition to or part of voiding diary
- Identify alternatives to potential trigger foods

Promote adequate hydration

Approach: Talking with Providers

Work with client to identify language and approach to communicate to providers what is going on

Help client with tracking occurrences and frequency of the issue

- Can bring voiding diary to medical visit

Advocate for referrals or physical exam

Medication reconciliation and changes to manage side effects

Medication prescriptions to address incontinence

Approach: Specialty Referrals

Specialists for Underlying Conditions:

- Endocrinologist
- Neurologist
- Urologist

Physical and Occupational Therapy

- Address mobility needs – adequate devices, safety in movement, increase stability
- Increasing skills or using adaptive strategies for dressing, toileting, and ADL
- Pelvic floor and continence certified therapist can provide more advanced techniques and address physical function of pelvic muscles

Registered Dietician

- Managing irritants with other dietary recommendations

Behavioral Health

- Address stress, anxiety, and/or trauma

Resources

Low or no-cost suggestions for environmental changes to reduce falls:

- https://www.aarp.org/content/dam/aarp/livable-communities/livable-documents/documents-2015/HomeFit2015/AARP-HomeFit-Brochure-Flat.pdf
- https://www.cdc.gov/steadi/pdf/STEADI-Brochure-CheckForSafety-508.pdf

CDC Resources for Caregivers and clinicians:

- https://www.cdc.gov/steadi/patient.html
- https://www.cdc.gov/steadi/pdf/STEADI-CaregiverBrochure.pdf

National Council on Aging Falls Prevention Resources for Caregivers:

- https://ncoa.org/caregivers/health/prevention/falls-prevention

Case Example

David is a 54-year-old man living within a group home geared for adults diagnosed with serious mental illness. David has lived within the same home for the last 8 years without any difficulty.

However, over the last several months David has begun having some difficulties, becoming concerning to his care providers. Notably, David has begun to experience frequent falls, mostly occurring during the night. Although David has not had any serious injury from the falls, there is concern that he could injure himself. Additionally, David has demonstrated some difficulty with memory, forgetting to complete some routine tasks or attend appointments, and his room has overall become more disorganized.

David's providers are worried he will not be able to continue living in his home, however, David has identified his goal is to continue to live in his home and in the community.

Case Example

What are different actions that could be taken to support David and enable him to remain living in his home?

Cognitive

- Develop checklists for routine activities
- Use a calendar for scheduled appointments or phone alarms/ reminders for important tasks

Environmental

- Work with David to organize his space to reduce clutter and make it easier to find items
- Ensure that no items are where he steps off the bed or are in the pathway to the bathroom
- Put in night lights in the hallway and bathrooms

Individual Support

- Help David use any recommended strategies from his providers, such as reducing the number of drinks before bed
- Help David in accessing any recommended devices, such as a cane
- Provide direct supports to implement and help David learn the new strategies

Medical Support

- Have David connect with his medical providers to assess for potential issues with incontinence, mobility, and memory loss
- Have David's providers review his medications for potential side effects that may be causing these issues

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Questions?

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