COMPANION GUIDE

Module 5: "Bill's Search for Lois"

Tips for facilitators:

- Watch the Module 5 DVD prior to the training so that you can anticipate questions and identify supplementary materials needed for your particular audience.
- This module is 44 minutes.
- Review your county profile and be prepared to talk about the prevalence of Parkinson's disease in your community.
- Consider working with a co-facilitator who will complement your own expertise and knowledge of the community.
- Handouts for this session include PowerPoint slides, Participant Companion Guide, and evaluation forms.
- Feel free to stop the DVD at any point in the program for discussion.
- Refer to the introduction of this manual for more tips.

Plan for the Session

- With knowledge you have from stakeholder interviews and with assistance from your manager/supervisor, determine optimal scheduling. Consider
  - the best times to help ensure cross-training (i.e., participation from both aging and behavioral health services)
  - how many modules to view at one time—modules are designed for 90-minute sessions to allow time to view modules and discuss content and implications for the community
  - frequency of training (e.g., weekly, monthly)

- Estimate the prevalence of Parkinson's disease in your community.

  - Approximately 1.5% (0.015) to 2.0% (.02) of the 65 and older population has been diagnosed with Parkinson's disease, with the prevalence increasing dramatically with age. Use your county profiles to estimate the prevalence of Parkinson's disease among older adults in your community. First multiply the percentage of adults age 65 and older (e.g., 13.6% → 0.136) by the total population in your county (e.g., 0.136 × 375,922 = 51,125.392). Then multiply that number by 0.015 (51,125.392 × 0.015 = 767), and separately by 0.02

(51,125.392 × 0.02 = 1,023) to estimate the prevalence range. These resulting numbers give you the range of the prevalence of diagnosable Parkinson's disease in your community (e.g., 767–1,023 older adults with Parkinson's disease). Note: This will be a slight underestimate.

- Prepare handouts:
  - Copy PowerPoint handouts for participants.
  - Copy the resource section of the *Participant Companion Guide* as a handout for participants.
  - Determine which, if any, fact sheets you will copy and distribute as handouts.

- You may adapt the PowerPoint slides to fit community needs and interests. The presentations are saved to your project flash drive.
- Anticipate responses from participants and plan how to redirect comments if necessary. For example, typical responses when people view Module 5 are
  - "A mental health provider would not be able to provide on-site training to the staff at a care facility"
  - "The Behavioral Health Support program is only available to Medicaid clients, and the one in our county has a long waiting list"
  - "It's not realistic to expect staff at a care facility to be able to educate a resident."
  - "People with dementia cannot participate in end-of-life planning?[1]

  Keep the focus on collaboratively addressing the needs of older adults with a chronic disease such as Parkinson's for which co-occurring disorders like dementia and depression are common. The multidisciplinary team, for example, presents an ideal system that Older Adult Behavioral Health Specialists are trying to create. Comments about Bill or individual providers can contribute to exploring issues in your community such as autonomy versus safety, evidence-based best practices, and opportunities for collaboration.
- Prepare to offer NASW CEUs when the DVD is presented with discussion:
  - Make one copy of the roster (for signing in) and a copy of the evaluation form for each participant. Fill in forms with the title of the module, date, and location.
  - Ask participants to sign in on the roster and to complete the evaluation at the end of the session.
  - Give each participant a certificate with his or her name and the date.
  - Mail roster and completed evaluation forms to the Oregon Chapter of NASW (address is on the form).

Welcome Participants

If you are presenting the modules in sequence, most of the participants may be familiar with each other by now. You can use the introduction time for participants to reflect on the previous

[1] This issue is also addressed in Module 8, *Behavioral Health Issues and Advance Care Planning.*

module and how they have used information since the last training. Be sure to welcome and include new members.

Show the DVD

If you wish, you may stop the DVD for discussion rather than watching it all the way through prior to discussion.

Facilitate Discussion

Much of the learning will take place or be reinforced through discussion. Because no module can cover all aspects of chronic disease and co-occurring disorders, discussion is important for exploring variations on the scenarios presented to address the expertise and learning needs of the people in the room. You will have important information from the stakeholder interviews you have conducted to help you with this.

Below are some questions designed to help participants connect the material to their own practice and to their communities. Consider how much time you will have for discussion and select the questions you feel are most important. Note that some questions focus on clinical issues and others on systems issues of the broader community.

Use the resource guide (that is, the *Participant Companion Guide*) for Module 5 to identify supplemental information that will be relevant for your audience.

Discussion Questions

1. If you wish, stop the DVD after Bill and Daniel describe their experience and the slide titled "What did you Notice?" appears.

   What did you notice? Be specific. Would you be concerned? What else would you want to know?

After the DVD concludes, consider these questions:

2. This Module illustrates what can happen when a family member has to move an older adult into a care setting under urgent conditions.

   How helpful is the information and assistance that family members in this situation currently receive from our community's hospital discharge planners, emergency departments, outpatient clinics, APD staff, AAA staff, or others to

   (1) find an appropriate care setting? and

   (2) help smooth the transition from home or hospital to the care setting?

   Where is there room for improvement?

3. Without a timely intervention that addressed Bill's behaviors, the Adult Foster Home manager might have started the process to evict him.

   How often does this kind of event happen in our community? What is the usual sequence of events that leads up to a placement "crisis"? For example, Bill's son didn't have accurate information about Bill's care needs. Where in the sequence were there opportunities to prevent a crisis?

4. This Module illustrates the role that Options Counselors can take in helping family members navigate community services on behalf of an older adult. Have you familiarized yourself with the Aging and Disability Resource Connection (ADRC) in Oregon and how to access the Options Counseling services in your county? (See Module 3 for more information about Options Counseling.)

   Bill is an example of an older adult whose care needs will continue to increase as his physical illness progresses. In our community, what is the potential for ADRC or Aging Services staff to serve as the appropriate "point person" for these older adults and their caregivers?

5. Parkinson's Disease is only one of several chronic health conditions where depression, anxiety or cognitive impairment are part of the clinical picture. Cardiovascular disease (including congestive heart failure and stroke), diabetes, and chronic obstructive pulmonary disease (COPD) are others. People living with these chronic conditions may be taking

medications that have side effects that add to their behavioral conditions. (See *Participant Companion Guide*, Module 1, for more information.)

What are some chronic health conditions you have encountered in your work that you think are important for services providers to know about? What can be done to support the person with this condition, their family, and the provider?

6. Bill's situation is not uncommon; his care needs to change. Bill is also an example of an older adult whose situation rises to the need for a complex case consultation, including behavioral health, primary care, aging services, and care facility staff.

   Who should take part in the decision-making process about the next steps for Bill? How might that occur? What is the process in our community for conducting multi-disciplinary, multi-agency case conferences? What barriers do we need to address (e.g., interpreting HIPAA rules, ensuring that staff closest to the client attend, including family members)?

7. Bill's primary care physician ordered an Allen Cognitive Level Assessment, a tool that was originally developed for use by occupational therapists working with adults with psychiatric disorders and adults with dementia (see *Participant Companion Guide* for this module for a link to this resource). This assessment focused on Bill's remaining cognitive abilities, not his deficits. It provided a useful direction for Bill's caregivers and his son.

   As staff who provide direct services to older adults, how do we currently ensure that our care plans focus on strengths and potential as well as behavior management?

8. People living with a chronic health condition who participate in evidence-based programs like "Living Well with Chronic Conditions" learn strategies for managing both their health condition and the emotions around it. They often have better health outcomes as a result. (See *Participant Companion Guide*, Module 1 for more information about this program and where it is available in Oregon.)

   Does your community have a "Living Well" program or something like it? If so, who is eligible to participate and what is the referral process?