Chronic Illness and Evidence-based Practice with Older Adults

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Older Adults

• Proportion of population United States

(US Census Bureau, 2014; WHO, 2016; HealthyPeople.gov)

Older Adults

• Proportion of population globally

(United Nations, 2015)

Older Adults

• Growth of diversity in United States

(US Census Bureau, 2014; WHO, 2016; HealthyPeople.gov)
Older Adults

Definition Chronic Disease/illness:
- lasts 3 months or more
- it cannot be prevented by vaccines or cured by medication, nor do they just disappear.

Examples: diabetes, dementia, cardiovascular disease

(U.S. National Center for Health Statistics, 2017)

Health Risk Behaviors & Chronic Disease

Co-Morbidity among Medicare Beneficiaries

<table>
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<th>Number of Conditions</th>
<th>Percent of Beneficiaries</th>
<th>Percent of Expenditures</th>
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<td>1</td>
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</tr>
<tr>
<td>2</td>
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<td>4</td>
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<td>5</td>
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<tr>
<td>6</td>
<td>3</td>
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<td>7+</td>
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(Who, 2016; HealthyPeople.gov)
Chronic Conditions by Age

Chronic Conditions by Gender

Chronic Conditions by Insurance

Mental Health & Substance Use

- Mental health disorders

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- Substance use disorders

(Official report, 2017; SAMHSA, 2016)
Co-occurring Disorders

- Prevalence among older adults

![Graph showing prevalence among older adults from SAMHSA, 2016](image)

What is an Evidence-Based Health Promotion Program?

- These are programs that have been researched and proven to be effective in promoting health, preventing disease, and symptom management of chronic health conditions...
- ...and that have integrated science and community participation.

**GENERAL ASSUMPTIONS:**
- People have some control over their health
- Empirical testing & rigor
- From a pilot study to large scale testing
- Confidence that if you implement one, you are implementing one that works
- Stakeholder and community preferences make a difference
- Widespread adoption can lead to better population health

Why Use EBHPPs?

- Better decision-making
- Better health outcomes – individuals & populations
- Public health practitioners (executive / managerial)
- Policy makers (fiscal, state, national, etc.)
- The public, interest groups, consumers
- Researchers, evaluators

What makes a practice “evidence-based”?

- The program is successful.
- It is published in “peer review” sources.
- It is considered evidence-based vs. best practices.

![USC School of Social Work](image)
Process of Evidence-Based Practice

- Develop questions to meet needs of clients
- Track down best evidence to answer the questions
- Critically appraise the evidence in terms of its validity
- Integrate this appraisal with one’s clinical expertise, client preferences, to include biological variables, values & preferences
- Evaluate one’s effectiveness in undertaking these steps; use research methods to evaluate
  1. evidence-based actions
  2. outcomes they seek to achieve

Steps/Process in EBP

- Step 1: Converting information needs related to practice and policy decisions into well-structured questions
- Step 2: Tracking down, with maximum efficiency, the best evidence with which to answer them.
- Step 3: Critically appraising that evidence for its validity (closeness to the truth), impact (size of the effect), and applicability (usefulness in our clinical practice)
- Step 4: Integrating the critical appraisal with our clinical expertise and with our [clients’] unique characteristics and circumstances
- Step 5: Evaluating our effectiveness and efficiency in executing steps 1 to 4 and seeking ways to improve them both for next time

(Gambrill & Gibbs, 2009)

An Updated Model for Evidence-Based Decisions (Haynes, Devereaux, & Guyatt, 2002)


- Target population
- Goals
- Rationale
- Benefits
- Programmatic structure
- Staffing
- Facility & equipment
- Program evaluation
- Fidelity checklist
- Costs
Integrated Behavioral Health and Primary Care

A practice team of primary and behavior health care, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care. May address mental health, substance abuse conditions, health behaviors, life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

—The Academy Integrating Behavioral Health and Primary Care, 2013
Essential Element of Good Chronic Illness Care

Informed, Activated Patient
Productive Interactions
Prepared Practice Team

Chronic Illness Care EBPs

Stanford
Self-Management Resource Center

- Chronic Disease Self-Management Program
- Diabetes Self-Management
- Chronic Pain Self-Management
- HIV Positive Self Management
- Building Better Caregivers

Chronic Illness Care EBPs

- Evidence-based treatment for depression in older adults with co-morbid chronic illness living in the community
- 6-8 sessions
- Uses problem solving treatment, behavioral activation & pleasant activity scheduling

Chronic Illness Care EBPs

- Enhance Fitness
  - Increases strength
  - Boosts activity levels
  - Elevates mood
- Enhance Wellness
  - Decreases hospital stays
  - Lowers psychotropic drug use
  - Facilitates self-efficacy
  - Improves symptoms of mood disorders
Motivational Interviewing

- Evidence-based practice
  - Key points for clinicians:
    - Motivation to change is elicited from the client
    - It is the client's task, not the counselor, to articulate and resolve his or her ambivalence
    - Direct persuasion is not an effective method for resolving ambivalence
    - The counseling style is generally a quiet and eliciting one
    - The counselor is directive in helping the client to examine and resolve ambivalence
    - Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction
    - The therapeutic relationship is more like a partnership or companionship than expert/recipient roles

- 2 sets of principles and skills
  - Principles: DEARS (set 1)
    - Develop Discrepancy
    - Express Empathy
    - Avoid Argumentation
    - Roll with Resistance
    - Strategies
  - Skills: AROSE (set 2)
    - Affirmations
    - Reflective Listening
      - Simple
      - Double sided
    - Ask Open-ended questions
    - Summarization
    - Eliciting Change Talk

Problem Solving Therapy

- 7 steps:
  - Step 1: Identifying the problem
  - Step 2: Setting the goal
  - Step 3: Brainstorming options
  - Step 4: Weighing the pros and the cons
  - Step 5: Selecting the best options
  - Step 6: Creating an action plan
  - Step 7: Evaluating the outcome
Solution-focused Brief Therapy

**SFBT Intervention Overview**

- **Pre-session change**
  - "What changes have you started to notice since deciding to get this problem sorted out?"
- **Between session change**
  - "So what is better, even a little bit, since last time we met?"
- **In-session questioning**
  - Coping questions
  - Miracle questions
  - Scaling questions
  - Exceptions
  - Compliments
- Experiments and homework assignments

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Behavioral Activation

**Structure of sessions:**
1. review progress
2. set an agenda
3. attend to the client’s understanding
4. solicit feedback
5. use homework

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Cognitive Behavioral Therapy

**What is it?**

![The Cognitive Triangle]

- THOUGHTS
- FEELINGS
- BEHAVIOR

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CBT

• How to use it?
  – For depressed clients...
  – How the sad feelings are connected to the maladaptive thoughts and behaviors

The Cognitive Model

CBT

• Techniques
  – Thought records
  – Dysfunctional ways of thinking
  – Behavioral experiments
  – Pleasant activity scheduling
  – Mood monitoring
  – Psychoeducation

Ethical principles governing clinical practice: Beneficence

• the principle of benefiting others
• accepting a responsibility to do good
• underlies the profession

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Nonmaleficence

• do no harm
• not to perpetuate physical or emotional harm
• not to engage in behavior that could harm others

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Autonomy
• The belief that clients have the right of self-determination

Justice
• The requirement of social workers
• Act fairly
• Balance the rights of clients with those of others

Case Study
• Maria is a 51 year old Mexican-American female referred by her primary care physician to the social worker for a consultation due to dietary and medication non-compliance with diabetes. According to the physician’s report her blood sugar was 750 over the weekend and she went to the ER. Maria also presented with a necrotic big toe which became infected, requiring partial amputation. Maria has hypertension, high LDL cholesterol, is overweight and smokes 1 pack of cigarettes per day. She lives in an inner city community with few grocery stores, multiple liquor stores and fast food restaurants. She works in a fast food restaurant earning minimum wage with no employer provided health coverage, she has 3 children, and her spouse also works at a fast food restaurant. She and her family are members of the local Catholic parish in their community, she has siblings and extended family nearby. Her primary language is Spanish, she speaks minimal English and the highest grade level she completed was 8th grade. She does not drive, she uses the public transit system for transportation. Maria was admitted to Home Health after her hospitalization, she has a health nurse providing wound care and education on medication management/compliance, physical therapy and occupational therapy are working with Maria on ambulation, ADLs, and home safety.

Biopsychosocial Spiritual Assessment
• health related factors - Maria has Type I diabetes. Currently, Maria has complications from her chronic disease manifested by amputation of partial big toe and blood sugar out of control. She reports having no functional health limitations prior to hospitalization, however, she has limitations in ambulation and the ability to perform ADLs due to partial amputation of her big toe. She reports no history of depression or anxiety.
Biopsychosocial Spiritual Assessment

- **Family factors**: Maria reports no strain in family dynamics between her spouse, children, and extended family which live nearby. She reports that she sees her extended family several times per week. Maria works full time as does her spouse, extended family assist with getting the 3 children to and from school. Maria does most of the household tasks such as laundry, cooking, cleaning, and does the shopping. Her spouse manages the family finances and pays the bills. Maria has been independent in administering her insulin in the past, not requiring assistance from her spouse or other family members. Maria states a preference for her spouse to be involved in health care decision-making.

- **Developmental stage**: at age 51, Maria is meeting the developmental milestones characteristic of the developmental stage of generativity versus stagnation, as she has been working and guiding the next generation (raising her own children).

- **Diversity**: Maria was born in Mexico and emigrated to the United States at age 13, she practices Catholicism and is actively involved in her parish. Maria believes that God can heal her diabetes and complications she is experiencing, she reports no use of complimentary or alternative medicine. Maria married her spouse at the age of 18. Her primary language is Spanish, she speaks minimal English and prefers communication and documents in Spanish.

- **Support system**: Maria’s support system consists of her spouse, children, extended family and friends (informal support); physician and home health professionals (formal support); her friends and priest from her parish (faith-based support). Maria reports she has not accessed community support such as diabetes education or promotores programs in the past.

- **Social, environmental, or financial barriers**: Maria reports that she has had difficulty with obtaining diabetes supplies to maintain compliance with diabetes management. Maria reports that she has difficulty accessing fresh fruits and vegetables. Specifically, she reports that they cost too much at the local store. She reports she does not get regular exercise due to fears of crime in her neighborhood.

- **Grief and loss history**: Maria reports that she has been living with diabetes her entire life, she reports that the best way for her to cope is to seek support from and talk with her family and friends. She also reports her faith and parish provide her with strength and support.

- **Current psychological functioning**: Maria is alert and oriented to person, place, time, and situation. She presents with a pleasant mood, bright affect, and appropriate behavior. Maria is currently not prescribed psychotropic medications, she has no current or past suicidal ideations.

- **Interdisciplinary team communication**: the goals of treatment among the interdisciplinary team are to assist Maria with diabetes management and home safety.
Application of the diversity to interdisciplinary treatment with Maria:

Maria expressed a preference to have her spouse involved in health care decision-making, therefore, he attended all visits with the physician, diabetes nurse practitioner, and social worker.

Maria reports no use of complimentary and alternative medicine. Her Catholic faith influences her perceptions of health and she believes that God can heal her, respect for this belief was demonstrated by health care providers and recognized as a strength. Maria follows a diverse dietary pattern. She reports that she consumes a traditional Mexican American diet of maize foods (corn), rice, beans, and meat; very little fruits and vegetables (due to the cost); and a high of refined foods and sweets (due to access and low cost).

Discussions between Maria, her spouse, the physician and nurse educator surrounding dietary preferences and the relationship between diet and chronic disease occurred, the social worker provided reinforcement of this association and explored barriers to accessing traditional foods as well as fruits and vegetables. She speaks Spanish primarily, therefore, the social worker ensured that translation services were in place for encounters with health care providers and that all materials were provided to her in her preferred language, Spanish.

The social worker described the Motivational Interviewing perspective to Maria as well as the evidence on the use of Motivational Interviewing with Mexican Americans with diabetes, Maria consented to 6 weekly sessions with the social worker. Using the principles and skills of Motivational Interviewing, the social worker delivered the intervention consistently and monitored the effects of the intervention each session on Maria’s ambivalence about change as well as her motivation and readiness to engage in change behaviors that would promote diabetes management. By the 3rd session, Maria’s ambivalence about changing prior medication compliance, dietary and physical exercise patterns was reduced and Maria’s self efficacy increased as she expressed a desire to work with the interdisciplinary team to effectively take actions that would lead to diabetes management.

The interdisciplinary team developed a treatment plan to include a nurse educator emphasizing psychoeducation, medication and dietary compliance; physical therapy emphasizing a physical exercise regime that Maria could access and maintain, and the social worker to assist with ongoing counseling throughout the treatment plan, referrals to the American Diabetes Association for ongoing literature and support, assistance with applying for state disability compensation, and identifying community resources to improve her access to fresh fruits and vegetables through community gardens, farmer’s markets, food banks and transportation services.
THANK YOU!!

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