



Behavioral Health Brief: The Intersection of Grief and Trauma
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By Lisa S. Zoll, LCSW, and Leslie Davila, MS

Three Ds of Trauma:

- 1. Disorientation**
- 2. Distress**
- 3. Devastation**

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Traumatic grief occurs when a loss or death is sudden, tragic, and unexpected. The traumatic event that led to the loss or death can impact the grief reactions of individuals, families, and communities. It can cause intense fear and a feeling of helplessness that engulfs the individual's immediate ability to cope.

In the aftermath, those affected are left to identify ways to reorder their lives. These events are explored through the lenses of trauma and grief and how they intersect under the definition of traumatic grief. Clinical approaches and concepts can be applied to traumatic grief.

Individuals, families, and communities may experience traumatic grief when a death causes distressing preoccupation with the way the person died. Common reactions include shock, irritability, anger, yearning, disbelief, and numbness.

There is clinical debate about whether trauma and grief are individual events or entities that should be treated as such or whether there is an intersection or connection between trauma and grief and, therefore, they are not mutually exclusive.¹

The following case study examines the intersection between trauma and grief in the aftermath of the death of a first responder in the line of duty by applying the concept of order, disorder, and reorder to the event.²

Case Study

Order: The daily rhythm, routine, and structure of our lives.

From the age of 14, Connor wanted to be a firefighter. His uncle, who was a firefighter, inspired him to serve the community and help the people around him. Connor was hooked by the excitement of riding on a fire truck, hanging out at the firehouse, and being part of the brotherhood of first responders.

He moved through the ranks, eventually becoming a captain. He took a job at the county's 911 dispatch center because it was connected to the fire service. He wanted to see "the big picture," from the beginning of a call when the pagers went off to the end when the first responders returned to their respective firehouses.

Connor moved into the firehouse and was bunking with his best friend Jerome, who had a similar dedication to the fire service.

Disorder: An event that disorders the order of our lives. The notification of an event is the catalyst for disorder.

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Guidelines for Licensees: How to Choose and Document Continuing Education

The Bureau of Professional Licensure does not pre-approve continuing education providers, sponsors or individual programs. It is the licensees' responsibility to determine if the continuing education programs they attend meet the requirements of their professional licensure board.

A percent of licensees are randomly audited following each license renewal cycle. If selected, the licensee must submit to the board office an individual certificate of completion issued to the licensee or evidence of successful completion of the course from the course sponsor. These documents must contain the course title, date(s), contact hours, sponsor and licensee's name. In some instances, licensees will be requested to provide to the board additional information, including program content, objectives, presenters, location and schedule. Many times an inclusive brochure meets this requirement.

When selecting continuing education programs, licensees need to make sure they are compliant with administrative rule requirements. Some professions require specific conditions to exist such as presentation method (home study, ICN, etc.), specific hours on ethics and Iowa law and rules, certification status by national associations or boards, clinical content, and hours required in a specific practice discipline, as well as other items. To ensure compliance, each licensee must understand the continuing education administrative rules for their profession prior to choosing and attending a particular program. **No matter what a program brochure indicates, it is the responsibility of the licensee to ensure compliance with licensing requirements.**

In summary all licensees should:

- Be familiar with the continuing education requirements of their professional boards
- Obtain inclusive written materials about continuing education programs from program sponsors for post-renewal auditing purposes
- Maintain certificates of completion that includes the program or course title, date(s), contact hours, sponsor and licensee's name for four years.

<https://hhs.iowa.gov/Licensure/Iowa-Board-of-Social-Work/Licensure>



Grief and Trauma ~ Continued

Continued from Page 1

On March 9, 2020, at approximately 1:30 am, Connor, Jerome, and a driver were on the first engine responding to a house fire with entrapment. The house was fully engulfed in flames; it was impossible to enter.

"You take the front, and I'll take the rear," Connor said to his friend. They fist-bumped as they always did on calls.

"I ran toward the back of the house and dropped the nozzle where I wanted to stand with the hose," Connor says. As he ran to the side of the house, he could see Jerome on his knees 25 to 30 yards from the front of the house waiting for water. "We couldn't get any closer due to the intensity of the heat," Connor says.

Soon after arriving on the scene, the chief noticed that the porch had collapsed, and the handline was under it. A firefighter's helmet lay on the ground. The chief shouted, "Mayday, mayday, mayday, firefighter down, side A."

Connor says, "Shortly after the mayday call went out, a firefighter from another company came to the back of the house and took over my hose line and told me that I needed to go to the front of the ladder truck with the rest of my company. At that point, I asked what was going on. Someone said that the roof of the porch had collapsed on Jerome, he was unconscious, and they were doing CPR on him.

"I remember walking to the front of the ladder truck ... seeing the medevac helicopter crew walk by the ladder truck and everybody seemed to be in shock. Someone told my fire chief that there was nothing further they could do to resuscitate Jerome. Then the fire chief told the company, and everybody broke down, and that is when I went numb."

While Connor remembers one of his good friends from his company hugging him and crying, he says, "I felt no emotion."

Reorder: The new order of life after the event that caused disorder.

In the following weeks, Connor remembers, "I was still feeling really numb. ... I didn't sleep. Since I was living at the firehouse with Jerome, all his stuff was there. Basically, I went through the motions."

Reordering life after a traumatic event takes time. Connor decided to move out of the firehouse four months after the fateful call. "I moved back into my parents' house where everything wasn't staring me in the face, and I wasn't looking at all the reminders every day," he says.

Connor has done several things to reorder his life. He sought treatment for the trauma he experienced that night, he moved out of the firehouse and minimized his time there, and he took time off from work and began to play golf and hike. He became engaged to be married. On the day Connor got married, his oldest son carried Jerome's picture down the aisle with the other groomsmen.



Connor says that not being as involved in the firehouse has made his life less stressful. He feels calmer. He has reordered his priorities. Where once he put the firehouse first, he now places family above all.

Applying the Three Ds to Trauma

There can be a variety of responses to trauma that create disorder. These may vary in intensity, frequency, and duration. Consider the three D responses: disorientation, distress, and devastation. The event can cause disorientation and leave an individual in shock, feeling confused or lost, or in an altered mental state. Grounding is a type of coping strategy designed to anchor individuals in the present moment, the "here and now," by using the five senses of sound, touch, smell, taste, and sight when their capacity to cope has been overwhelmed by the circumstances.³

A psychological reaction associated with emotional suffering, distress includes a wide range of emotions such as sadness, despair, uncertainty, anxiety, and fears that can be difficult to cope with and are often out of the ordinary demands of life. Clinicians can help provide emotional regulation to a client's psychological distress by using active listening, validating the perception of the experience, providing education about responses, and offering support and validation to assist in normalizing their responses to the experience.⁴

Devastation is defined by Oxford Languages as "severe and overwhelming shock or grief." After a traumatic event, many factors can disrupt the normal grieving process, raising the risk for traumatic grief. It will be important to process the precipitating event through interventions that allow the client to form a cohesive narrative of the impact of both grief and trauma. This involves finding ways to absorb the event, doing the work needed to adjust to the new reality of life following the event, and accommodating the impact of the event while moving forward.⁵

Posttraumatic Growth (PTG)

A theory that explains the transformative growth following trauma, PTG can take place because of the struggles and challenges faced after a crisis or a traumatic event. Human beings can be changed in a positive way after experiencing a devastating loss. Individuals have different levels of resilien-



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cy—some will have trouble recovering after experiencing trauma because their core beliefs about their world may be challenged. Individuals who experience PTG may struggle psychologically to make sense of what has happened to them. It is through the processes of struggle that we see areas of growth.⁶

Tedeschi and Calhoun posit that PTG tends to occur in five general areas: appreciation of life, relationship with others, new possibilities in life, personal strength, and spiritual change.⁷ Clinicians can help clients connect with their internal resources and strengths to deal with challenging situations. Clinicians can also help clients reframe the priorities in their lives and, where possible, highlight their growth in those areas. It is more than bouncing back; it is living forward into a positive life after a traumatic experience. We can grow through what we go through.

Clinicians doing grief work must be aware of trauma. Clinicians doing trauma work must be aware of grief. When we are focused on just one or the other, we may fail to address how both may be impacting our clients.

— Lisa S. Zoll, LCSW, the founder and owner of Grief Relief, LLC, specializes in helping individuals challenged by loss and grief. She holds a master's degree in social work with a clinical concentration from Temple University and has published several articles and spoken on the local, state, and national level about loss and grief and how they can impact individuals, families, communities, and organizations.

— Leslie Davila, MS, has a master's degree in criminal justice from Saint Joseph's University and a Bachelor of Arts in sociology and criminal justice from La Salle University. For 23 years, she has committed her career to advocating on behalf of children and victims/survivors of crime. Appointed director of the Office for Child and Youth Protection of the Archdiocese of Philadelphia in 2011, Davila oversees the Archdiocesan commitment to protect children and young people and its efforts toward healing and reconciliation for those who were sexually abused as minors.

References

1. Regehr C, Sussman T. Intersections between grief and trauma: toward an empirically based model for treating traumatic grief. *Brief Treat Crisis Interv.* 2004;4(3):289-309.
2. Rohr R. *The Wisdom Pattern: Order, Disorder, Reorder.* Franciscan Media; 2020.
3. Tull M. Grounding techniques for post-traumatic stress disorder: using the five senses to cope. Verywell Mind website. <https://www.verywellmind.com/grounding-techniques-for-ptsd-2797300>. Updated April 16, 2021.
4. Zoll L, Schwartzman J, Shiner L. *Drew and the Grief Thief: A Story for Children and Adults Experiencing Loss and Grief.* CreateSpace Independent Publishing Platform; 2018.
5. Zoll L, Shiner L. A grief trajectory. *Social Work Today* website. http://www.socialworktoday.com/news/pp_063017_5.shtml. Published 2017.
6. Collier L. Growth after trauma: why are some people more resilient than others—and can it be taught? *Psychol Today.* 2016;47(10):48.
7. Tedeschi RG, Calhoun LG. The Posttraumatic Growth Inventory: measuring the positive legacy of trauma. *J Trauma Stress.* 1996;9(3):455-471.

~ Submitted by Lori Miller, LBSW



LTCSWI Spring Conference

April 4-5, 2024

Gateway Hotel & Conference Center, Ames

We plan to offer *Ethics* at this conference.

Other topics we are looking into...

Benefits of Telehealth

Effective Communication

Post Traumatic Stress Disorder

Long Term Care: Advance Care Planning for Families of Adults With Dementia

By Debra Hain, PhD, APRN, AGPCNP-BC, FAANP, FNKF; Mary Brown, DNP, MS, MSN, FNP-BC; and Maria Ordóñez, DNP, APRN, GNP-BC, PMHNP-BC, FAANP, FAAN

Today's Geriatric Medicine Vol. 12 No. 5 P. 30

Alzheimer's disease and related dementia (ADRD) affects more than 5 million Americans and is the sixth leading cause of death.¹ Alzheimer's disease, a worldwide problem, involves the loss of intellectual functioning including memory and judgment. Over the next decade, the global population of individuals older than 60 is projected to grow at an unprecedented rate. In 2017, there were about 962 million adults older than 60, a number expected to rise to nearly 2.1 billion by 2050.² The risk of ADRD increases with age, which will lead to a substantial number of older adults living with dementia. According to Alzheimer's Disease International's 2016 report, "Improving Healthcare for People Living With Dementia: Coverage, Quality and Costs Now and in the Future," the number of persons worldwide with dementia is projected to increase from 47 million in 2015 to 132 million by 2050.³

ADRD progresses slowly over many years from mild, moderate, and severe to the terminal stage of this neurodegenerative disease. As the disease progresses, individuals experience diminishing cognitive function with decreased ability to engage in meaningful communication about their health care, which includes end-of-life (EOL) care decisions.³⁻⁷ Therefore, it's critical that advance care planning (ACP) including EOL choices are started in the early stages of dementia when older adults have the cognitive capacity to make informed decisions.

ACP is a process of engaging in shared decision making and documenting a person's choices, preferences, and wishes to guide their future health care for when they are no longer capable of making decisions for themselves due to injury or illness, including ADRD.⁸⁻¹² A recent review of ACP best practices reported that ACP should focus on communication between patients and their families and health care providers about values and preferences for health care at EOL, rather than on merely completing a document.¹³ In a review about ACP for adults with dementia, researchers concluded that ACP discussions should take place early in the disease trajectory, but EOL discussions frequently were not done before ADRD progressed to a stage at which individuals were unable to disclose their EOL wishes.^{14,15} In addition, recommendations from a consensus statement related to EOL care in advanced dementia from the Summit on Intellectual Disability and Dementia called for intensive attention and effort to ACP for individuals with ADRD. This statement supports the crucial need to start EOL discussions as early as possible before the onset of disease or before disease progresses to moderate to severe stages.¹⁶ Because of the importance of ACP and the awareness that many older adults are not engaging in these discussions with their health care providers, several initiatives such as the Conversation Project from Institute for Healthcare Improvement (IHI) have become available.

The Conversation Project focuses on empowering people to have their wishes for EOL care expressed and respected. A Conversation Starter Kit is an important part of the IHI initiative.¹⁷ The Conversation Starter Kit is a tool that was developed to help people have conversations with their loved ones about their wishes regarding EOL care. It's available in multiple languages and includes free resources, education tools, and training programs that promote ACP conversations between those with cognitive impairment and their loved ones. There's also information designed for specialized populations and strategies for community outreach.¹⁸ Several other kits (eg, choosing a health care proxy, Alzheimer's dementia starter kit) found at the IHI website can be used to support ACP conversations with community-residing older adults in the early stages of ADRD. Supporting such conversations is extremely important and could be done at established dementia-specific day centers or memory disorder centers. In a memory disorder center in Southeast Florida, health care professionals were inquiring about ACP with older adults who presented to the center for evaluation of their cognitive status. However, postvisit assessment revealed that many older adults were not engaging in ACP conversations. To improve ACP conversations, the health care providers at the center decided to conduct a quality improvement project with family caregivers of older adults with ADRD before designing a research study aimed at enhancing ACP conversations in community-residing older adults with ADRD.

Project

A nurse practitioner seeking her doctor of nursing practice (DNP) degree conducted a quality improvement (QI) project at a Florida State designated Memory Disorder Center. The QI project was developed using the Conversation Project Starter Kit to increase ACP conversations with family caregivers of older adults with ADRD who had undergone an evaluation of their cognitive status at the center. The purpose of this QI project was to evaluate knowledge, completion of the Conversation Project, and attendance of adult family caregivers of older adults with ADRD at the Louis and Anne Green Memory and Wellness Center in Boca Raton, Florida, not to contribute to generalizable knowledge. Therefore, this study does not fall under the purview of the institutional review board, but rather was reviewed by the DNP committee for ethical issues related to human subjects.

Process

After permission to conduct the project was obtained from the director of the center, a discussion about recruitment strategies and development of the educational intervention about ACP helped guide the next steps.

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Caregivers who utilized the many supportive services at the center were recruited through flyers posted in the center's lobby. Potential participants were informed they could refuse to be involved in the project at any point and still receive services at the center and that any data collected would be deidentified. Participants agreed to attend DNP student-led, one-hour group educational sessions once weekly for a total of six weeks at the center. The educational sessions provided information and content that fostered group discussion and interaction about ACP. The Conversation Kit guided the discussions, as participants were encouraged to ask questions and provide feedback to the ACP process.

Outcomes Measured

Before and after the six sessions, caregiver knowledge of AD RD was measured by the Alzheimer's Disease Knowledge Scale, a valid and reliable 30-item, true/false scale that takes about 10 minutes to complete. Items on the scale include assessment, diagnosis, symptoms, trajectory of AD RD, life impact, caregiving, and treatment and management.¹⁹ Completion of the Conversation Project and attendance were measured before and after the six-week intervention.

Results

Six female caregivers ranging in age from 39 years to 74 years (mean age 62.4) agreed to participate in the project. All participants attended all the sessions. Fifty percent completed the Conversation Kit and reported plans for future conversations with their health care providers. One participant stated she was not ready to have the conversation, and two reported they were contemplating completion of the Conversation Kit. Before vs after the intervention, knowledge increased for all participants. All participants reported appreciation for having this knowledge to support them in the decision-making process about ACP with their loved ones.

Discussion

Although the project was limited by small sample size and a narrow demographic profile of participants, the results contributed to the evidence-based knowledge about possible ways to enhance ACP discussions. The caregivers in this QI project were at different stages of caregiving (this was not measured), with some having more experience than others, which is something to consider in future projects. Some participants (n=3) were more willing than others to complete the Conversation Kit; it would be worthwhile to discover whether caregiver experience played a role. There's evidence that barriers to ACP include lack of knowledge, procrastination, dependence on family, difficulty talking about the subject, and waiting for the health care provider to bring up the topic.²⁰ Participants in this QI project had similar reasons as to why they have not engaged in ACP. The outcomes of this QI project could be useful to support ACP in clinical settings such as primary care practice and dementia-specific centers. The findings from this project provided important information about recruitment of adults for ACP. It's well established that recruitment for studies is one of the biggest challenges researchers face. Although this was a QI project in a center where these caregivers utilized supportive services, there were still difficulties recruiting. Interestingly, caregivers often were busy with

their lives and didn't feel they had the time to come to all the sessions. This should be considered when designing future QI projects or research.

An important finding that addresses the barrier of lack of knowledge was that the participants appreciated the time taken to help them gain knowledge and insight into the importance of ACP in early AD RD. Having knowledge is a prerequisite to behavior change, and when family caregivers think ACP is of value to honor their loved ones' wishes and preferences for care, it's more likely they will promote early ACP in those with AD RD. The education sessions were well attended, and in part this may be due to the interactive aspect of the project. Caregivers were able to share their stories as they discovered possible strategies to support their loved ones. A key facilitator to ACP is the availability of a dedicated professional to educate both patients and families. Best practices recommend that clinicians increase their awareness and ability to utilize evidence-based strategies for ACP interventions.²¹

Conclusion

The results of this QI project are not generalizable but can be used to support future projects focused on improving outcomes such as hospitalization, increasing appropriate use of hospice and palliative care services, and, most important, the development of programs that increase ACP in this vulnerable population. Trying to understand patients' stories by involving caregivers may be an essential aspect of ACP completion. The family caregivers in this project had various reasons for not completing ACP. Any future work should include increased understanding of current fears and other barriers to ACP completion.²²



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— *Mary Brown, DNP, MS, MSN, FNP-BC, has a passion for aging in place for seniors and is a nurse practitioner for Palm Beach PACE providing clinical care for elder adults.*

— *María Ordóñez, DNP, APRN, GNP-BC, PMHNP-BC, FAANP, FAAN, is an associate professor and the director of the Louis and Anne Green Memory and Wellness Center of the Christine E. Lynn College of Nursing; coordinator of the Florida Atlantic University (FAU) Memory Disorder Clinic, part of the State of Florida's Alzheimer's Disease Initiative; and an assistant professor of clinical biomedical science (secondary) at FAU's Charles E. Schmidt College of Medicine.*

List of References can be found at:

<https://www.todaysgeriatricmedicine.com/archive/SO19p30.shtml>



~Submitted by Lorene Austin-Bennett

Fall Conference Resources



Department of Inspections, Appeals, and Licensing

If you have questions...

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Huntington's Disease

GUIDE: *Caregiver Guide for Mid to Late Stage Huntington's Disease: For Long-Term Care Facilities and In-Home Care Agencies*
<https://hdsa.org/healthcare-professionals-resources/resources-for-social-workers/>

BOOK: *Hurry Up and Wait: A Cognitive Care Companion; Huntington's Disease in the Middle and More Advanced Years*, by James Pollard

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Care Planning: NASW Preamble

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's dual focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation, administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence

This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.



PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

For a state to have its Medicaid plan approved by the Centers for Medicare and Medicaid Services (CMS), it must maintain a Preadmission Screening and Resident Review (PASRR) program that complies with the relevant federal laws and regulations.

Everyone who may admit to a Medicaid certified nursing facility (NF), regardless of funding, must be "screened" for evidence of serious mental illness (MI) and/or intellectual disability, developmental disabilities, or related conditions (collectively abbreviated as "ID").

A NF must not admit an applicant who has MI and/or ID unless the appropriate state agency has determined whether:

The individual meets the level of care that a NF provides

Whether individuals who meet NF level of care also need specialized services, rehabilitative services, or community placement supports.

The intent of PASRR is to ensure that all NF applicants are thoroughly evaluated, that they are placed in nursing facilities only when appropriate, diverted when possible, that they receive all necessary services while in a NF, including any supports that might assist them in transitioning to a lower level of care.

There are two levels of the PASRR process: Level I and Level II. The Level I screen is to determine whether an individual might have MI and/or ID, also known as PASRR conditions. If an individual has a positive finding for possible PASRR condition at Level I, the subsequent Level II evaluation will:

Confirm or disconfirm the results of the Level I screen, and

For individuals who have MI or ID, determine where they may be placed - whether in a NF or in the community, and

Identify the services they require to optimize the potential for recovery, facilitate return to lower level of care when consistent with needs and choices, and enhance quality of life.

The information above is from the PASRR Technical Assistance Center: Home | PASRRAssist.

Iowa's PASRR website provides: How to register for an account on the Iowa PASRR system, Announcements, A PASRR Tip of the Month, Provider and Supervisor Tools, and many resources which are available to the public. PASRR related webinars are available on a frequent basis and face-to-face full day training events are offered in multiple Iowa locations annually. Registration links are available for all upcoming free training events on the website, which are posted under "announcements."

For more information, contact:

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Tip of the Month:

Please make sure to complete all Admission, Discharge, and Transfer Notices in Path-Tracker Plus, within 2 days of the date an individual admits or discharges from your facility. Iowa Medicaid Enterprise (IME) has asked that we have a goal that such changes be made within this time frame in order to help make tracking and payments as accurate and speedy as possible.

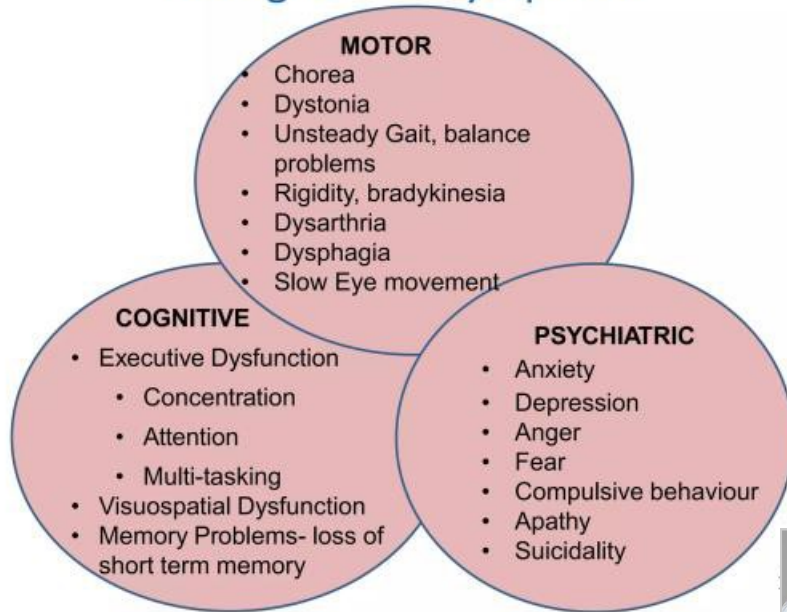


What does HD progression look like? Phases of Huntington’s Disease

	<u>Stage 1 – Early</u>	<u>Stage 2 – Middle</u>	<u>Stage 3 -- Late</u>
Symptoms	Subtle, manageable with meds	Intrusive motor, cognitive, neuro- behavioral	Poorly controlled movement
Location of Care	Home	Home w/assistance	Long term professional care
Disability	Work modifications	Unable to work	Unable to work
Emotional / Cognitive	Depression, elevated suicide risk	Mood changes, irritability, perseveration	Dementia, reduced ability to communicate

Each individual manifests and progresses differently.

HD Signs and Symptoms



From Huntington's Disease Presentation
By Amy Lemke
LTCSWI Fall Conference 2023



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Membership Directory

The LTCSWI Membership Directory for 2023 will soon be emailed to all members. Updates will be sent periodically as new members join during the year. The email address you listed as a preferred email is included. If you have any changes or corrections, please contact me. This directory is a tool for your personal use and is not to be used for solicitation purposes, nor is it to be provided to non-members.

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LTCSWI Fall Conference in Review

The fall conference was held on October 27, at the Gateway Conference Center. Fifty people registered for the conference. Trisha Easton, LISW, Hospice Social Worker for Care Initiatives Hospice, presented on *Care Planning Toward Teamwork*. Christopher Dunn, RN, Long-Term Manager for the DIAL, discussed *Hot Topics in the Department of Inspections, Appeals, & Licensing*. Our conference concluded with a presentation on *Demystifying Huntington's Disease: Tools for Providing Person-Centered Care* by Amy Lemke, PhD, LISW, Clinical Social Worker and Coordinator for the Huntington's Center of Excellence at the Univ. of Iowa Hospitals and Clinics. Nine exhibitors attended the conference. Attendees had the following comments:

- *Lots of good information; Good to humanize DIA- collaboration vs scary organization trying to shut everyone down (DIAL Hot Topics)*
- *Very good; Really made me realize how much more personalized my care plans can be and will be in the future (Care Planning)*
- *Loved this presentation; I had very little knowledge of this disease before today; The compassion Amy has was evident and inspiring (Huntington's Disease)*
- *The most helpful part of the conference was the collaboration at the table with co-social workers*
- *All parts were helpful to me personally as I am in a new position as a social worker*
- *Thank you! Really glad to see neuro-anatomy with HD presentation; Neuro education really important for dementia/aging population*
- *As always, good information, vendors, and chance to see other social workers and visit with them*

