Introduction to GRAT

The Geriatric Regional Assessment Team
grat@soundgenerations.org

Who is GRAT?

- **A team of four clinical social workers (three clinicians and one clinical supervisor) with specialization in geriatric behavioral health.**
- **Employees of Sound Generations, a multi-service non-profit partnering with older adults to provide accessible and inclusive services so they can age their way.**
- **Operating 9:00 AM to 5:00 PM on weekdays (except federally observed holidays) and closed weekends with no on-call or after-hours availability.**

What is GRAT?

- **A strategy of the King County Veterans, Seniors, and Human Services Levy (with additional funding allocated from the MIDD Behavioral Health Sales Tax).**
- **A home-visiting team of behavioral health professionals who provide comprehensive assessments in pre-crisis situations for older adults who live in the community but are not well connected to supports and services that can help them manage declining behavioral health.**
- **Our work emphasizes populations likely to face barriers in access to healthcare and social services.**

Who we serve

- **Adults 55 and older**
- **Living in King County**
- **Experiencing a behavioral health issue in which cognitive, mental health, and/or substance use issues are likely contributing to safety risks and disrupting everyday functioning**
- **Must be able to receive support services at home**
- **Not actively receiving a comparable service or higher level of care**

Why is GRAT?

As we grow older, all of us may face major life and health transitions that impact our cognition, mental health, and substance use. These challenges are often worsened by isolation from support and resources, potentially leading to a crisis and higher use of emergency services.

By providing outreach, assessment, and early intervention, GRAT endeavors to:

- **reduce the likelihood of older adults experiencing acute behavioral health crises and the need for high-cost crisis services;**
- **help older adults remain in their communities and prevent avoidable institutionalization or harm to themselves or others;**
- **promote better health outcomes for older adults in a more sustainable healthcare system that anticipates and prevents emergencies.**

Focus on assessment

- **To help clarify a person's situation:**
  - **what needs are unmet**
  - **what barriers and risks affect well-being**
  - **what strengths and supports exist**
  - **what beliefs and experience are used to make meaning of the situation**
  - **what factors are changeable**
- **To provide a "roadmap" for care so that clients (and their support systems) can navigate current challenges and opportunities to improve their quality of life and services.**

How do we succeed?

- **Collaboration with referral sources to identify key issues, clarify the purpose of assessment, and achieve desired outcomes.**
- **Building rapport with clients and exploring their goals, concerns, and care preferences to develop a plan that they endorse.**
- **Consultation and coordination with relevant service providers.**
- **Drawing on identified supports in family and community.**
- **Enhancing strengths and protective factors that can reduce safety issues.**
- **Following up to ensure continuity of care and a “warm hand-off.”**
- **Overall, cross-agency communication and partnership to address the systemic issues that vulnerable adults face.**

Case example

A 70-something Spanish-speaking woman referred by an ED SW for difficulty following through on treatment recommendations and apparent distress about managing her medications, finances, and basic needs. She reportedly has no natural supports in the area.

One of our clinicians outreached the woman using a tele-interpreter service to complete an assessment. During the interview, the woman focused on her limited income and difficulty affording basic necessities. She discussed her distress with the clinician and participated in cognitive and mood screenings. Together they developed a care plan that included follow up with her health care provider and connecting her to assistance and community support (the woman declined a referral to mental health services).

After consulting with the woman's primary care team, the clinician referred her to a Spanish-speaking Case Manager at Neighborhood House (for assistance with benefits) and a Spanish-speaking Social Worker at a local Senior Center (for meals and culturally-relevant community activities). Once these services were confirmed, the clinician closed the case.

What GRAT is not

We do not provide:

- **emergency or crisis response services**
- **treatment or therapeutic services**
- **case management services**
- **housing services**
- **legal services**

Eligibility Issues

These situations are likely better for another type of response:

- **Actively suicidal or homicidal older adults with a plan and intent to act**
- **Adults who already have existing behavioral health services**
- **Those receiving a higher level of care while residing in an assisted setting (ALF/AFH/SNF) or an inpatient setting (hospital care, psych or detox program)**
- **Those able to effectively self-refer and navigate services independently**
- **Those who are unable to participate in our service due to acuity of symptoms**

Making a referral

Use the professional referral form

https://soundgenerations.org/our-programs/grat/grat-referral-page/

Referral Examples

1. **77-year-old man having difficulty following recommendations of primary care provider and navigating long-term care services possibly due to cognitive issues. Report from referent of unintentional weight loss, limited mobility, social isolation, no natural supports, and history of depression and anxiety.**
2. **81-year-old woman referred by resident services for behavioral issues due to cognitive decline. She is reportedly more forgetful, misplacing items, and distressed, going to building staff for assistance or calling 911 for health issues.**
3. **68-year-old man showing signs of needing assistance with everyday activities due to cognitive issues. He told referent that he can no longer retain information that he reads. Per referent, man has limited mobility, is estranged from family, and has not paid rent for two months.**
4. **70-year-old woman referred by crisis response team for depressive and psychotic symptoms. She has a history of stroke and related TBI. Referent reports that the woman seems to manage basic needs independently but has difficulty following through on services beyond calls to 911 and 988, so evaluation of cognitive functioning needed.**

Additional information

- **There is no charge for GRAT services.**
- **We accept referrals on a rolling basis and follow up with each in the order they are received. We notify referents when we have longer wait times due to a high number of pending referrals.**
- **We follow up with referents for screening purposes, additional information, and updates. When a referral is accepted, we work to contact the relevant parties within 1-5 business days to begin outreach to the referred person.**
- **We work within a short timeline, typically less than two months, and we usually meet a client in-person one time for the assessment interview.**
- **We use language services for interpretation (by telephone and when available in-person) as well as to translate documents to a client's preferred language.**

Contact Information

Main phone number: 206-448-5730

****Please leave a message since we do not answer calls live****

Main e-mail: GRAT@soundgenerations.org

For the general public and resource navigation, please call Pathways Information and Assistance: 206-448-3110

SOUND generations

Questions?

Thank You!