People of all ages can experience transfer trauma (or relocation stress syndrome) when moving to a new home. But the elderly can be particularly susceptible, with severe physical and psychological effects. As a caregiver or caretaker of a loved one, it’s important that you learn about the signs and potential repercussions of transfer trauma so that the impact can be minimized or prevented altogether.

Transfer trauma may occur when an older person is moved from their home to a long-term-care facility or when they are relocated within the same facility. Symptoms can show up before and during a move, as well as for several months afterward, and will vary in severity depending upon the individual and their circumstances.

3 Types of Symptoms
Tracy Green Mintz, LCSW, an expert in relocation stress syndrome, has categorized the symptoms into three clusters: mood, behavior and physiology. Elderly people who are suffering from cognitive impairment, such as dementia or Alzheimer’s disease, are prone to more serious symptoms. For such patients, the loneliness and confusion that stem from being disoriented in a new environment tend to exacerbate the situation.

Mood symptoms come on because the senior doesn’t know or understand what’s happening to them. Common feelings experienced by a person with transfer trauma include:

- Sadness
- Anger
- Irritability
- Depression
- Anxiety
- Tearfulness

A number of challenging behaviors may also be exhibited, such as:

- Combative
- Screaming
- Complaining
- Wandering off
- Withdrawal and isolation
- Refusing care and not taking medications
- Drug seeking
- Drinking or smoking

Typical physiological symptoms include:

- Mental confusion
- Falling
- Increased pain
- Rapid heartbeat
- Sleeplessness
- Poor appetite
- Indigestion or nausea
- Weight loss or gain
- Irritable bowel syndrome

Left untreated, relocation stress can take a physical toll and lead to long-term debilitating effects. A senior’s ability to function may permanently decrease, and studies have shown that the mortality rate of patients with relocation stress can triple if caregivers don’t properly address the issue.

From: eCareDiary: Simplifying Life for the Caregiver ~ Chris Cooper ~ January 25, 2017

Continued on Page 2
Assessing the Risks

Risks are involved with any major move late in life, but certain situations can be more danger-prone than others. As one example, elderly patients who move from their homes to a residential facility are more vulnerable than those who simply switch rooms where they have been living for some time. Relocation can be especially difficult for those who believe they are still capable of living independently and thus don’t see the need for the move. For this reason, Alzheimer’s patients are significantly more at risk, as their memory loss can inhibit their ability to understand why they have been moved.

While certain people are definitely more susceptible, it’s critical to understand that relocation stress syndrome can affect anyone. Since many of the symptoms highlighted above do not specifically point to transfer trauma, it’s imperative that family members remain aware of this potentially devastating issue whenever planning a move.

Preventing Transfer Trauma

The “how” of preventing relocation stress syndrome relates to the most common cause of move-related suffering: loss of control over one’s own life. When this is successfully addressed, seniors have shown an increased ability to move. When it comes to your loved one, some key actions that you can take to minimize trauma include:

- Involving the senior in decision-making and planning
- Providing them with an opportunity to ask questions and discuss concerns
- Honoring their preferences and allowing them to maintain control
- Maintaining their daily routine as much as possible.
- Safeguarding their personal possessions
- Involving them in setting up their new room or apartment
- Making their new home resemble the old one as much as possible
- Helping them become acclimated to their new surroundings

If they are not able to actively participate, it’s important that you remain attentive to their concerns. Being an active listener and answering questions can be a tremendous help in preventing or alleviating the confusion that can come with moving homes. It’s also helpful to spend ample time with them while they are acclimating to their new environment. The presence of familiar faces can help them adjust to their new homes and reduce stress.

Finally, it’s important to understand that it takes time for a person to adjust to a new home. The amount of time varies based upon circumstances, but it generally takes at least 30 days for someone to feel fully at home in a new environment. You can help ease the adjustment process by providing the staff with information about your loved one’s background, habits, preferences and routines, and incorporating them as much as possible into their new home.

~ Submitted by Lori Miller
Spring Conference In Review

The LTCSWI Spring Conference was held April 5 and 6, at the Gateway Conference Center in Ames. There were 102 people in attendance. Seven Exhibitors came to showcase their products/services.

Catherine “Cat” Selman, Authority on Aging, presented New CMS Requirements for Participation (RoP) and Social Services for the first day of our conference. A common response on the evaluations was “Bring Cat back!”

Mercedes Bern-Klug and Nadia Sabbagh Steinberg for the School of Social Work at the U of Iowa began our Friday morning with Ethical Practice within Your Professional Boundaries: Negotiating Informed Consent When Working with Clients with and without Decisional Capacity. (Meets the requirements for SW Ethics). Our next topic covered Brain Injury and how to support the family and was presented by Thomas Brown and Benjamin Woodworth. Our day concluded with a presentation on Pet Therapy and its Application for the Long Term Care Population by Kari Stock who also provided presentations from pet therapy dogs.

Mark your calendars for the Fall Conference, Friday, October 26, at the Gateway in Ames.

~Submitted by Ceci Johnson

Cat Selman - New CMS Requirements of Participation & Social Services

- Cat has a variety of webinars available including: It’s All About Discharge - CMS RoP Training Series, The Most-Cited Deficiencies for Activities Under the New Survey Process, and Baseline Care Plan: What’s Required?
- Cat also has books and DVD training videos on a variety of topics
- For more information: thehealthcarecommunicators.com

Kari Stock - Pet Therapy

- Pet Partners: www.petpartners.org
- Alliance of Therapy Dogs: www.therapydogs.com (Facilities Tab)
- Therapy Dog International: www.tdi-dog.org/

Bern-Klug & Steinberg - Ethical Practice...Informed Consent

- “Name and Claim” the 9 Core Social Work Competencies:
- Assessing Mental Capacity Checklist for Social Workers
  www.ltcswi.com (Conference Handouts Tab)
Long Term Care: Parkinson's Disease Psychosis in Long Term Care

By Amita Patel, MD, CMD, MHA, CPE

Today’s Geriatric Medicine July/August 2017, Vol. 10, No. 4, Pg. 26

By the time a geriatric psychiatrist or long term care health care professional sees a Parkinson's disease patient, the disease has often progressed significantly. Caring families make the decision to transfer a loved one into the care of professionals after years of managing motor manifestations and nonmotor symptoms to the best of their ability. The development of hallucinations and delusions by a Parkinson's patient is particularly distressing for caregivers and a leading cause of nursing home placement.1 Recently a new treatment for hallucinations and delusions associated with Parkinson's disease has provided new hope for clinicians and families.

Undetected Parkinson's Disease Psychosis

Of the approximately one million people in the United States living with Parkinson's disease,2 more than one-half will develop the hallmark symptoms of Parkinson's disease psychosis (PDP)—hallucinations (often visual) and delusions, or false beliefs.3,4 Despite their common occurrence, only 10% to 20% of patients (or their caregivers) will proactively mention hallucinations and delusions to a health care provider, possibly because they are embarrassed by the symptoms or simply do not realize they are actual symptoms of a disease known as Parkinson's disease.5

Distinct from other psychotic conditions,4 PDP's accurate diagnosis relies on a Parkinson's diagnosis preceding the onset of hallucinations and delusions. A diagnosis of PDP requires that for at least one month, a patient must have experienced at least one of the following symptoms: illusions, false sense of presence, hallucinations, and/or delusions. Additionally, other potential causes for hallucinations and delusions, such as infection, must be excluded.6 Experience has shown that it's quite common for a patient to be completely lucid with the exception of making unverifiable claims about what he or she might be seeing or believing.

Identifying Symptoms

People with PDP most often experience visual hallucinations. At first, a patient seeing imagined groups of children in the yard, small animals in the bedroom, or deceased loved ones might not be bothersome. However, as the hallucinations increase in frequency or progress into more disturbing examples such as rodents scurrying on the floor, people with Parkinson's can become upset and agitated,7 particularly if their loved ones or caregivers will not agree that what they are seeing is real. Although visual hallucinations are most common, people with PDP might also experience auditory or sensory hallucinations as well as the experience of fleeting images or the sensation that "something" is there, just out of sight. Illusions occur as well; patients may mistake a real object, such as a tree, for something else, like a person wearing a green hat.8

Delusions are false beliefs that are not supportable by fact.1 Caregivers find it particularly challenging to reason with their loved ones who cannot be swayed. Remarkably, delusions across the patient population seem to have similar themes, as they are usually paranoid. A husband might accuse his spouse of 50 years of adultery or conspiracy to steal the couple’s life savings, even if they are just browsing the internet at home.

As mentioned, very few families report psychosis symptoms, which means that a patient's health history will be incomplete. The health care provider needs to take responsibility for eliciting symptom reporting as well as explaining the range of symptoms a person with Parkinson's might experience as the disease progresses. If clinicians can present hallucinations and delusions as another aspect of Parkinson's disease, then patients and their families may more readily share occurrences, which can enable more rapid development of a treatment strategy.

The Smith Family: A Case Study

In 2010, Mr. Smith (whose name is changed to protect his privacy), now 80, was diagnosed with Parkinson's disease. As a retired chief of police at a local hospital, his diagnosis at first didn't affect his quality of life. He remained fairly...
mobile and was able to accompany his wife of 61 years on errands and family visits. However, in the summer of 2016, Mr. Smith was admitted to an Ohio psychiatric hospital after his wife took him to the emergency department when he began to experience regular visions, confusion, and paranoid thoughts.

The admission was the culmination of symptoms that had begun two years prior. As described by his wife, Mr. Smith began to see a strange family of four in his home, and while he didn't recognize the strangers, he took a particular dislike to the man. Feeling vigilant, Mr. Smith would stay up all night watching the imagined strangers. In addition, he would claim to see an army dressed in red and living in the home next door. He became convinced they would soon attack. Eventually Mr. Smith's experience of visual hallucinations and delusions overtook his wife's ability to care for him. She became particularly distressed and frustrated when he accused her of adultery.

After careful questioning and a full evaluation at the psychiatric hospital, I diagnosed Mr. Smith with PDP and suggested that he start treatment with Nuplazid (pimavanserin). Pimavanserin is the first and only FDA-approved medicine for the treatment of hallucinations and delusions associated with PDP. In most patients, it takes from four to six weeks before an individual with Parkinson's and/or their family members will notice any change in behavior. In the case of Mr. Smith, he began to experience far fewer hallucinations and delusions within a few weeks. In fact, his ability to recognize when he was hallucinating improved to the extent that he was able to return home.

Treatment Relieves Caregiver Burden
Data show that due to the demands placed on caregivers by PDP, Parkinson's patients with hallucinations are 2.5 times more likely to be admitted into a nursing home than those without the condition.1 Once admitted, PDP patients are likely to remain permanently and have a high rate of mortality.9,10 In the case of Mrs. Smith, she felt she had no choice but to take her husband to the emergency department when his delusions became unmanageable.

With the FDA approval of pimavanserin, physicians have a new tool to address troublesome symptoms such as hallucinations and delusions. Unlike other atypical antipsychotics, pimavanserin is a selective serotonin inverse agonist, meaning it has a unique mechanism of action. This is important because pimavanserin does not block dopamine receptors so it does not impair motor function.10

The FDA approval was based on data from a pivotal phase III clinical trial and other supportive studies demonstrating that pimavanserin significantly reduced the frequency and severity of psychotic symptoms compared with placebo, without impacting motor function. Phase III data were evaluated based on the Scale for the Assessment of Positive Symptoms, adapted for Parkinson's disease. The scale included items that are reflective of hallucinations and delusions associated with PDP, such as visual, auditory, and jealousy measures.11 The most common adverse reactions in this study were peripheral edema and confused state. Adverse reactions occurred at an incidence rate of greater than or equal to 5% and at least twice the rate of placebo. The recommended dose of Nuplazid is 34 mg, taken as two 17 mg-strength tablets together once daily at any time of day without titration. The medication can be taken with or without food.

It is hypothesized that certain Parkinson's medications (addressing motor symptoms) can contribute to the experience of PDP, though this aspect of the disease also occurs independently. Therefore, some patients may experience a reduction in hallucinations and delusions if their primary Parkinson's treatment, which acts on dopamine, is reduced. It is important to remember, however, that reduction in primary Parkinson's treatment may consequently worsen motor symptoms.

As a geriatric psychiatrist, I've worked with many patients and their families. All too often, a person admitted into a nursing facility will spend the rest of his or her life away from home. The availability of an approved treatment to address hallucinations and delusions associated with Parkinson's disease is very encouraging to me as well as to families. Although it's only one specific example, Mr. Smith was able to leave the psychiatric hospital and return home with his wife. Given this success, I urge health care professionals to look for signs of hallucinations and delusions associated with Parkinson's disease.

~ Submitted by Lorene Austin-Bennett
Know someone who needs support but don’t know how to help? Encourage them to call 2-1-1.

Just like calling 9-1-1 in an emergency, 2-1-1 is a three-digit helpline that connects anyone with local support and resources. Professionals are trained to quickly assess a caller’s needs and identify the best solution.

2-1-1 is free, confidential, and available any time.

Callers can find information including:

- Rent assistance
- Food pantries
- Affordable housing
- Utility assistance
- Health and mental health resources
- Child care and after-school programs
- Elderly care
- Job training programs
- Legal services
- Crisis intervention
- Disability services
- Volunteer opportunities
- AND MORE

In times of disaster, 2-1-1 gives accurate and timely information, as well as referrals to disaster recovery services. 2-1-1 also identifies gaps in health and human services and helps our community with resource planning.

Learn more about 2-1-1 at:

www.unitedwaydm.org/2-1-1

~ Submitted by Lori Miller

Is there a cost for dialing 2-1-1?

Calling 2-1-1 from a landline is free. Most cell phone carriers have made 2-1-1 calling available to their customers. Organizations and hospitals have to incorporate 2-1-1 into their phone system, or you can dial 515-246-6555 to reach 2-1-1.

Who is listed in the 2-1-1 Iowa Database?

To be listed, nonprofits and government agencies must meet set criteria, and provide free or subsidized health and human services to Iowa residents. For-profit organizations providing a unique service may be included.

What if a caller doesn’t speak English?

2-1-1 call centers have access to a Language Line that provides interpretation services in 170+ languages at any time.

Will the call be confidential?

All information provided is confidential. A call specialist will ask for a ZIP code to locate services closest to the home of the person in need. The specialist may ask for additional information, but a caller is never required to share identifying information.

Can I access 2-1-1 anywhere?

2-1-1 is available nationwide. Visit 211.org and search by ZIP code, city or state. Or call 2-1-1 and ask your local representative to find the number for 2-1-1 in another area. In Iowa, visit www.211iowa.org or text your ZIP code to 898211.
Geriatric Lecture Series

The Geriatric Lecture Series is presented online as a series of monthly lectures. Each lecture can be viewed for one month and is accessible exclusively during the month it is scheduled. This series is sponsored by the Iowa Geriatric Education Center and the University of Iowa Roy J. and Lucille A. Carver College of Medicine. To learn more about the GLS and how to participate go to:

https://igec.uiowa.edu/gls

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Discussion Forum: Discharge and Care Plans

Was wondering if you had any guidance as to where I can find examples of how Nursing facilities are writing up their Discharge Plans and Care Plans. Thank you. ~ Karen Tellin, Northbrook Manor

Send responses to: Ceci Johnson at ltcswi@mchsi.com

We have not had any response to this discussion forum question which has been out there for several weeks. This would probably be a good topic for a future conference. Cat Selman does presentations on Documentation including Care Plans. Any other suggestions for presenters would be greatly appreciated.

Here is another resource that might be helpful: Social Service Care Plans for the Nursing Home Social Services Director, by Leta M. Perry, BSW. It’s available in hardcopy for $49 and is also available digitally. There is a link to this resource on the University of Iowa School of Social Work website. If any of you are familiar with this resource, please let me know what you think.

~ Ceci Johnson, Executive Director
Spring Conference Comments

We received excellent feedback from the Spring Conference participants.

- Best conference yet! Like the fact that changes/updates were addressed specifically to our positions/everyday tasks (Selman~CMS RoP and SW)
- Cat was wonderful; She was very knowledgeable and I enjoyed the real life examples; They helped me to learn the concepts a lot better (Selman~CMS RoP and SW)
- Q & A provided more answers that I think many of us were here for, especially based on the title of the presentation; Otherwise, good, well-informed presenters; just was looking for other/additional info on decision-making protocol (Bern-Klug & Steinberg~Ethical Practice...Informed Consent)
- Ethics was more interesting than other ethics programs I’ve been to (Bern-Klug & Steinberg~Ethical Practice...Informed Consent)
- Excellent; The stories and humor really helped to explain the concepts; I could tell they were very knowledgeable and passionate about the topic; Very interesting (Brown and Woodworth~Brain Injury)
- So good: Unique topic and Kari was very knowledgeable; Love the dogs! (Stock~Pet Therapy)

Topics we are looking at for the Fall Conference:
Veterans Benefits, Stroke, Parkinson’s Disease, Depression and Anxiety, and Funeral Service Planning

Mark your Calendars!
LTCSWI Fall Conference
Friday, October 26, 2018