The Interdisciplinary Team in a Specialized Geriatric Clinic

A growing number of elderly patients who have no or limited family and friends, and little to scarce interaction with the healthcare system, seem to be increasingly accessing the system through an emergency capacity. This group is the toughest for GPs to treat regarding the assessment and management of cognitive, functional and social issues. The interdisciplinary team in a specialized geriatric clinic offers comprehensive assessment, ongoing counseling and education on the dementia disease process, and provides support for the management of functional, cognitive and behavioral changes.

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The assessment for diagnosis and management of dementia is done in different settings by different people, including a general practitioner’s (GP) or neurologist’s office, a geriatric clinic or an acute-care setting.

An assessment for dementia typically begins when a family member or caregiver begins to notice changes in the patient’s behavior and cognition. As a result, caregivers seek guidance from healthcare professionals in search of answers. Once this support is sought, a comprehensive investigation is undertaken to understand the current issues (i.e., when the changes started) and factors which make the individual’s functioning better or worse. The investigation involves a thorough health review with a physical examination, laboratory work-up and diagnostic imaging to ensure there are no other comorbidities or medical illnesses contributing to these changes.

Once these investigations are completed, further assessment and screening tools are utilized, such as the Katz Activities of Daily Living (ADL) assessment, the Standardized Mini-Mental State Examination (SMMSE), the Clock drawing test, the Montreal Cognitive Assessment (MoCA) and the Frontal Assessment Battery (FAB), to review the individual’s current physical and cognitive functional levels. These assessments may or may not be completed by an interdisciplinary team (IDT). A diagnosis of dementia can then be made.

Specialized Geriatric Clinic

The healthcare members that are typically involved in a specialized geriatric clinic or an acute-care setting during an assessment include a nurse practitioner (NP), a geriatrics registered nurse (RN) and a geriatrician. When necessary and available, the IDT, consisting of a physical therapist (PT), an occupational therapist (OT) and a social worker (RSW), is also involved in the assessment and management process. The inclusion of these three specialists has demonstrated marked improvement in patients’ overall
health and helps to reduce their disability care needs.\textsuperscript{3}

Most often, individuals who present to their GP do not require an IDT approach as they have supportive family members and/or caregivers, as well as an involved GP who is actively providing ongoing care. However, there is a growing number of individuals who have no or limited family and friends, and little to scarce interaction with the healthcare system. These individuals tend to experience difficulties in their community/home environments, and end up accessing resources in an emergency capacity or through the justice system.

This isolated group presents as the greatest challenge to GPs and the healthcare system with regards to the assessment and management of cognitive, functional and social issues. It is particularly these individuals at risk who may require the services and support of a geriatric IDT.

**Case Study:**

**Mr. A and the IDT Process**

The following is an example of an at-risk individual requiring intervention from the IDT.

Mr. A is a 94-year-old single male who presents to his GP for prescription renewals. At this time, the GP notes that the patient does not seem his usual self, is losing weight, and appears unkempt. As a result, the GP seeks support from the community geriatric team who subsequently visit the patient’s home. Upon visitation, the team notes the home is in disarray with spoiled food, garbage and clutter. Mr. A’s personal information and documents are out in the open, and there appears to be an odor of smoke and mouse feces throughout the house. Additionally, the patient is unable to recall why the community geriatric team is visiting. Moreover, the patient cannot name the tenants residing in his building, or his surviving family members. Following the home visit, the GP and the community geriatric team request an urgent geriatric assessment at a specialized clinic wherein the patient is deemed incapable of managing his own personal care needs and finances.

At the specialized geriatric clinic appointment, numerous recommendations are made and initiated, which include:

1. An application is made to the Public Guardian Office (a branch of the Alberta provincial government) and the Office of the Public Trustee in the interest of the patient’s safety and decision-making.
2. Home-care services (i.e., bath assist, medication assist), medication in blister packages, Meals on Wheels and home-making services are added.
3. An ongoing assessment and intervention from the community geriatric team, and a follow-up from the geriatric clinic in one month’s time, are implemented.

After one month, the patient returns to the geriatric clinic, at which point it is noted that he has refused home-care involvement, has been unable to arrange payment for his meals, and has continued to lose a noticeable amount of weight. The team arranges for the patient to be admitted to a Geriatric Assessment Unit (GAU) for further assessment and intervention.

Once admitted to the GAU and with assessments conducted by the NP and RSW, collateral information reveals that the patient is financially wealthy and owns several properties for which alleged discrepancies have been noted. This new information also suggests that the patient is potentially a victim of financial abuse, identity theft and elder abuse, and it is discovered that local authorities are investigating the patient’s home as an alleged drug house. The RSW notifies the Public Trustee and Public Guardian of the alleged circumstances to protect the patient’s assets and resources, and actively pursues locating surviving family members within the province, country and internationally.

The RSW notifies the elder-abuse team to initiate an investigation and liaise with local police to pursue the other noted forensic issues. The OT

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also provides additional cognitive and functional assessments to establish the patient’s ability to manage his own ADLs. These assessments include ensuring a continuity of care from the specialized geriatric clinic and tertiary care geriatricians, as well as an assessment to provide for the Public Guardian and trusteeship applications.

Furthermore, the geriatric NP provides support for ongoing chronic-disease management and linkages back to the community geriatric team and GP, with the current plan of care initiated for the patient to manage his dementia care needs.

**The IDT Approach**

An IDT approach allows for a comprehensive assessment, ongoing counseling and education on the dementia disease process, and provides support for the management of functional, cognitive and behavioral changes. In this regard, the geriatric RN provides an assessment of current patient-care issues, a review of caregiver needs and coping strategies, and provides links to the IDT and community resources, acting as a liaison with ongoing supports as needed. The geriatric NP provides for ongoing medical care and dementia care medication management in collaboration with the GP and geriatrician as needed.

The RSW provides for an in-depth psychosocial assessment of patient and family social issues which is inclusive of legal matters (e.g., personal directives, enduring power of attorney, guardianship, trusteeship), financial and housing needs, and support networks and caregiver needs. The RSW also has the opportunity to facilitate ongoing support and counseling on these identified issues, while linking the patient and family to various community supports and referral agencies, such as the Alzheimer Society of Canada.

The OT provides assessments in the areas of cognition and physical function, and examines the patient’s ability to manage his own basic and instrumental ADLs. The OT also offers the dementia patient and their caregivers education on alternative modalities to help maintain independence as long as possible. These assessments and interventions target improving independence, and reduce care requirements, service use and fall rates.

**Conclusion**

In conjunction with the various IDT members in the community, specialized geriatric clinic and tertiary care settings, these complex patients are provided with an inclusive and comprehensive assessment with resource options for managing the dementia disease trajectory and improving their quality of health care. This approach further empowers the older adult and their caregivers to manage their health and chronic conditions.