Topic 4: Care Planning Process[1]

Overview

The concept of goals is relevant on at least two levels within interdisciplinary geriatric care teams. Teams are generally organized to achieve specific programmatic goals. Health care teams work with patients, families, and others to achieve patient-specific goals. In order for an interdisciplinary team to function effectively, the team's purpose and goals should be understood clearly and agreed upon by all members. With the increasing cost consciousness in health care, the goals of teamwork and the products of interdisciplinary collaboration are of paramount importance. In managed care, the measurement of outcomes is an important and widely accepted way of demonstrating that adequate care is being provided. Goals established -- whether long or short term -- need to be feasible, because interdisciplinary teams function in a variety of settings (e.g., home care, inpatient), the team membership, types and intensity of services provided, and overall goals will vary. One step toward establishing goals would be to have the team answer the question, "What do we want to achieve with this patient?"

Objectives

- Understand how treatment goals are determined within an interdisciplinary team and identify methods that maximize outcomes.
- Assess functional status in older adults.
- Assess cognitive status in older adults.
- Describe the functional (social, physical, emotional. and intellectual dimensions and interpretations of quality of life.
- Describe the perceptual dimensions and interpretations of quality of life.
- Recognize the importance of value maps and quality of life.
- Describe the relationship between interprofessional communication and quality of life.
- Identify the mechanism to evaluate quality of life utilizing valid and reliable measures.

Interdisciplinary Care Planning

Once programmatic goals are determined, team members next must agree on what they mean in reality. For example, if "improve patient outcome" is a goal used by a team, successful outcome will need to be defined case by case. The process of interdisciplinary team care planning is the means of achieving consensus on desired patient outcomes. One discipline might want to save the patient's life at all costs, while another discipline might want comfort and less aggressive medical care. For example, when a patient shows signs of confusion and an inability to care for herself, a doctor might want the patient hospitalized for her own safety, while a social worker might want to bring social services or health care into the home first. These choices can keep the team in a conflict mode without reaching a decision on the care plan unless the purpose and goals are clear and the patient or a surrogate is meaningfully involved in the decision about care.

[1] Topic 4 is from the University of Minnesota Center on Aging, University of Minnesota GITT, Minneapolis, MN

An interdisciplinary team developing care plans and treatment goals for patients must be able to conceptualize patients broadly, incorporating all relevant information and knowing how different pieces of information relate. The ability of each discipline to add to the overall care plan will depend on each team member's understanding of the linkages between problems. A general treatment outcome goal of optimum health for the patient can be agreed upon easily by team members but the best means of obtaining that goal will be considered differently by the various disciplines represented on the team. You may share your view of possible care plan initiatives and another person may share his or her ideas based on their professional knowledge or previous experience. This exchange will lead the group into areas that might not be considered if it weren't for the team expertise available. If the patient is having problems with fatigue, sleeping, and eating, one professional may believe depression needs to be considered and another team member will bring up overmedication as a possible physical cause. Within a team, these ideas need to be shared for the overall benefit of the patient. Members must communicate these as their own professional opinions and all members need to respect the different kinds of expertise each brings to the group.

For all the great effort put into developing a care plan, the plan cannot work unless the team has a system for documenting it and indicating clearly who will be responsible for what and by when. This documentation should be completed before the end of the meeting and available to all team members to remind them of their responsibilities. In addition, there must be in place a system (formal and informal) for communicating and continuing with the next steps of the care plan between team meetings. This is most often done informally with the different disciplines talking with each other as needed.

Steps in Assessing Patients Needs

Processing a complex clinical case requires students to consider the patient's medical, emotional, social, environmental, and economic needs. Using the grid in Table 3.1 in concert with the questions listed below should allow students to assess the patient's situation from each need aspect (medical, emotional, etc). Students should be able to identify the impact of the problem on the patient's health and quality of life, identify what strengths, community, or family resources could be redirected to address the problem, and identify outcomes or triggers to notify the team that the plan is or is not working. In creating the plan of care, the plan should identify not only what activities are expected but also which member of the team -- specifically -- is responsible for initiation, follow-up, and reporting the results back to the team..

Faculty who watch students process cases as teams, should be sure students are not only concerned about the clinical aspects of the case, but also assess the actual functioning of the team -- the team process. By the end of the exercise, students should be able to develop the plan and set the priorities for the team plan of care (Steps 6 & 7 & Column 4) and be able to evaluate what to look for and when to determine if the plan was effective. The last step reinforces the team's responsibility in ongoing management and evaluation of the care plan as a team.

Considering the patient's medical, emotional, social, environmental and economic needs, answer each of the following questions:

1. What is the overarching goal? At least three perspectives need to be considered and reconciled:

    - patient
    - his/her family
    - team

2. What are the patient's problems? (Again, consider them under a wide range of possible headings -- medical, emotional, social, environmental and economic).

3. What is the impact of each problem on the patient's health and quality of life?

4. What strengths and resources does the patient have or can be mobilized to deal with each problem?

5. What additional information is needed to adequately define the problem or its implications?

6. What is the plan of care? (What needs to be done; who will do it; when will it happen)?

7. What priority should be assigned to each problem (in either a linear order or categories of importance)? How important is its effect on the overarching problem? What other factors might influence its relative priority?

8. What outcomes should be expected for each problem? These should be expressed in measurable terms. When is the appropriate time to look for the outcomes?

Overarching Goals

The following grid can be useful to diagram the results of the answers for questions 1-8.

Table 3.1[1]

Patient's:____

Family's:____

Team's:____

Problem	Impact Health & Quality of Life	Strengths/Resources	Plan [What/Who/When] (Includes getting more info)	Expected Outcome (What to look for, When)
1.				
2.				
3.				
4.				
5.				
6.				

Functional Decline [2]

The incidence of chronic conditions increases with age (e.g., arthritis, hypertension, heart disease, hearing impairment, orthopedic impairment, and cataracts). Persons over 65 years of age use approximately one-third of available physician resources, one-fourth of total medications prescribed, and constitute more than two-fifths of acute hospital admissions. In 1990, there were an estimated 7 million older adults in the U.S. over 80; Census Bureau projections estimate there will be 14 million persons over age 80 in the year 2025. By the year 2020, of the 52 million persons over the age of 65, there are projected to be 5.4 million with severe disabilities and another 5.3 million with moderate disabilities, or a combined total of 22%t of the older population. Functional decline as measured in Activities of Daily Living and Instrumental Activities of Daily Living is more prevalent with age; 20% of older persons over 65 years require assistance with ADLs while 45% of older persons over 85 years require assistance with ADLs.

[2] Greenberg, S. (1999). Functional assessment (pp.4.3-4.4). In C. Mariano, E. Gould, M. Mezey, & T. Fulmer (Eds.), Best nursing practices in care for older adults. New York: John A Hartford Foundation, Inc.

Conditions that may impact negatively on functional status in an older adult include:

Acute illness
Chronic illness
Delirium
Dementia
Psychiatric comorbidities, especially depression
Medications
Alterations in nutrition and/or hydration
Psychological/social stressors
Economics
Environment

What is Functional Assessment?[2]

Functional assessment is a comprehensive evaluation of physical and cognitive abilities required for maintaining independence. Assessment tools provide objective measures of physical health, activities of daily living (ADLs), instrumental activities of daily living (IADLs), psychological, and social function.

Activities of Daily Living (ADLs) are the basic daily activities of personal care. Specifically, ADLs are bathing, dressing, toileting, continence, transfer/mobility, grooming, feeding, and communicating.

Instrumental Activities of Daily Living (IADLs) are the basic daily activities needed to live independently in the community, e.g., shopping, cooking, using the telephone, doing laundry, housekeeping, managing medications, managing finances, maintaining home and lawn, performing duties of employment or volunteer work, and traveling (driving or using public/private transportation systems).

Psychological Function is assessed by measuring cognitive, mental, and affective function independently.

Social Functioning measures social interactions and resources, subjective well-being and coping, and person-environment fit.

Instruments Used to Assess Function

A variety of tools are available to assess function. Generally, these tools provide objective measures to assess function. Some tools may act more as a monitor to remind clinicians of key aspects of geriatric assessment. These acronyms can be used in concert with validated measures of physical, psychological, and social functioning.

1. Lawton ADL

Measures ability to perform tasks of basic personal care including:

- Eating

- Ambulating
- Transferring
- Dressing
- Bathing
- Toileting
- Continence

2. Lawton IADL

Measures abilities associated with living independently in the community including:

- Cooking
- Cleaning
- Laundry
- Shopping
- Using the telephone
- Transportation
- Managing finances

3. PULSES Profile

Measures general functional performance in mobility and self-care, medical status, and psychosocial factors. The acronym is useful and easy to remember.

P = physical condition
U = upper limb function
L = lower limb function
S = sensory components
E = excretory functions
S = support factors

4. SPICES

An overall assessment tool

S = sleep disorders
P = problems with eating and feeding
I = incontinence
C =confusion
E = evidence of falls
S = skin breakdown

Cognitive Status Assessment[3]

In addition to having an understanding of an elder's functional capacity, it is also important to have background knowledge about the cognitive status of an older adult. Cognitive impairment and psychiatric symptoms are relatively common in the elderly, with an estimated 4-5 million

[3] Matthews, M. (1999). Cognitive/mental assessment (pp. 5.2-5.7). In C. Mariano, E. Gould, M. Mezey, & T. Fulmer, (Eds.), Best nursing practices in care for older adults. New York: John A Hartford Foundation, Inc.

older adults experiencing cognitive disorders. Of community residing elderly, 5% aged 65 to 75 and 25-30% aged 85 or older have evidence of dementia, most commonly Alzheimer's disease. Sixty percent of nursing home residents have dementia.

Depression is the most common psychiatric disorder of older adults, with 8-15% in the community and 30% of institutionalized older adults experiencing significant depressive symptoms.

Quantified versions of mental status examination can be used to screen for cognitive and emotional disorders in older persons across settings. Mental status tools (cognitive and mood) aid in screening but do not provide a diagnosis.
Quantified measures of cognition provide systematic, standardized assessment, and can be used to monitor older adults with cognitive impairments over time.

Components of Mental Status Assessment

Mental status assessments are designed to elicit cognitive abilities and deficits, emotional functioning, and basic intellectual functioning.

Components of mental status assessment include:

- Level of consciousness (alert, lethargic, coma).
- Physical appearance (clothing, grooming).
- Orientation to person, place, time.
- Speech and language.
- Emotional status.
- Memory -- ability to recall recent experiences.
- Attention and concentration -- ability to focus selectively on stimuli in the
- environment.
- Intelligence -- ability to respond to unknown situations.
- Judgment-- ability to compare or evaluate alternatives.
- Insight -- ability to see and understand connections between objects and situations.
- Construction – ability to accurately reproduce simple objects.
- Comprehension.
- General information -- measure a person's contact with their environment.
- Perceptual disturbances (delusions / hallucinations).

Instruments for Assessing Mental Status[3]

A variety of tools are available to assess mental status. They examine different aspects including presence of organic disease, changes in mental status, areas of cognitive disability and depression.

Mini-Mental-Status-Examination (MMSE)

Purpose of MMSE: To assess presence of organic disease and changes in mental state, and to identify areas of cognitive disability.

Scores may indicate: 24-30 = no cognitive impairment

18-23 = mild cognitive impairment
0-17 = severe cognitive impairment

People who score below 23 should be referred for follow-up.

Strengths of MMSE:

- MMSE is a valid, reliable screen for delirium and dementia requiring 5-10 minutes to administer.
- Can be administered by clinicians or lay persons with very little training.
- Assesses orientation, registration, attention and calculation, recall, language, reading and obeying a simple command, and visual construction.

Limitations of MMSE:

- Performance on the MMSE may be influenced by educational level.
- Older persons may score lower due to advanced age.
- Areas of cognitive functioning are not assessed: judgment, insight, and remote memory.
- Cannot be used in persons with severe sensory deficits or poor verbal ability.
- Valuable for screening cognitive deficits but does not provide a diagnosis.
- Does not assess mood or perceptual disturbances.

Geriatric Depression Scale (GDS)

Purpose of the GDS: To screen for depression in older adults. People with scores of 5 and above should be referred for follow-up (scores: 0 – no depression; 30 – very depressed).

Strengths of the GDS:

- Self-rated tool that permits the client to answer absent or present, thereby overcoming need for client to make subtle discriminations in answering.
- Can be completed by client, no training required (self-rated scales generally thought to be very effective in screening minor depression).
- Short version (15 item) available for use (rather than full 30-item scale).
- GDS can be used in screening the physically healthy as well as physically ill and cognitively impaired (MMSE > 15).

Limitations of the GDS:

- Cannot be used if client cannot self-report (limited in persons with severe depression and/or psychosis).
- In the presence of cognitive impairment (MMSE < 15), reliability of scale is questionable.
- GDS not able to differentiate between clinical diagnostic categories.
- GDS is not as sensitive to changes in symptomatology over time as observer-rated scales.

Cornell Depression Scale (CDS)

Purpose of the CDS: To screen for depression in older adults with dementia. People who score 12 or above should be referred for follow-up (scores: 0 – no depression; 12 – probable depression; 19 – severe depression).

Strength of the CDS:

- Able to assess for dementia in clients with advanced dementia (MMSE < 15).

Limitations of the CDS:

- Requires clinicians to rate items.
- Takes slightly longer time to rate than GDS.

Quality of Life Evaluation

Interdisciplinary collaboration, for the purpose of developing an interdisciplinary care plan for a frail older adult, rarely takes place without a discussion of quality of life(QOL). The complexity of this concept, confounded by values, culture and professional socialization, contributes to an array of definitions and personal understanding of quality of life. Therefore, it is essential that individual team members have an understanding of quality of life and how values and culture influence the interpretation of this complex concept.

Quality of Life -- Dimensions of Meaning

Functional Dimensions (Social, Physical, Emotional, and Intellectual)

The term quality of life (QOL) often is used interchangeably with other complex concepts such as health status and functional status. However, due to the subjective component of this concept, care must be taken not to assume we understand the path each person will choose to reach his or her own goal toward QOL. There are both benefits and pitfalls in equating functional independence with QOL. Using functional terms to describe QOL enables initial dialogue and contributes to increasing the awareness that QOL discussions are essential components of geriatric care. However, it is important to recognize that the concept of QOL goes beyond discussions of function. Therefore, exclusive use of functional concepts to define QOL is limiting and can add to the surrounding this complex concept.

In attempting to define QOL, researchers have linked personal control or autonomy to the concept of successful aging and to positive health outcomes. Currently, traditional individualistic conceptions of autonomy are being questioned. No longer can we exclusively explore the simplistic dichotomy between independence and dependence. Rather, we need to further examine concepts such as “autonomy within community” as a more appropriate expression of the complex concept of autonomy and function.

Disability, aging, and their relationship with QOL are discussed repeatedly in the context of interdisciplinary team care. Inappropriately, diminished function and chronic disease have been used interchangeably with “successful” and “unsuccessful” aging and discussions on QOL. Care must be taken not to rely on terms such as “successful aging,” as this may reinforce the prejudice against older adults with disabilities.

Perceptual Dimensions (Life Satisfaction and Health Status)

The term “health-related quality of life” (HRQL) is seen throughout the literature. This concept has enabled health care providers to move beyond a physiological focus of health and consider terms such as income, freedom, and quality of the environment,

when discussing QOL. HRQL is an essential component of geriatric care, as it measures the impact of chronic disease. Although health professionals often utilize objective measures such as vital signs, laboratory data, and financial resources to develop a plan of care, these measures can be limiting and may have little or no impact upon well being. It is also observed that patients may have similar clinical criteria but have dramatically distinct responses.

Personal Value Maps

Major differences exist between the value maps of individuals, families, and professionals. Values of care, including physical health, interpersonal relationships, and psychological well-being, are identified by professionals to be of greatest importance. Frail elderly identify the following values of care as paramount: environmental factors, self-identity, and interpersonal relationships. Families and friends report that the three major areas of value are: care, security, and psychological well-being. This disparity leads to the recognition that communication among individuals who are responsible for the development of plans of care is essential.

Quality of Life Perceptions and Team Communication

The philosophical basis for open communication, in the long-term care decision-making context, has been developed by Moody,[4] in his concept of the communicative ethic. The emphasis is placed on the three Cs (communication, clarification, and consensus-building) in negotiating the shifting waves of client autonomy and professional paternalism in long-term care decision-making for the frail elderly. Therefore, when dealing with difficult QOL issues, it is essential that professionals examine the concepts, assumptions, and values underlying their various approaches to defining the clinical problem and the resulting solution.

Quality of Life and Professional Socialization

The success of interprofessional collaboration is dependent upon effective communication, mutual trust and respect, and the recognition of varying roles. One factor that may influence the ability of health care professionals to collaborate is the culture or professional socialization of each discipline. The way in which differing professions assess, treat, and evaluate geriatric patients is influenced by the professional lens they see through to provide care. The development of professional socialization is a process that is influenced by the identity and norms of each specific discipline. Patterns of practice influenced by discipline-specific values, attitudes, and role identity, contribute to the way in which patient care is provided. A better understanding of the nature of professional socialization and geriatric care planning will provide greater insight into the dynamics of geriatric interdisciplinary team care.

Qualls and Czirr[5] suggest that professionals differ in their logic of geriatric clinical assessment, particularly in defining the problem. Differing styles of practice are characterized by two distinct approaches, one emphasizing ruling out problems by systematically eliminating possibilities until one problem and a matching solution are discovered. The other approach of ruling in problems depends upon expanding the range of professional view to encompass an increasingly long list of potential factors.

[4] Moody, H. (1988). From informed consent to negotiated consent. Gerontologist, 28, suppl: 64-70.

[5] Qualls, S., & Czirr, R. (1988). Geriatric health care teams: classifying models of professional and team functioning. The Gerontologist, 28, 372-376.

Medicine

Physicians are trained in diagnostic techniques that narrow down the range of options, relying heavily on objective data such as laboratory tests in the process. Geriatricians are embracing new models of care as we begin to move away from the traditional problem-based model of care and move toward a goal-oriented approach to geriatric care. The traditional model focusing on acute medical problems loses relevance when dealing with chronic, disabling conditions experienced by older adults. The more recent models of care focus not only on how the problem is described, but also on who controls how the problem is defined and, subsequently, treated. This new goal-oriented approach includes the following assumptions:

- Ultimately, each individual must define health. That definition may be different for different persons and for the same person at different times.
- An individual's health goals can be determined best through a dialogue involving the individual and his or her health care provider(s), each using the special information they bring to the caring relationship.
- The development of health goals requires assessing the individual's strengths and resources, interests, needs, and personal values – in addition to determining obstacles and challenges.
- Final decisions about health goal priorities and the amount of effort expended in their achievement, must reside with the individual. Health professionals must decide whether their involvement will be beneficial and how they can participate.
- Success for both the individual and the health professionals is measured by the extent to which the individual's health goals are achieved.

This new model of medical care enhances communication, as this approach focuses on a collaborative effort between the care provider and the older adult.

Social Work

Social workers are taught to go beyond the narrow, presenting problem to encompass larger psychosocial issues, such as income, family relationships, and the environment. They tend to rely on subjective data collected by interviews that are heavily interpreted by clinical judgment and experience.

Although social workers have traditionally emphasized the rights of their clients to self-determination and have enabled older adults to develop their own skills, a renewed theme in social work has underscored the central importance of client self-determination and empowerment in social work practice.

Nursing

Nurses, depending on their background, training, and experience, may fall somewhere between these two extremes. While traditional models of nursing vary in their emphasis and assumptions, those with ties to biomedical models emphasize a problem-based structure. Although many of these theories focus on functional abilities, problems and deficits, a compartmentalization of care is observed, with the subsequent creation of nursing sub-

specialists who deal exclusively with distinct components of the whole. More recent models of holistic care, emphasizing the unity of an individual receiving care, emphasize quality of life as perceived by the individual and his or her own family.

An emphasis is placed on the values and life goals of the older adult participating in their own care. Nurses on the interprofessional teams are challenged to advocate for the values and goals of the patient. As Mitchell[6] states:

"The values of traditional nursing direct nurses to focus on assessment, prediction, and control of problems. This approach is enacted with the misguided belief that reverence for the person and ethical decision-making can then be "added on." But ethics is not a separate way of knowing. All knowledge is already rooted in an ethic, and practice related to that knowledge reflects the ethic."[7]

Such differences in delimiting the domain of inquiry in clinical practice have major implications for communication over such conceptually slippery concepts as quality of life.

Measuring Quality of Life

Two basic approaches to QOL measurement are utilized in the literature. Specific measures exist that measure QOL itself, such as instruments that focus on HRQL. Another mechanism used to evaluate QOL is through the use of specific instruments that focus on problems associated with single disease states, patient groups, or areas of function. Both these approaches are not mutually exclusive and each approach has its strengths and weaknesses, depending upon the circumstances and the purpose of measuring the concept. Researchers interested in different instruments for QOL assessment should access the "Researcher's Guide to the Choice of Instruments for Quality of Life Assessment in Medicine" from the Division of Psychology at the Istituto Nazionale Tumori in Milan, Italy. The guide is available on the World Wide Web at: http://www.qlmed.org.

[6] Mitchell, G. (1992). Parse's theory and the multidisciplinary team: clarifying scientific values. Nursing Science Quarterly, 5(3):104-106.
[7] Mitchell, G. (1992). P.105.

Exercises

1. Minnesota GITT Complex Case Studies[8]

These case studies provide further opportunity for students to practice operating in teams. The goal of the case discussions is to encourage the team members to seek a higher level of problem identification, which draws on the collective insights from the four disciplines represented. From the experiences, each student teaches the others about what his/her discipline can offer about the particular case.

Facilitator's Notes

1. *Students should be assigned to teams before beginning to work on the case studies.*
2. *As the teams begin to work on the cases, provide them with these questions to structure their investigation.*

   a. *What is the overarching goal?*
   b. *What are the patient's problems?*
   c. *What is the impact of each problem on the patient's health and quality of life?*
   d. *What strengths and resources does the patient have for addressing each problem?*
   e. *What additional information is needed?*
   f. *What is the plan of care?*
   g. *What are the expected outcomes?*

3. *Included with each case are case-specific Facilitator's Notes.*
4. *Assign each team an observer who can record the conflicts that arise during the work on each case. These records will serve as a bridge to the following topic, Conflict Management.*

2. Minnesota GITT Glossary of Social Work Terms and Glossary of Medical Terms[9]

These lists (both alphabetical and separated by case) identify key terms that students should understand across disciplines to enable full discussion. The terms were created by the Minnesota GITT so some terms may only apply in Minnesota. Faculty can, however, use the lists to identify similar terms that will apply in their states.

[8] Feldt, K., Smith, S., Luptak, M., & et al. (1997). Case studies 1-9. In R. Kane, University of Minnesota GITT: complex case studies. Minneapolis, MN: University of Minnesota GITT.

O'Connell, M.E., Reinardy, J., Feldt, K., & et al. (1997). Case study 10. In R. Kane, University of Minnesota GITT: complex case studies. Minneapolis, MN: University of Minnesota GITT.

[9] Smith, S., Kane, R.L., Feldt, K., & et al. (1997). Medical glossary. In R. Kane, University of Minnesota GITT: complex case studies. Minneapolis, MN: University of Minnesota GITT.

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Patrick, D., Kinne, S., Engelberg, R., & Pearlman, R. (2000). Functional status and perceived quality of life in adults with and without chronic conditions. Journal of Clinical Epidemiology, 53(8), 779-785.

Pearlman, R., & Uhlman, R., (1988). Quality of life in chronic diseases: perceptions of elderly patients. Journal of Gerontology: Medical Sciences, 43, M25-M30.

Qualls, S., & Czirr, R. (1988). Geriatric health care teams: classifying models of professional and team functioning. The Gerontologist, 28, 372-376.

Researcher's guide to the choice of instruments for quality of life assessment in medicine (www.qlmed.org).

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GITT Exercises: Topic 4

Minnesota Geriatric Interdisciplinary Team Training Complex Cases

Complex Case #1:	Mrs. Emma Cook[10]
Complex Case #2:	Miss Bertha Larson
Complex Case #3:	Mr. Jim Rich
Complex Case #4:	Mrs. Rose Carmine[10]
Complex Case #5:	Mrs. Gertie Treat
Complex Case #6:	Ms. Clara Germaine
Complex Case #7:	Mr. Roger Anderson
Complex Case #8:	Mrs. Josie Wells
Complex Case #9:	Mrs. Betsy Jones
Complex Case #10:	Mrs. Lin Trang[11]
Complex Case #11:	Ms. Tonita Brown

[10] Feldt, K., Smith, S., Luptak, M., & et al. (1997). Case studies 1-9. In R. Kane, University of Minnesota GITT: complex case studies. Minneapolis, MN: University of Minnesota GITT.

[11] O'Connell, M.E., Reinardy, J., Feldt, K., & et al. (1997). Case study 10. In R. Kane, University of Minnesota GITT: complex case studies. Minneapolis, MN: University of Minnesota GITT.

Complex Case #1: Mrs. Emma Cook[10]

Mrs. Emma Cook is an 89-year-old woman who is new to the senior health clinic. The initial screening questionnaire and home interview made by the team social worker identified her as widowed for 15 years and living alone in a two-story home in a neighborhood that has become less desirable over the years. The house is paid for but is somewhat run down and in need of some basic repairs. Inside, the house was clean but cluttered. There were old insulin syringes lying about the house. In fact, the social worker almost sat on one during the home evaluation. Mrs. Cook gave conflicting messages in regards to how she was taking her medications. Mrs. Cook's report of the medications was as follows:

- Cardizem dosage four times a day
- A little orange pill for my heart, a full tablet one day and a half tablet the next
- Lanoxin one a day
- Lasix one tablet in the morning
- Novolin 70/30 26 units in the morning and 20 units in the evening

At this point, the social worker asked to see the pill bottles and discovered the following:

- Cardizem 60mg by mouth or orally four times daily
- Lasix 20 mg by mouth or orally qd
- Zantac 150 mg by mouth or orally qhs
- Novolin Insulin 70/30 26 units in the am and 20 units in the pm
- Lanoxin 0.125 mg by mouth or orally qd
- Coumadin 2.5 mg alt. With 5.0 mg qod
- Centrum Silver one a day

Mrs. Cook seemed very indecisive. She has thought that she may be better off in an assisted living facility but every time arrangements are made to look at sites, she either has an excuse not to go or states she "is not ready yet." She has few hobbies, but does like to read, although that is becoming difficult with her failing eyesight. She never worked outside of the home. She finished high school and was married shortly thereafter. She was unable to have children, which still makes her sad. She used to volunteer at a local hospital. She is Catholic but has not attended services in some time.

She has no close friends in town. Her only family are some nieces and nephews who live out of state. It turns out that Mrs. Cook owns a large piece of property located near to the State University and plans to leave the land to the university. She is very afraid to tell this to the relatives, as they believe that they are going to inherit the land, which is worth a great deal of money. She believes they maintain what little contact they do just so that she will leave them the property.

Although she has a fair amount of money in assets, they provide no cash flow or cash on hand. The university offered to support her until her death in exchange for the land but she has refused to accept this offer. Thus, she is trying to get by on her social security income ($650) which she states, at times, just barely meets her needs.

On the GDS screen at home, Mrs. Cook scored 6/30.

On the MMSE screen at home, she scored 24/30.

Mrs. Cook denied any difficulty with dressing, ambulation, feeding, or incontinence. Although she reported no difficulty preparing meals, it was noted that there was little food in the refrigerator. Mrs. Cook reported that she took care of all her bills herself. She does not drive any longer because of failing eyesight and walks to the local corner store to get her groceries.

Her medical evaluation found her to be a pleasant elderly woman who was somewhat obese. She would get out of breath quickly with exertion. She had some difficulty rising from a chair and her gait was somewhat unsteady. She had poor vision as demonstrated by difficulty reading newsprint. She had poor hearing on gross exam. Pulmonary exam revealed fine rales at the bases. Cardiovascular exam revealed an irregular heart rate, and a 3/6 systolic ejection murmur best heard at the right upper sternal border. Some mild jugulovenous distension was present as well as hepatojugular reflux. Abdominal exam revealed bowel sounds throughout, no palpable masses, and a liver that was 13cm in span in the right midclavicular line, non-tender. External genitalia were remarkable for some atrophy. Examination of her extremities revealed pitting edema approximately half the way up both shins. No skin breakdown but some redness was apparent on both sides. The skin over the feet was very dry with a moderate amount of moist, desiccated skin in the toe webs.

<u>MMSE</u>: 26/30; she seemed to the team to have some cognitive impairment but it could not be well defined.

<u>Labs</u>: HbgA1C: 11% (suggest mean blood glucose of 280-300).

TASK: It is now team rounds and time to develop a plan of care for Mrs. Cook

Faculty Information Only: Mrs. Emma Cook

TEACHING POINTS:

The case is useful in demonstrating how essential a team approach is to the management of a complicated geriatric patient. Each team member should have something to offer to this particular case. The case should be useful for the following:

- promote comprehension of roles, responsibilities, and skills of each of the disciplines involved.
- generate an understanding of the overlapping functions of the disciplines.

1. What is the overarching goal?

The team will need to work to earn the client's trust and establish the goals of the client. It will be important to explore how the client wants to address the problems, to identify past coping skills, and reinforce strengths/positive steps already taken.

2. Patient's problems: See Plan of Care Attachment.

The major concerns (BTIs) are as follows: tenuous home situation; visual and hearing impairment; potential cognitive impairment.

3. What is the impact of each problem on the patient's health and quality of life?

Each problem (listed above) will make it more difficult for Mrs. Cook to live independently. Examined independently, none of the problems seems insurmountable. However, when one considers the impact of all the problems taken together, it appears that her ability to live independently is very much in question.

4. What strengths and resources does the patient have for addressing each problem?

Large financial assets; has lived independently in her own home to date; extended family may be a resource.

5. What additional information is needed?

- home environmental assessment.
- in-home functional assessment.
- needs thorough psychosocial assessment that should include:
  - ♦ further testing of cognitive function, perhaps neuropsychiatric testing
  - ♦ identification of patient's personal strengths/ resources, previous ways of coping, motivation.
  - ♦ identification of other family and community resources (extended family, neighbors, friends, church members, formal resources, etc). If someone can be found to administer medications and insulin appropriately, make sure that nutritious food is in the home, and assure patient safety, she may be able to continue independent living.

6. Plan of care: See Plan of Care Attachment.

7. Expected outcomes:

Maintain patient in living situation of choice, provided that the team is comfortable with safety of patient.

- Better control of medical problems:
  - diabetes
  - congestive heart failure
- Decrease functional impact of visual and hearing impairment.

Plan of Care Attachment -- Complex Case #1: Mrs. Emma Cook

Problems	Suggestions/Interventions
Tenuous home situation	• inform client of resources available, make recommendations, and refer as needed (i.e., Lifeline, Home Health and/or community outreach worker for more frequent monitoring, Senior Companion, MOW, Senior Center, transportation, alternate housing if need to relocate, financial planning/money management, possible APS referral) • provide patient education re: disposal of needles • home safety assessment
Potential cognitive impairment	• entire team continue to be aware of and watch for functional impairment • consider further cognitive testing (i.e., neuropsychiatric or Allen testing) • involve informal and/or formal caregivers, have client/family meeting to inform of diagnosis and resources, make recommendations, and refer as needed (i.e., Alzheimers's Association, education and support groups, services in the home and/or alternate living options, long range planning (financial and health care) • provide supportive counseling (client and family)
Visual impairment	• refer to vision loss resources (i.e., Society for the Blind, adaptive equipment, support groups) • refer for routine eye exam • provide supportive counseling to address feelings about significant losses, monitor for depressive symptoms
Hearing impairment	• refer to community resources for hearing loss • examine ears for wax and other problems • consider audiology evaluation
AODM -- poorly controlled	• help patient to understand disease and how to monitor serum glucose, also help patient to administer insulin correctly and safely • review diet, and meal planning • monitor serum glucose and change medication as needed to achieve better control
CHF	• adjust medications to achieve better control of heart failure. • consider an ECHO to help with management
Atrial fibrillation	• monitor use of medications • is patient a candidate for cardioversion • is this patient a safe candidate for anticoagulation with Coumadin; if so, will need to monitor INR closely
Dyspnea on exertion related to CHF and/or deconditioning	• discuss activities, exercise, and limits
Valvular heart disease:possible aortic stenosis	• consider an ECHO
Peripheral edema	• discuss skin and foot care with patient; reinforce information about disease, medications, activities
Vaginal atrophy	• discuss aging and sexuality relationship to mild depression, sadness about not having children • consider treatment if symptomatic
Poor understanding of medications	• provide education regarding any medication changes • devise system for medications (self) administration • review medications with patient and suggest ways to improve compliance with dosing schedules
Assisted living	• explore what she knows, her fears, expectations, relationship to depression, social situation

Complex Case #2: Miss Bertha Larson

Miss Bertha Larson is an 89-year-old nursing home resident, who was noted to be increasingly lethargic 3 months ago. She was referred to the hospital for evaluation by her physician and was found to have a subdural hematoma. This was drained surgically and the patient was transferred back to the nursing home on day 3 following the procedure. It was noted in the hospital that she was still too lethargic to eat and, thus, she returned to the nursing home with a nasogastric feeding tube in place. It has been asked that she be taken on as a new patient.

Prior to going into the hospital, Miss Larson was pleasantly demented and living in the dementia ward at the nursing home. She was oriented only to person and knew her family. She was able to feed herself but needed assistance with all other activities of daily living (e.g., bathing, dressing, and toileting). On readmission to the nursing home, the staff found Miss Larson to be lethargic and difficult to arouse. She was not oriented to person, place, or time, nor did she respond appropriately to any of their questions. Two days later, the physician was called because the nasogastric feeding tube had become occluded. While the tube was being replaced, Miss Larson fought and resisted. At one point, she was apneic for several minutes. In the end, the physician managed to get the tube, down but not easily. Three days later, the tube again becomes occluded. The staff was concerned because they remember the difficulty with the tube placement the last time. Also, they had learned that the patient has a living will that specifically states she does not want to be “kept alive with tubes,” which they presume includes tube feedings.

The patient has a niece who is her health care power of attorney. The niece, a former LPN, understands that a “feeding tube can be placed in the stomach” and wishes to give this type of “feeding tube” a trial, since her “favorite aunt might recover” from this episode. However, no specific endpoint of the trial is stated.

Past Medical History:

- Dementia x 4 years
- Hypertension, diet controlled, No medications
- Osteoporosis

Allergies:

- Sulfa

Medications:

- Oscal 500 mg bid
- Tylenol ES ii tabs by mouth or orally 3 times daily as needed
- Jevity tube feeding 60 cc/hr continuous with bolus of 100 cc free water after meds.

Social History:
Miss Larson worked as an elementary school teacher for many years and retired at the age of 65. She has one living brother whose daughter lives within 20 miles. Miss Larson shared a home with another school teacher for the past 50 years. This close friend, Angel Hansen, is 85 and still living in their shared home. Several years ago, when Miss Larson was becoming more

forgetful, she assigned her niece durable power of attorney for health care because her niece had a health-related background and “would understand these kinds of things.” The niece is now 68 and visits the nursing home weekly. Miss Larson’s friend comes to the home daily.

Activities of Daily Living:
Currently dependent in all cares due to her cognitive status and lethargy.

Advanced Directives:
Has assigned a durable power of attorney for health care and had indicated on her living will that she did not want to be “kept alive with tubes.” Has DNR/DNI status written on her chart.

Physical Examination:

Weight: 110 lbs Height: 5' 4" BP: 122/64 Pulse: 98 Temp: 99.2
Gen: Frail white female in no apparent distress, opens eyes in response to questions but does not provide any verbal response.
HEENT: Poor cooperation with exam. PERLA. Appears to track examiner.
Chest: Diminished breath sounds at R base, otherwise clear to auscultation.
Cardiac: RRR with soft I/VI SEM at right sternal border.
Abdomen: Soft, non-tender, + bowel sounds, no masses
Extremities/Skin: No LE edema. Has 1.5 cm area of redness, posterior heels bilaterally. Has small < 1 cm open area over lower sacrum with redness of surrounding tissue to 2 cm in diameter. No exudate. No swelling of surrounding tissue.
Neuro: Unable to follow commands: cranial nerves grossly intact, no facial asymmetry, moves all extremities in effort to push away examiner. No verbal responses to questioning but calls out periodically for “Angel.”

MMSE: 0/30

Labs: Na^+ 147, K^+ 4.1, BUN 22, Creat 1.1, Hgb 11.8

TASK: You are attending the care plan meeting and it is the job of this group to decide how to proceed with care for Miss Larson.

Faculty Information Only: Miss Bertha Larson

TEACHING POINTS:

1. What is the overarching goal?

Patient: Since the patient is unable to state her goals, statements in living will should be examined. Team should also recognize that this patient may have made statements to her companion of 50 years that would help to clarify what her wishes might be.

Niece: Goal appears to be to try to return her aunt to her former condition.

Team: Evaluate quality of life and provide information and guidance to the assigned proxy to assist in decision making that best reflects patient wishes. Provide for patient comfort.

2. Patient's problems: See Plan of Care Attachment.

Big ticket items: Team must be careful not to bulldoze the niece with their own wishes. Student statements should reflect a need to clarify patient wishes. (Example, "If your aunt was able to see herself right now, what might she say about this situation. . ." is a better approach than "If it was me I wouldn't want to live that way," which reflects student feelings and does not reflect sensitivity to patient's wishes).

Faculty should know that a gastrostomy tube is a permanent feeding tube that requires a simple surgical procedure. Once placed, it can be used for a fairly long time without replacement.

Other big ticket items important to care: identification of comfort needs, skin care, pain control (if needed), and referral to hospice (if no tube feeding is decided) for support of niece and companion.

3. What is the impact of each problem on the patient's health and quality of life?

Regardless of the decision whether to tube feed, students should recognize maintaining comfort is key to quality of life. Students should also recognize the ethical conflict in this situation and focus on the patient's best interest not on their own personal values. Students should recognize the uncertainty of the prognosis in this situation and that they may not be able to provide clear and certain answers to the niece's questions.

Students should recognize that if the permanent feeding tube is placed, risk of aspiration is still a concern. Tube feedings often cause diarrhea, which places the patient at further risk for skin breakdown. They should know that after a surgical placement of a permanent feeding tube, if there is no improvement in the patient's condition, the trial of feeding could be stopped. However, decisions regarding withholding food and fluids are often more difficult for family members when a permanent feeding tube is in place. The patient is approximately 1 1/2 weeks post-surgery and may show some improvement over the next few weeks.

4. What strengths and resources does the patient have for addressing each problem?

Although the patient is severely impaired at this point, the situation presents with several strengths. The patient does have a living will and a companion who has lived with her for most of her life. These resources may provide some insight that will help with the decision-making process. The patient is also returning to a nursing home where staff members are familiar with her behavior prior to the subdural hematoma. This familiarity may enhance their sensitivity to behaviors reflecting discomfort.

5. What additional information is needed?

Since decision-making capacity is impaired, the team members should recognize the need to further explore the patient's previously stated wish regarding end-of-life care.
Medical perspective may be helpful in terms of likelihood of patient returning to previous status. It would be helpful to explore the companion's knowledge of the patient's wishes and to explore if there are any other important persons (relatives, religious connections) who might provide insight into the patient's wishes. The niece's feelings about her aunt's condition should be clarified. The patient should have an assessment for pain or discomfort.

6. Plan of care: See Plan of Care Attachment.

7. Expected outcomes:

Patient will be comfortable with attention to either returning back to baseline status or providing for a comfortable death.

Plan of Care Attachment -- Complex Case #2: Miss Bertha Larson

Problems	Suggestions/Interventions
Dementia/cognitive impairment secondary to subdural hematoma	• passive range of motion for extremities • avoid restraints • assessment and monitoring of bowelstatus and skin condition • periodic assessment for discomfort
Dysphagiasecondary to above/altered nutritional status	• if tube placed, monitor for gastric distention, diarrhea, constipation • check for bowel sounds, lung sounds; possible aspiration • flush tube after medications· provide good oral care • keep head of bed elevated 30-45° at all times • check for gastric residual, stop feeding if residual is greater than 150 cc
Decubitus ulcers/potential for skin breakdown	• low-pressure mattress for bed • heel cradles -turn/reposition q 2 hrs. -duoderm dressing to sacral wound -treat for discomfort as above
Osteoarthritis	• continue routine Tylenol • repositioning and range of motion as above
Hypertension	• continue routine monitoring, no meds indicated at this time
End-of-life care	• refer to hospice if indicated • refer to chaplain service

Complex Case #3: Mr. Jim Rich

Mr. Jim Rich is a 74-year-old man who was recently admitted to the nursing home following an above the knee amputation of his right leg. After drinking one night, he sustained a fall and fractured his right ankle. He did not seek help for several days, as he did not recognize the severity of the injury. He was admitted to the hospital for the consequences of that delay, a gangrenous right foot. At the time of the hospital admission, he was noted to be disheveled and poorly nourished. A psychiatric consult was obtained and it was felt that he was severely depressed. During the hospital stay, he was started on antidepressants. He was discharged to the nursing home on the antidepressant medication and has a scheduled follow-up visit with the psychiatrist. He understands that placement in the nursing home is necessary for rehabilitation and that he will eventually get a prosthesis so that he will be able to walk again. Medicare benefits will probably cover the first 20 days of his stay as well as a portion of the next 80 days, as long as he requires skilled services to progress with his rehabilitation.

Past Medical History:

- Hypertension
- Pack year history of smoking
- History of myocardial infarction 8 years ago (after which he quit smoking)
- Alcoholism for which he has been treated 2 -3 times

Allergies:

No known allergies

Medications:

- Sertraline 50 mg qd
- Amlodipine 5 mg qd
- Tylenol #3 1 tab q 6 hr as needed pain

Social History:
Mr. Rich is a retired banker who was living alone in an apartment. Although well educated, he has had a long history of alcoholism and had gone through treatment “two or three times” with his wife while she was living. Since her death one year ago, he had become more isolated, drinking heavily alone in his apartment. He has about $3,000 dollars in a savings account that he hopes will cover his funeral expenses. He lives on his Social Security check, which is about $900/month. Mr. Rich has had to borrow money from his daughter at times in order to make ends meet. He has a son and daughter who live in town with children of their own. At one point in his life, Mr. Rich was active in his community. For a time, he served on the school board. He likes to read and used to keep up with the local baseball and football teams.

Review of Symptoms
- Stump pain
- Poor circulation in left leg
- Constipation
- Depression
- ETOH abuse

- Hard of Hearing (HOH)

Activities of Daily Living (ADLs)
- Able to feed, dress, and bathe self
- Assistance to toilet x 1
- Assistance to wheelchair x 1

Instrumental Activities of Daily Living (IADLS)
Although able, exhibits signs of lack of interest in many activities.

Advanced Directives
Has no living will.

Environment
Lives in nursing home for rehabilitation. Previously lived alone in an apartment.

Physical Exam:
Weight: 200 lbs. Height: 6'2" BP: 146/90 P: 80

On exam, Mr. Rich is alert, oriented, and pleasant, although responses are limited to few words and he seems to avoid direct eye contact. His only complaint is occasional pain in the amputated leg at night and constipation. His vision was excellent with corrective lenses; he could easily read newsprint. His hearing seemed moderate-severely impaired on gross exam. Chest was clear. Cardiovascular exam revealed a regular heart rate, no murmur or gallop. Abdominal exam revealed bowel sounds through-out, no palpable masses, although he was noted to have a large amount of hard stool in his rectum. Examination of his left lower extremity reveals normal proximal pulses but diminished distal pulses. There is an absence of toe hair on the foot and a mild rubor when the foot is dangling. The right stump is wrapped with a compression bandage, shows a well approximated, healing incision, and some mild edema. The skin over the lower portion of the sacrum is noted to be red and non-blanching.

MMSE: 27/30; Mr. Rich had to be prodded for answers, but usually responded correctly.

TASK: It is now team rounds and time to develop a problem list and plan of care for Mr. Rich.

Faculty Information Only: Mr. Jim Rich

TEACHING POINTS:

- This case illustrates the need for a team approach. The case should be useful for: complexities of alcohol abuse in the elderly.
- Need to consult with other disciplines (e.g., OT, PT, nutrition).

1. What is the overarching goal?

Return to independent living in the community with no alcohol dependency.

2. Patient's problems: See Plan of Care Attachment.

3. What is the impact of each problem on the patient's health and quality of life?

Key is to focus on ETOH/depression as overriding problem and the effects that this has on quality of life for elders. Impact is physical, psychological, social, spiritual.

4. What strengths and resources does the patient have for addressing each problem?

Patient's education, intelligence, physical strength, family support system, eligibility for MA.

5. What additional information is needed?

- GDS
- Assessment by PT/OT for ambulation and of home environment
- Pharmacy consult
- Coordination meeting with psychiatrist
- Social worker to assess MA, family
- Nutrition consult

6. Plan of care: See Plan of Care Attachment.

7. Expected outcomes: Included in the Plan of Care Attachment.

PLAN OF CARE ATTACHMENT -- Complex Case #3: Mr. Jim Rich

Problems	Plan	Outcome
Healing of stump	• Observe for signs of infection	• healed -- no infection
Stump pain	• Change to Tylenol; consider low dose of Nortriptyline • Position carefully • Assess phantom pain	• managed, eliminated if possible
Ambulation	• Assess strength, gait • Fit for prosthesis • PT/OT	• (strength) up ad lib • (prosthesis) without assistance
Depression	• Assess; meds and state (GDS) • Psychotherapy • Involve in nursing home activities • Continue Zoloft (Sertraline)	• decreased GDS score • increased socialization and activity attendance • improved appearance and attention to ADLs
ETOH abuse	• Referral to AA volunteer • Assess family situation • Coordinate with psychiatrist	• decrease ETOH intake
Constipation	• Eliminate codeine; • add Sorbitol 70%, 15-300 cc by mouth or orally as needed • Increase fluids, fiber in diet • Increase activities	• no bowel problems
Stage I Decubitus	• Skin care • Positioning • Ambulate/ up in chair	• eliminate
Peripheral vascular disease	• Monitor for complications • Assess nutrition	• no peripheral ulcers
HTN	• Assess BP control	• BP in range < 150/90
CAD	• Monitor • ASA x1 qd • Assess cholesterol levels	• no increase/worsening
Hearing impairment	• Hearing aid	• improved hearing
Decreased financial status	• Assess for MA eligibility • Assist with application process • Meet with family	• manage independently at home
Housing	• Discharge planning by social worker with client and family	• manage independently at home or in assisted living
Safety	• Assess home environment • Stabilize ETOH problem • Assess medications, orthostatic hypotension	• safe at home alone or in assisted living

Complex Case #4: Mrs. Rose Carmine[10]

Mrs. Rose Carmine is a 77-year old African-American woman with a history of multi-infarct dementia, an unsteady gait, urinary incontinence, numerous falls, and paranoid and aggressive behavior. She has three adult children in the metropolitan area, two sons and one daughter. Mrs. Carmine is currently living in her own home with her daughter, although the daughter expresses that she is becoming exhausted and depressed. She would like to place her mother in the nursing home but has been told by her brothers that she can't because they promised "never put her away." Currently the daughter leaves her mother at home alone if she needs to go out. The daughter is somewhat concerned that if her mother does go the nursing home, the mother's home would have to be sold and the daughter would lose her free place to live. The family has had arguments about Mrs. Carmine's care ever since her daughter moved in to care for her. The son wants her to have no psychotropic meds; but the daughter cannot live with her mother's aggression with daily care and her frequent paranoid comments that someone is trying to "kill her." One month ago Mrs. Carmine was hospitalized in a psychiatric unit for 20 days after an episode of physically attacking another resident of an adult day program she had been attending. During that hospital stay she initially responded to Haldol 0.5 mg bid and Paxil 20 mg daily, but within 1 week she began drooling excessively and was switched to Risperidone 1 mg daily and Paxil 30 mg daily. The daughter indicated that her mother was also receiving as needed Ativan during that hospitalization and was "pretty much a zombie." The family was upset by this experience. They requested all psych meds to be held, removed her from the hospital, and changed physicians. She continued to be very aggressive and paranoid. After several aggressive incidents with other residents at the day care center, a re-trial of Haldol and Paxil at lower doses was initiated. This resulted in a more highly agitated state and excessive extrapyramidal side effects. The medications were again discontinued. Recently, a low dose (10 mg) of Mellaril was started in the morning and Trazadone 50 mg was started at bedtime.

Mrs. Carmine "has never liked" her daughter. The youngest son had always been Mrs. Carmine's "favorite" and she was so proud that he was a paramedic with a "good job." The paramedic son wants his mother to be "full code," the daughter feels that DNR would be "more humane."

The daughter feels that her mother is depressed because she bursts into tears unexpectedly. The daughter has brought her to the clinic to get her treated appropriately and to discuss nursing home placement. The daughter brings a bag of pills along to the visit but says "I can't get her to take any of them because she thinks I'm poisoning her." Mrs. Carmine is seen out by the clinic desk, arguing in response to any comment by others; she is not able to discern which comments are directed at her.

The medications in the bag include:

- Avitan 1 mg, bid; may repeat x2 up to maximum dose of 4 mg/d
- Vasotec 5 mg qd
- Hydrochlorothiazide 25 mg qd
- Buffered ASA 325 mg. qd
- Prenatal vitamins 1 tab qd
- Haldol 0.5 mg bid
- Paxil 20 mg qd
- Mellaril 10 mg

- Trazadone 50 mg

Physical Exam
The initial exam reveals an elderly African-American female who was somewhat obese.

Vital signs: BP: 188/98, P: 72, R: 18, T: 97.8.

During the interview with her, she reveals many paranoid delusions and comments consistent with depression. She is concerned that “they are trying to kill her,” and states that she is “no good” and that she “might as well be dead.” She appears distraught and weeps intermittently. She is noted to have a left field loss of vision and is unable to read newsprint. Her hearing is impaired. She had some difficulty arising from a chair and her gait is very unsteady; she veers off to the left while ambulating with a walker. Without the walker, she leans and grabs onto anything within reach, almost falling in the hallway of the clinic. She had poor hearing on gross exam. Pulmonary exam revealed fine rales at the bases. Cardiovascular exam revealed a regular heart rate, with a 2/6 systolic ejection murmur best heard at the right upper sternal border. Some mild jugulovenous distention was present as well as hepatojugular reflux. Abdominal exam revealed old scars, bowel sounds throughout, no palpable masses. Examination of her extremities revealed a contracture of her left hand, and decreased upper extremity strength on the left, normal strength of the right upper extremity, 1+ pitting edema approximately half way up the left shin and at the ankle on the right. No skin breakdown. There were several healing areas of ecchymosis on her left hip and left arm.

Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs)
Mrs. Carmine requires assistance in all instrumental ADLs. She would not be able to make a phone call in an emergency situation if she needed to. She needs help with bathing, which she often refuses to do.

MMSE: Incomplete due to patient refusals, scores 6 out of the 20 items that were tested (fails all orientation questions and short term recall).

TASK: It is now time to develop a problem list and plan of care for Mrs. Carmine.

Faculty Information Only: Mrs. Rose Carmine

TEACHING POINTS:

- This case illustrates a severe management problem.
- A major focus is on how to support the informal caregivers. Illustrates frequent paradigm of conflict among family members about what is best. When is the stress on the informal caregiver too great? A primary question is whether this patient can be managed at home, or even in the community.
- There are also many opportunities to improve the medication management..
- Her medical problems are not well evaluated.

1. What is the overarching goal?

To develop a workable management plan that will accommodate (or resolve conflict among) the patient's expectations, daughter's stress, and rest of family.

2. Patient's problems:

- ·dementia with aggression and paranoia*
- ·possible depression*
- ·caregiver burnout*
- ·family dissension
- ·polypharmacy*
- ·potential medication side effects
- ·medication compliance
- ·hypertension
- ·urinary incontinence
- ·instability and falls
- ·hearing
- ·possible congestive heart failure
- ·vision
- ·*big ticket items

3. What is the impact of each problem on the patient's health and quality of life?

- agitated and depressed (even in demented patients, one can assess at least some elements of QoL)
- daughter's QoL very low
- medications may be aggravating problems
- unsteady gait raises additional risks
- incontinence must make things worse for patient

4. What strengths and resources does the patient have for addressing each problem?

- daughter clearly cares
- other members of family may be a resource

- has been attending day care
- live-in caregiver

What additional information is needed?

- family beliefs about best disposition in light of actual status
- response to adjustments of medications
- evaluation of heart and circulation
- evidence of depression
- incontinence status and management
- hearing
- vision
- financial resources

6. **Plan of care:** See Plan of Care Attachment.

7. **Expected outcomes:**

- less agitation
- better depression control
- daughter's care burden reduced
- family agrees on disposition
- better hypertension control
- better congestive heart failure control
- possibly better incontinence control (don't know extent now)

Plan of Care Attachment -- Complex Case #4: Mrs. Rose Carmine

Problems	Suggestions/Interventions
Dementia with aggression and paranoia	• change medication regimen
Possible depression	• evaluate (possible therapeutic trial) & treat
Caregiver burnout	• work with family to develop reasonable plan of • care -burden sharing -consider NH placement
Family dissension	• family meeting to discuss realistic expectations • and prior commitments
Potential medication side effects	• review doses and combination of behavior • control meds -Haldol -Mellaril -Ativan • cardiovascular meds -ASA -Vasotec -Hydrochlorothiazide • depression meds -Paxil -Trazadone
Medication compliance	• simplify drug regimen • work with patient to support need for meds
Hypertension	• more aggressive treatment
Urinary incontinence	• evaluate, trial of timed toileting
Instability and falls	• evaluate, especially: -potential role of medications -safety evaluation -role of poor vision
Hearing	• evaluate
Possible congestive heart failure	• evaluate and treat

Complex Case #5: Mrs. Gertie Treat

Mrs. Gertie Treat is an 82-year-old nursing home patient who is a new referral to your care. Until 3 years ago, Mrs. Treat was active, in excellent health, living in the community, bicycling daily, and in very good health. Three years ago during a routine diagnostic x-ray, Mrs. Treat was left alone on the x-ray table and aspirated. Although she was eventually "successfully resuscitated," she was left with permanent brain damage secondary to anoxic encephalopathy. She was quadriplegic and expressively aphasic. A feeding tube was placed during her hospital stay and she was sent to a long-term care facility for chronic care. A "large" financial settlement was paid to Mrs. Treat in response to the accident.

Although Mrs. Treat has five children, her daughter, Helen, has made the bulk of the health care and financial decisions since the accident. Nursing home staff note that some of Helen's nieces come into the nursing home periodically to thank their great Aunt Gertie for her generous gifts. Helen moved into her mother's home, which was closer to the nursing home, and visited her mother daily. None of the other adult children visited after the first 6 months.

The daughter recently made a decision to switch health care providers because your clinic team makes visits at the nursing home. When you raise the issue of advance directives, the daughter notes that she just wants her mother to be comfortable, and then bursts into tears. She confesses that years ago her mother wrote a living will indicating that she would never want to live like this. The daughter had been unwilling to share this information previously because she thought her mother might recover. The daughter then says "I know it's too late now because you can't take out a feeding tube once it's in."

The living will that the daughter produces clearly spells out that Mrs. Treat would not want any extraordinary measures taken if she was terminal and specifies no tube feeding in particular.

Medications:

- Synthroid 0.125 mg qd per G-tube
- Unifiber 1 tablespoon qd per G-tube
- Zantac 150 mg (liquid) qhs per G-tube
- Tylenol 650 mg 3 times daily as needed for discomfort per G-tube

On exam, Mrs. Treat is a well-nourished, elderly female who looks much younger than her 82 years. She has no skin breakdown and has not had problems with recurrent aspiration. Her weight is stable. She is nonverbal and completely dependent. Although she makes eye contact, it is not clear how much she understands. Chest is clear; cardiac exam, pulse of 66 regular rate and rhythm, no murmurs. Abdomen is soft; no masses, g-tube site shows no irritation or breakdown, has bowel sounds in all four quadrants. She has multiple contractures of her upper and lower extremities.

The social worker at the nursing home approaches you later that week and mentions that Mrs. Treat's daughter has recently attempted to apply for medical assistance for her mother but had been turned down because of some assets that had been transferred within a recent time frame. She also notes that the daughter is $40,000 in arrears in her payments for her mother's care.

TASK: It is time to develop a goal and a care plan for Gertie Treat.

Faculty Information Only: Mrs. Gertie Treat

TEACHING POINTS:

The purpose of this case is to help team members:

- critically examine -- from the perspective of all disciplines represented in the team -- their own notions and values on life-sustaining treatment for a brain-damaged patient;
- appreciate and effectively employ one another's professional responsibilities and skills in:
- determining a treatment plan for the patient, and
- educating/involving family members in the treatment decision.

1. What is the overarching goal?

Determining a treatment plan that, as much as possible, is in keeping with the directives/intentions of the patient and that respects the value of life.

2. Patient's problems:

- Patient is incapable of indicating what medical treatment she wants, although a living will suggests that the current treatment may contravene her wishes.
- Patient's daughter does not understand the conditions under which it is acceptable to remove a feeding tube.
- Patient's daughter–and other family members–are particularly involved and affected by any treatment decision, given the history of treatment for the last 3 years.
- Some information suggests the patient may be financially exploited.

3. What is the impact of each problem on the patient's health and quality of life?

- Maintaining current treatment may run counter to patient's wishes regarding quality of life and death with dignity.
- Financial exploitation, if it exists, would violate patient's property rights, and perhaps patient's intentions on how her estate should be divided. It could conceivably affect the patient's quality of care, although it is remote that the NH would attempt eviction (according to APS, this is rare but still is attempted despite federal mandates on discharge). Or, NH might be forced to eat costs — in the end, this affects everyone.
- If it is reasonable to suspect exploitation, it may be reasonable to question any information (other than documents) given by the daughter regarding the patient's wishes for treatment

4. What strengths and resources does the patient have for addressing each problem?

Patient has completed advance directives regarding terminal illness (living will). Although the patient's condition may not be terminal, this still may be helpful in deciding upon treatment. Patient's daughter appears genuinely interested in addressing the treatment issue. Patient has five children, some or all of whom may know what she would want in this situation.

5. What additional information is needed?

Physical condition of the patient appears to be stable; information is needed regarding advance directives for treatment and exploitation issues. The daughter's comment that her mother would never want to live like this suggests that she is aware of her mother's wishes over and above what may be stated in the living will. It is important to find out what all family members (not just the daughter) know about the mother's wishes, and to examine any written documents, including the living will. Also, how does the daughter relate to the decision-making responsibilities? simply as family member, durable power of attorney, durable power of attorney for health care? Any other persons have such responsibilities?

Regarding possible exploitation what is legal status of daughter? Does she have durable power of attorney over finances? The gifts to the children are not in themselves suspicious (a person or their legal representative can give up to $10,000 per individual per year without transfer problems regarding Medicaid eligibility — financial planners encourage that they do so). The $40,000 in arrears to NH is a problem since a primary responsibility in handling someone's care is making sure that their care is paid for. It is mandatory to report if there is a reasonable suspicion of exploitation; protective services would wonder why the matter was allowed to reach $40,000 before it was reported. The team would want to at least find out from the nursing home social worker the circumstances and if she/he has reported the matter to APS. If there were a reason for reporting the arrears to APS and the NH social worker did so, the team member would not be legally required to do so. [Since 1995, mandatory reporters are not required to report if they know someone else has done so]. It is very unlikely that the NH would have waited this long without acting.

6. **Plan of care:** See Plan of Care Attachment.

7. **Expected outcomes:**

- The patient lives out her remaining days in a manner that respects human life and that is as close as possible to the conditions she would stipulate were she able to do so.
- The family understands and is satisfied with the role they have played in helping their mother obtain the treatment she would have wanted.

Plan of Care Attachment -- Complex Case #5: Mrs. Gertie Treat

Problems	**Suggestions/Interventions**
Uncertainty re: advance directives	• Address daughter's/family's misconception that tube can't be withdrawn (NP/MD). • Review living will and any written documents; determine who represents patient re: health care decisions); involve them/family (SW): educate re: condition and comfort of patient and likely outcomes both with and without feeding tube (e.g., tube will not prevent occurrence of aspiration pneumonia, impact of tube on longevity, comfort) (MD/NP). • Educate family re: importance of its role in addressing what treatment their mother would have wanted; help family develop a consensus, if possible, on what treatment their mother would want (team or team reps). • Supportive counseling if needed for family, particularly daughter (SW). • Educate family and discuss palliative care, including what medications would be helpful (Pharm)
Exploitation	• Determine what durable powers of attorney the daughter holds; approach this as a major issue for the NH rather than clinical team but, since information was shared with the team's social worker, have him/her follow up to find out what NH has done/reported in APS. • COMMENTS ON DIVISION OF RESPONSIBLITIES: Tasks could be divided many different ways. Should whole team meet with family re: advance directive decision? Depends on circumstances; could be overkill. Perhaps at least MD/NP (explain condition of patient and options) and SW (guide family in decision process if need for follow-up, etc.)

Complex Case #6: Ms. Clara Germaine

Ms. Clara Germaine is an 89-year-old resident on a skilled unit of the nursing home. She has a long history of being an anxious person. She lived at home with her parents until they died. At the age of 43, she married a much older man. When he developed symptoms of Alzheimer's disease within the first 12 months of marriage, she had the marriage annulled. She underwent many treatments for depression as a younger person and had a series of electroshock therapy on three different occasions between the age of 40 and 67. She has refused any further shock treatments and has had trials of Nortriptyline, Desipramine, Paxil, Zoloft, Ascendin and, most recently Serzone. With each of these antidepressant trials, she takes the medication as ordered for the first 2 weeks and then identifies some side-effect that is annoying and refuses to take any further doses. Her mental status score is 28/30 on the MMSE. She has changed primary physicians four times in the past 3 years. The psychiatrist who has been seeing her for the past year has been unsuccessful in implementing a behavioral approach that the staff will follow consistently. He has recently explained to Ms. Germaine's conservator that he can no longer help her if she will not follow through on his recommended treatments. Ms. Germaine has alienated her brother and sister-in-law with her continuous dependency issues and chronic complaints. Her brother's impression is that she has been coddled all of her life and needs someone who does not give in to her whims.

In interviewing Ms. Germaine, it is evident that she complains about the same issues repeatedly, focusing on her losses and needs for more care. Some of her common complaints include: "My vision is so bad that I just can't see a thing anymore." "My legs are numb and I can't walk and they are so mean to me." "They won't push me in the wheelchair and they won't help me when I ask." "I'm just so nervous and I can't see why they don't help me more." "I might fall." When she is asked to demonstrate how she walks, she can do so easily with a walker, is steady, and has no history of falling. When the interview is ended, the interviewer extends her hand to shake hands with Ms. Germaine who sees the cue and responds without any verbal prompting. She is reluctant to end the conversation and will do anything to keep the nurse practitioner, physician, or nursing staff in the room with her. At the end of the interview she pleads for a sleeping medication, even though staff identifies that she is always asleep when they check on her at night.

TASK: Identify a few long-term goals and develop a care plan for Ms. Germaine.

Faculty Information Only: Ms. Clara Germaine

TEACHING POINTS:

This case provides very little "medical" information about the patient. The physician members of the team may suggest that some of the patient's complaints be evaluated, but that should not be the focus of the intervention or care plan.

It should be obvious to the team that a behavioral approach is what is needed to help both Ms. Germaine and the staff who are working with her. This may be an uncomfortable situation for the physician team members unless they have some psychiatric background. Physicians for the most part have little or no training in basic concepts of behavioral modification. This case gives the GNP and Social Worker a chance to demonstrate their expertise in managing a patient with behavioral issues, as well as to offer to help the nursing staff develop a behavioral treatment plan.

Faculty should observe the dynamics of the team interaction, looking for who takes the lead on this case. The team should not allow the physician members of the team to apply a purely biomedical model and dominate the discussion.

The team should be instructed to direct their discussion to the other team members. The faculty may wish to play the role of the nurse aide member of the team who is very frustrated with trying to care for this person. In this role, one can push the team in several directions:
- "Can't you just give this woman a pill to fix her?"
- "I don't know how to do 'behavioral management.' What specifically do you want us to do?"

1. What is the overarching goal?

To assist the nursing staff in implementing a behavioral plan that:
encourages Ms. Germaine to be more self supporting, and
reduces her dependency behaviors that are expressed through complaints and drug seeking.

2. Patient's problems:

- Dependent personality disorder
- Dysthymic disorder
- Somatizing disorder

3. What is the impact of each problem on the patient's health and quality of life?

- Dependent personality disorder: patient alienates those around through her complaining and requests.
- Dysthymic disorder: Patient is chronically unhappy and dissatisfied with her life. It is likely that she has a sense of hopelessness about her future and poor self-esteem.
- Somatizing disorder: Patient's focus on her physical complaints and limitations interferes with her ability to engage in activities that would improve her life satisfaction. It also stresses her relationships with providers, possibly leading to impaired ability to deliver care.

4. What strengths and resources does the patient have for addressing each problem?

Although she has a number of complaints, the history leads one to believe that she is medically quite stable. She is in a supervised environment. She has a court appointed conservator and her brother and sister-in-law are somewhat involved with her.

- Alienation of those around her: Patient in all likelihood has high level of social sensitivity and desire to engage with people. Her ability to read people and her genuine liking of people provides powerful incentives.
- Life dissatisfaction: patient responds to attention. Providing her with attention contingent upon her accomplishments rather than on her needs would likely increase her accomplishments.
- Somatic preoccupation: Patient can be strongly engaged through discussions about her health.

5. What additional information is needed?

One might ask why Ms. Germaine is on a “skilled unit?” Under “rule 36," there are group homes that provide a behavioral approach to caring for patients with mental health disorders. Although people of all ages with a serious and persistent mental illness might be eligible to live in a “rule 36 facility,” many older persons end up in nursing homes instead. One factor is that “rule 36 facilities” are often set up with younger persons in mind -- they expect residents to participate in maintaining the residence and take on various responsibilities, such as instrumental activities of daily living. Many residents go to sheltered workshops during the daytime. In other words, they tend to be geared to the pre-retirement age group and it is hard to bring in an 89-year-old when most of the residents are much younger. There is much work to be done when it comes to comprehensive care for elders with a serious and persistent mental illness.

How does Ms. Germaine see her life? What does she see as important things to know about her besides her physical and psychological complaints? What are the patient's interests? What are the things the patient feels proud of in her life?

How does she spend her time when not engaged in help-seeking behavior? What is the pattern associated with help-seeking behavior? Is there a pattern in terms of when she seeks out staff, whom she seeks out, etc? What are the antecedents of help-seeking behavior? What is the specific nature of these behaviors? What are the consequences and how might these consequences reinforce the behavior?

6. Plan of care: See Plan of Care Attachment.

7. Expected outcomes:

Dependency behaviors in the form of complaining and help-seeking should decrease and behaviors for which Ms. Germaine gets praised should increase. Ms. Germaine’s quality of life should increase as she becomes more involved in activities in which she feels pride and connected with others.

Plan Of Care Attachment -- Complex Case #6: Ms. Clara Germaine

Problems	Suggestions/Interventions
Mental Health Disorders	• Work with nursing staff to implement a behavioral plan that: • Responds to complaints with brief assurance but limited attention. It is especially to decrease staff's alienation from this resident and minimize any rejecting behaviors, as these will predictably increase her anxiety and, thus, her dependency behaviors. • Have staff seek out Ms. Germaine when she is not complaining and give her attention. Focus of attention should consistently be on praising her for accomplishments rather than paying attention to or responding to complaints. • Engage Ms. Germaine in an exercise or other health promotion which focuses on improving her health and gives her attention for active coping behaviors. • Engage Ms. Germaine in situations in which she is helping others. Use these situations to increase her social contacts while refocusing her on others' concerns.

Complex Case #7: Mr. Roger Anderson

Mrs. Roger Anderson brings her husband, Roger, to the geriatric clinic for an appointment. He has a 4-year history of progressive dementia and lately has been refusing to take a bath and cursing at her when she tries to help him undress for bed. He insists that she is not his wife and occasionally tries to leave the house explaining that he "is getting out of this joint and going home." She explains that she has to keep the door locked because she is afraid he will run away and get lost. He wanders around the house most of the night. Her voice sounds weary and helpless as she asks, "Isn't there a pill for this?"

Past Medical History:
- Dementia x 4 years.
- Hypertension. Diet controlled. No medications
- Mild COPD, related to 30 pack yr. history of smoking (quit in 1976).
- Angina, (hospitalized 1976 for 2 days, no MI, no other cardiac hosp)

Allergies:
Sulfa

Medications:
None

Social History
Mr. Anderson is a 79-year-old retired school janitor. He held many part-time jobs over the years in addition to his school janitor job to support his family. He had few hobbies during his working years. He has two grown sons who live within the metropolitan area. Mr. and Mrs. Anderson own their own home in the Midway area of St. Paul. Upon retirement, Mr. Anderson did not take interest in community volunteer work but enjoyed working out in his garage repairing lawnmowers and other equipment with small engines. His wife is also 79 and has problems with high blood pressure and diabetes. Mrs. Anderson has a frail older sister in whom she confides. She does not drive because of vision problems related to diabetes. Her daughters-in-law occasionally come over to "sit with" Mr. Anderson and her son takes her grocery shopping once a week. Although previously the Andersons were active members of a local church, they have been unable to attend on a regular basis due to Mr. Anderson's very short attention span.

Activities of Daily Living (ADLs)
Mr. Anderson is ambulatory and independent in transfers. He requires assistance with bathing and grooming (has on occasion filled a sink with water, lathered up his face, and then tried to use the electric shaver). He is able to dress himself if handed clothing in the correct order. He can feed himself, but gets up frequently from meals and needs to be redirected.

Advanced Directives
There is nothing on the clinic chart that indicates that advanced directives have been discussed.

Review Of Systems And Physical Exam
ROS: 25-pound weight loss over the past 2 years, no other physical complaints or problems.

Weight: 157 lbs. Height: 5' 9" BP: 146/87 Pulse: 88 Temp: 98.2

General: Unkempt, elderly man who appears suspicious of examiner but cooperates with exam.
HEENT: Able to read slightly larger newsprint with corrective lenses. Bilateral cerumen impactions. Moderate-to-severe hearing loss, corrected partially with hearing aids.
Chest: Clear, no wheezes or rales.
Cardiac: RRR, no gallop, no murmur.
Abdomen: Soft, non-tender, + bowel sounds, no hepatomegaly.
Extremities/Skin:
Neuro: MMSE, 13/30. He is completely disoriented to time but knows that he lives in St. Paul, MN. Is able to repeat words but has no short-term recall and can follow only one step of a three-step command. No focal neuro deficits noted. Has wide-based but fairly steady gait with some difficulty on turns.

Labs: Chart indicates dementia workup completed 2 years ago (MMSE at that time 20/30); normal TSH, chem panel, CBC: Hgb 12.5, mild macrocytosis (MCV 100), RBC folate was low, B12 WNL, PFTs showed mild changes thought to be related to smoking history.

TASK: It is now team rounds and time to develop a care plan for Mr. Roger Anderson.

Faculty Information Only: Mr. Roger Anderson

TEACHING POINTS:

1. What is the overarching goal?

Patient: The team should recognize that this scenario provides no indication of the patient's wishes.
Wife: Goal appears to be to try to maintain care for her husband in the community and to find a way to decrease his anxiety and agitation levels.
Team: Evaluate caregiver's ability to continue care, patient safety in the current environment, and overall goal to provide care in the location that best reflects patient wishes.

2. Patient's problems:

Big ticket items: Team should express concern about patient weight loss (potential for etiologies other than poor attention to meals), caregiver health and fatigue (if she's up all night trying to make sure the patient is safe). Part of plan should be to work up other possible problems that can increase behavior changes in demented elderly such as ruling out infections or pain. Should also wonder why the patient isn't taking folate supplements.

3. What is the impact of each problem on the patient's health and quality of life?

The anxiety related to the dementia and lack of sleep are probably increasing this patient's general irritability and contributing to his poor attention to eating. An effort should be made to promote good sleep hygiene without sedating the patient excessively. The caregiver's fatigue can cause irritability and her own anxiety can be reflected by the patient. Her response to his anxiety may improve if she can get some respite.

4. What strengths and resources does the patient have for addressing each problem?

A spouse caregiver who appears committed to continuing care in the community; adult children who live within the community. Financial resources are unknown.

5. What additional information is needed?

Since decision-making capacity is impaired, the team members should recognize the need to further explore the patient's previously stated wishes regarding care. Need assessment of financial status, wife's awareness of community resources (such as adult day care) and willingness to use respite services. Need to assess for reversible medical problems that could be contributing to increased anxiety and sleeplessness.

6. Plan of care: See Plan of Care Attachment.

7. Expected outcomes:

Patient will be able to safely remain in the community under the wife's care with assistance from respite services.

Plan Of Care Attachment -- Complex Case #7: Mr. Roger Anderson

Problems	Suggestions/Interventions
Dementia Anxiety/poor sleep hygiene Secondary to above	• Rule out reversible causes of behavior change; infection, impaction, dehydration, pain, nutritional deficits • Start Trazadone 25-50 mg qhs for sleep, increase if tolerated, re-evaluate sleep at next visit • Have caregiver monitor pt for psychotic symptoms; paranoia, delusions (if present consider use of low dose antipsychotic)
Self-care deficits	• Provide caregiver with information about one-step commands, using visual cues for care activities • Provide caregiver with 36-hour daybook or other resources on behavior changes
Impaired coping, caregiver	• Access financial status, goal of caregiver • Provide caregiver with information about Alzheimer's Association, classes for caregivers • Provide caregiver with information about respite services, including adult day care, HHA Services, nursing home respite
Folate deficiency	• Recheck CBC, RBC folate • Start Folic Acid 1 mg qd
Weight loss/nutritional deficit	• Evaluate for anemia, stool guiac, consider lower GI workup if guiac positive • Encourage caregiver to provide pt with nutritional snacks throughout the day and evening • Consider use of nutritional supplements (e.g.,Carnation instant breakfast) or shakes
Hypertension	• Monitor on three consecutive visits • Continue low sodium diet • No medications indicated at this time
COPD, mild	• Currently inactive problem, monitor for URI symptoms

Complex Case #8: Mrs. Josie Wells

Mrs. Josie Wells is an 89-year-old white woman who is being seen in the Geriatric Assessment Clinic for the first time. She is accompanied by her daughter-in-law who has told the team that she is worried about Mrs. Wells, who has fallen three times in the last 10 days.

Fall #1: Patient got up at night to go to the bathroom. She lost some urine in the bathroom on the way in. When she stood up to leave the bathroom, she slipped as the floor was wet (tile) and fell.She bumped her left side and head. No loss of consciousness. No laceration. Left side still somewhat sore.

Fall #2: Patient was going down the hallway in her home and had a sensation of unsteadiness. Her legs seemed to “give out” and she fell to the floor, this time on her right side. No loss of consciousness. The hallway was carpeted. She did not strike any furniture and received no significant injury.

Fall #3: Patient was in her living room reading at night. She got up to go to the bathroom, took several steps, and fell. As best she can recall, her feet simply got “tied up” and she tripped. This time, her head struck the coffee table and she lacerated her forehead requiring eight sutures to close the wound.

Past Medical History:

- AODM x 10 years. She was initially controlled with oral agents but in the last several years, has been on insulin. She does not watch her diet very well.
- Hypertension: for the past 10-15 years; believes it is controlled. Verapamil x 10 years; Vasotec x 5 years
- Myocardial Infarction: 3 years ago. She had chest pain when admitted. Not considered an angioplasty or CABG candidate. Since that time, she has only rare episodes of angina for which she takes sublingual nitro.
- Congestive heart failure: First episode 2 years ago. Patient presented to primary doctor with lower extremity edema, and was started on digoxin and a diuretic. Patient does not recall having an echo done.
- Osteoarthritis. Primarily in her knees. She is stiff in the morning and improves throughout the day. She takes extra-strength Tylenol, 2 tabs 2-3 x day when she feels the need.
- Stroke: About 1 year ago patient had “mild CVA” that left her with some weakness in her right leg but it does not bother her.
- Poor vision felt to be secondary to diabetic retinopathy.
- Hearing impairment. Patient has had hearing aid for several years that she wears intermittently.
- Obesity.
- Urinary Incontinence.

Allergies:
No known drug allergies.

Medications:

- Ditropan 5 mg, one by mouth or orally 3 times daily
- Lasix 20 mg by mouth or orally qd

- Verapamil SR 240 mg, by mouth or orally qd
- Vasotec 5 mg, by mouth or orally qd
- Digoxin 0.125 mg by mouth or orally qd
- NPH insulin 20 units in am
- Tylenol extra-strength, 2 tabs 2-3 times a day
- Tylenol PM at bedtime as needed

Social History:
Mrs. Wells never worked outside the home. She cared for her husband, who had multiple medical problems until he died 10 years ago. She raised three children, one daughter and two sons. One son lives in town and is "looking out" for Mom. The other two children are out of state and have very little contact. She has few interests. She is primarily sedentary. She has never exercised on a regular basis. She has never smoked but has always had two "high balls" each night before supper.

Review:
Reports polyuria and nocturia x 2-3 each night.
She has been more forgetful as of late, but attributes that to normal aging.
Reports weight gain of 40 lbs. over the past 2 years.
Decreased visual acuity to the point where she has difficulty reading the newspaper.
Incontinence of urine 5-6 times per week. This occurs when she has the urge to urinate but cannot make it to the toilet before wetting herself.

Activities of Daily Living (ADLS):
Intact (patient is able to feed, dress, and bathe self; ambulating without assistance; she does have occasional incontinence).

Instrumental Activities of Daily Living (IADLs):
Stopped driving due to poor vision. "She can cook when she wants to." Family takes her shopping once a week.

Advanced Directives:
Has a living will. Eldest son (husband of person with her) is her health care power of attorney.

Environment:
Patient reports that she lives in a three-story Victorian home. She primarily lives on the first and second floors. There is a half-bath on the first floor and all the bedrooms are on the second floor. The floors are hardwood covered with rugs of various sizes. The bathroom has a clawfoot tub with a shower curtain. There is no lighting on the stairway and dim lighting in the hallways.
The daughter-in-law states that the house is cluttered with magazines and various "knick-knacks."

Physical Examination:

Weight: 280 lbs.	Height: 5' 6"	Sitting BP: 160/80	Pulse: 62
		Standing BP: 142/70	Pulse: 60

Gen: Obese white female in no apparent distress, responds appropriately to questions.
Skin: Warm, laceration on her forehead, ecchymosis over the right hip.
HEENT: Poor vision, cannot read newsprint, she can count fingers; poor hearing- you have to speak loudly for her to hear and she still misses things at times.
Chest: Clear to auscultation, no rales, rhonchi, or wheezes.

Cardiovascular: Regular rate and rhythm with a 3/6 systolic ejection murmur best heard at both the RUSB and LLSB; occasional ectopy noted; no S3 or S4.
Abdominal exam: Abdomen is soft, non-tender, bowel sounds present, no masses or organomegaly.
Extremities: Mild ankle edema bilaterally, full range of motion (FROM) in both upper and lower extremities; pain with range of motion of knees; left>right; crepitus present in both knee joints; no hot, red, or swollen joints.
Neuro: Cranial nerves grossly intact (except for hearing and sight); patient has difficulty arising from chair, right foot drop present; gait is somewhat shuffling with little sway; when patient turns she is somewhat unsteady; no rigidity present.

MMSE: 17/30 (not oriented to month, date, day, or year (-4), -3 on recall, -5 on serial 7's, -1 for praxis)

LABS:
Hgb: 11.2 Hct: 33.0
Fasting Serum glucose: 312
Hgb A1c: 11% (suggest average serum glucose of 280)

TASK: It is now team rounds and it is time to develop a plan of care for Mrs. Wells.

Faculty Information Only: Mrs. Josie Wells

TEACHING POINTS:

1. The students should recognize that the patient's cognitive abilities have a significant impact on all other conditions and any plan of care that will be developed.
2. This is a very complicated case, which should provide many opportunities for participation of each team member

1. What is the overarching goal?

Patient: The case gives no indication of patient wishes.
Daughter-in-law: Expressed concern regarding frequent falls. Goal of family may be to prevent future falls.
Team: To evaluate and eliminate potential iatrogenic causes of falls. To assess and make recommendations regarding ability to live safely independently.

2. Patient's problems:

Polypharmacy: the patient is on multiple medications that could be causing problems.
Cognitive impairment: raises numerous concerns regarding safety, ability to manage independently, etc.

3. What is the impact of each problem on the patient's health and quality of life?

Rather than go through each problem, students should identify that the cognitive impairment has an overriding impact on the other conditions. If the cognitive impairment is reversible, patient's ability to live independently is greatly increased. If not, she may require a supervised setting.

4. What strengths and resources does the patient have for addressing each problem?

Has an attentive daughter-in-law; patient lives in her own home, and is willing to seek help, as evidenced by the fact that she has come in for the office visit. She has survived for 89 years.

5. What additional information is needed?

- Good functional assessment including behavior issues to help evaluation degree of dementia. Assessment should include observed use of telephone, medications, meal preparation, ability to handle finances, ability to use stove, and appropriate storage of food. Also, should evaluate frequency and ability to bathe appropriately (set hot water?), climb stairs, and transfer in and out of chairs in her home.
- Need thorough psychosocial assessment that includes:
  a) identification of patient's personal strengths/resources, previous ways of coping, and motivation.
  b) identification of other family and community resources (extended family, neighbors, friends, church members, formal resources, etc). If someone can be

found to administer medications appropriately, give insulin appropriately, make sure that nutritious food is in the home, and assure patient safety, she may be able to continue independent living.

c) Need better ETOH evaluation, is it only 2 drinks or is it 6? Is she amenable to reduction of ETOH to try to improve memory, thinking skills. Is this a recent or longstanding pattern ?

d) Need to know more about her financial status; are her finances adequate?

e) Need good skin exam.

6. Plan of care: See Plan of Care Attachment.

7. Expected outcomes:

Priority should be given to eliminating any reversible causes of dementia and instituting medication changes. Other factors that may be contributing to possible dementia are uncontrolled diabetes and ETOH use.

- Medications (Ditropan, Tylenol PM)
- Electrolyte abnormalities
- B12 deficiency
- Depression
- Thyroid disease (hyper-, or hypothyroidism)

Plan of Care Attachment -- Complex Case #8: Mrs. Josie Wells

Problems	Suggestions/Interventions
Medications: • eliminate the Ditropan • eliminate the diuretic, if possible • eliminate the Verapamil -- its nodal effects are likely contributing to her orthostatic problem • consider eliminating the digoxin, if there is no history of atrial fibrillation and rapid heart rate (it would be helpful to get an echocardiogram. If she has significant decrease in her ejection fraction, then one would likely want to keep her on the digoxin) • eliminate the Tylenol PM (it has benadryl, which has anti-cholinergic properties)	• UA/UC to rule out UTI as cause of incontinence • the HTN can be controlled with the Vasotec • obtain electrolytes, renal functions • obtain digoxin level, (will indicate if patient is even taking the med); consider EC ASA qd for MI and stroke prophylaxis • discuss sleep hygiene issues with her and d-in-law. Evaluate daytime sleep habits and use of caffeinated beverages; recommend discontinue caffeine; needs to be aware of sleep changes that occur with aging
Probable Dementia • need to look for reversible causes; • raises numerous concerns regarding safety, ability to manage medications, etc.	• assess for impaired judgment, ability to use phone, obtain assistance. • assess ability to appropriately take medication. • recommend daughter-in-law or son administer medications. • simplify medication routine. • complete dementia workup: TSH, folate, B12, FTA-ABS, CBC, Chem panel.
Osteoarthritis	• suggest pain control with scheduled extra-strength Tylenol (this may lead to improved mobility) • physical therapy and assistive device may also improve strength, reduce pain
Poor vision (recommend eye exam)	• contact vision loss resources and arrange a visit (this is a community service that is offered at no cost)
Orthostatic hypotension	• this will likely resolve with the above medication changes; re-evaluate at next visit • consider TED hose
Valvular Heart Disease: • Examination suggests that she may have significant valvular heart disease (i.e., aortic stenosis, that may be limiting her cardiac output and leading to her orthostatic problem)	• suggest an echocardiogram
Incontinence	• eliminate ditropan· • UA/UC to rule out UTI (at-risk diabetic) • rule out fecal impaction (sedentary) • eliminate ETOH, replace with non-ETOH fluids • evaluate skin in perineal area

Problems	Suggestions/Interventions
Obesity/deconditioning	• suggest physical therapy for increased exercise tolerance and strengthening • may need assistive device (i.e., cane or walker) • evaluate dietary intake; assess availability of nutritious foods • provide education for daughter-in-law since she does the grocery shopping • consider Meals on Wheels
Right foot drop	• patient will need an AFO (ankle-foot-orthotic) splint that PT can provide support; • consider extra-depth shoes for optimal support and prevention of foot ulcers
Proximal muscle weakness/unsteady and shuffled gait: These findings may suggest early Parkinson's disease or may be related to motor slowing with dementia	• suggest observation for now • re-evaluate after Phys. Therapy completed • recommend sturdy shoes • eliminate throw rugs form home environment • have PT/OT evaluate furniture for ease in transferring
Adult Onset Diabetes: poorly controlled at present	• assess her ability to administer insulin, observe her draw up and administer. • if unable, refer to home care. • before making any medication changes, have an intact person administer daily insulin to determine possible control. • have home care or daughter-in-law check daily BG, teach use of glucometer to daughter-in-law • consider use of oral agent since NPH use is <30 units/day • evaluate feet for sores, obtain extra-depth shoes
ETOH dependence/? abuse	• recommend discontinue ETOH use to rule out contribution to mental confusion • recommend substitute non-ETOH beverage for highballs • retest cognitive status after free of ETOH for 2 weeks • it is important to remember that should she need to be admitted to the hospital, she is at risk for withdrawal symptoms • recommend community supports, i.e. Chemical Health Seniors Project for support groups, outreach. or consider alcoholics anonymous
Psychosocial interventions:	• suggest lifeline — this may help to reduce patient and family anxiety regarding the potential of another fall • suggest increased family involvement • may want to recommend temporary placement in a safe environment (NH) for short term tune up and rehab, if family is unable to provide more intense supervision
Environmental assessment	• evaluate safety for use of stove, appliances • assess for appropriate lighting on stairs • assess need for grab bars or mats in the bathroom, etc.

Problems	Suggestions/Interventions
Hearing loss	• assess for cerumen impaction, tx • refer to audiology if still impaired • consider hearing aide • refer to hearing loss resources in community

Complex Case #9: Mrs. Betsy Jones

Mrs. Betsy Jones was referred to a geriatric ambulatory clinic by her primary care physician who was leaving the community. She is 76, Caucasian, divorced for many years, and lives in a two-bedroom subsidized, handicapped-accessible apartment with her 43-year-old daughter, who is currently unemployed, and her 13-year-old granddaughter. Mrs. Jones states that she depends on her daughter and is satisfied with their relationship, although they disagree at times on the best way to raise her granddaughter. She has a high school education and worked as a legal secretary until her retirement. She states she drank her way out of many jobs. She quit drinking on her own when she had a stroke 11 years ago. She has been wheelchair-bound since then, and currently uses a motorized wheelchair. She has been treated for depression with Prozac since her stroke and is also taking Percocet 3 times daily for pain control. Mrs. Jones comes alone to clinic visits using Metro Mobility. The team told Mrs. Jones that her daughter was welcome to accompany her to the clinic, however, a brief phone conversation with the daughter led the team to believe she was not interested in coming in "because my mother never follows doctor's orders anyway".

At the initial visit to the Senior Clinic, Mrs. Jones said she wanted help with the following problems: a loss of bladder control (she complains that she has had to start wearing incontinence pads because she usually has a sudden urge to urinate and then it's "already too late to get into the bathroom." She denies pain or burning with urination; sleep problems (she goes to bed at 11 pm but complains that her mind keeps 'going and going' at night; she sometimes has "wild" dreams. She's fearful of people breaking into the apartment at the subsidized complex where she lives; she rarely leaves her apartment, watches TV in her w/c most of the day, and usually takes a morning and an afternoon nap to make up for lost sleep. She has trouble getting around (daughter has back problems and can't help much with transferring); she has had several falls in past year while attempting independent transferring; has pain in both hips and in knees that improves with use of pain meds; is just generally "weaker" since she's been in the wheelchair).

Other data obtained during the history include dietary intake of approximately one pot of coffee per day; smokes about pack cigarettes per day.

Medications:

- Prozac 20 mg qd
- Percocet 1 tab q 4-6 hrs as needed (but she takes 1-3 times daily)
- Dyazide 1 capsule qd
- Folate 1 mg qd
- Extra Strength Exedrin (1 with Percocet at hs, because her doctor wouldn't let her take 2 Percocet)

Physical Examination:
Weight: 175 Height: 5' 3" afebrile BP 145/80 Pulse:72 R 16.
Gen: obese, elderly female who appears somewhat jittery and nervous.
Skin: Some areas of redness and excoriation on buttocks, no measurable open areas. MS: Knees are enlarged bilaterally, no increased warmth, mild flexion contractures at right knee and hip, otherwise range of motion of extremities is good.

Neuro: General decreased strength of upper and lower extremities. Right side is somewhat weaker than left. Is unable to stand up without assistance. Cannot demonstrate walking more than 2 steps without assist of two persons. Didn't bring walker in to clinic because she hasn't used it in a long time.
Mental status: Scores 25/30 on MMSE, has difficulty copying figures, misses two points on calculations, gets 2/3 words on recall, and misses 1 orientation question (date of month).

TASK: Identify a main problem and goal for Mrs. Jones; develop a care plan to achieve this goal; identify 2-3 specific issues for team consultation.

Note, for this Assignment

- You are to independently examine this case--you should not consult with other student/learner team members;
- You are strongly encouraged to consult with your discipline-specific mentor at the Clinic; and
- You are strongly encouraged to consult with at least one other discipline mentor at the Clinic.

Faculty Information Only: Mrs. Betsy Jones

TEACHING POINTS:

Students should recognize that previous health care providers' plans likely did not consider the patient's values or goals, leading to "noncompliance." The team should recognize that the patient and family are an essential part of the team. The team will need to determine what the patient is willing to do and how she would hope to reach those goals.

It is most important that all students are able to identify the need to make joint plans and goals with the patient and daughter.

1. **What is the overarching goal?**

   Goal is keeping patient in the community.

2. **Patient's problems:** See Plan of Care Attachment.

   - Major concern is patient's difficulty maintaining independence due to multiple factors:
   - ♦ limited mobility, obesity, fatigue, and incontinence.
   - ♦ mental health issues (depression, chemical dependency hx, possible pt. lack of
   - ♦ motivation, etc).
   - ♦ relationship with family may be contributing factor.

3. **What is the impact of each problem on the patient's health and quality of life?**

   - impaired mobility as a result of the stroke and her knee and hip pain.
   - urinary incontinence may contribute to her falls.
   - knee pain likely contributes to her insomnia.
   - depression will have an adverse effect on almost all aspects of daily life.

4. **What strengths and resources does the patient have for addressing each problem?**

   She has faced difficult problems in the past and survived; she quit drinking on her own; family is living with her and may (or may not) be a source of support; has Metro Mobility for transportation; apartment is handicapped accessible.

5. **What additional information is needed?**

   - obtain further history regarding ADL and IADL functioning.
   - take a much more detailed history about her depression.
   - explore client's social/recreational needs and interests.
   - determine social history and, in particular, family dynamics.

6. **Plan of care:** See Plan of Care Attachment.

7. **Expected outcomes:**
   - improved mobility
   - reduced risk of falls
   - improved sleep

Plan of Care Attachment -- Complex Case #9: Mrs. Betsy Jones

History of stroke - extent of stroke ill-defined, she has been in a wheelchair since the event. Physical exam suggests right lower extremity weakness/paralysis; she was able to take several steps.	• PT consult for increased exercise and transfer training. This should also help to define the extent of the physical impairment related to the stroke. • Obtain further history regarding ADL and IADL functioning.
Knee and hip pain - again, this is somewhat ill-defined in the case history. Pain improved with pain medication, a list of previously attempted interventions is not given, nor is there a very detailed pain history (quality, quantity, relieving/aggravating factors, radiation of pain, course of illness).	• Avoid narcotic pain relievers, especially given her history of substance abuse. • Would discontinue extra-strength Exedrin and taper or discontinue Percocet. • Switch to 650 to 1000 mg Tylenol 3-4 times daily.
Urinary incontinence - history suggests a combination of both urge incontinence with certainly a functional component. The fact that she has the urge to void would suggest that the stroke has not caused a neurogenic problem. No comment regarding loss of urine with activities (e.g., stress). The learners should recognize that dyazide is probably contributing to the pt's incontinence.	• Evaluate need for the diuretic • Have the patient start on a scheduled toileting plan. • A trial of Ditropan may be warranted but should recognize that this med alone will not solve the functional problems of transferring to the toilet. • OT consult for a home visit to check on the placement of bars near the toilet, and make recommendations for the use of a bedside commode during the night.
Falls and decreased mobility - likely related to functional impairment (weakness/paralysis). Raises concerns regarding safety.	• Home safety evaluation by either PT or OT. • Recommend assistive devices that will aid the client in performing daily activities • Consider "life line" emergency response system.
Borderline cognitive impairment - No specific mention of concern regarding memory of patient from family. MMSE 25/30.	• Consider evaluation of reversible causes (CBC, RPR,TSH, electrolyte imbalance) • Monitor and repeat MMSE over time.
Insomnia - again, not well-described, it sounds like she has difficulty falling asleep because "mind keeps going;" she is sedentary and naps during the day; caffeine intake is moderate. Causes are multiple: age related, unrelieved pain, caffeine intake, poor sleep hygiene, and depression. Prozac is a stimulating antidepressant with a long half-life (2-3 days). It can cause bad dreams and sleep problems; extra-strength Exedrin contains 65 mg of caffeine and is not a good choice for a sleep time pain medication.	• Consider changing antidepressants. • Better control of pain, if present. • Discuss age-related sleep changes so that patient is realistic regarding sleep. • Recommend ways to improve sleep including: reducing daytime napping, increasing daytime activities, reducing time spent in bed.
History of depression - from the history we are told that she has been treated for depression since the stroke, but previous psychiatric history is unknown except for pt's report of alcohol abuse. Difficulty sleeping is noted, TV seems to be her major source of entertainment, and we don't know if she rarely leaves her apartment because of fear or lack of interest. On PE, affect is "nervous."	• Consider changing her antidepressant for the reasons discussed above. • Take a much more detailed history about her "depression." • Identify client's social/recreational needs and interests and make appropriate referrals. • Gather info on pt/family function (how they interact/communicate with each other, impact of client's addiction on family, goals and needs for the family unit, etc.). • Consider a joint pt/family conference to do problem solving and to develop a mutually agreed upon plan of care.
Dangerous neighborhood - patient worries about crime in her subsidized housing complex.	• Explore patient's fears. • May identify ways to take action including a move to alternate housing if pt is interested.
Low income - one may assume that the patient is dependent on a fixed low income.	• Need for financial assessment (pt may be on or qualify for medical assistance, food stamps, elderly waiver services, etc.). • Explore problem of unemployment.

	• Can family be linked to further resources?

Complex Case #10: Mrs. Lin Trang[11]

Mrs. Lin Trang is a 72-year-old Hmong woman who is in clinic today for the first time. She has lived in the United States for about 3 years and speaks little English. She used to live in Texas with her son, but after several disagreements about his failure to follow Hmong traditions, she moved to Minneapolis to live with her daughter. At the assistance of her oldest daughter, Lillian, she has come to the clinic to renew her prescriptions for medications that have run out. She is accompanied by her daughter.

Lillian has been in the United States for 25 years and is a waitress at the local Vietnamese restaurant. She has had seven children by her first marriage and is currently divorced, living in an older, run-down house with three of her children, one with three children of her own. The two oldest, ages 11 and 12, are expected to watch over their great grandmother after school while Lillian is working. There have been some truancy problems and quite a few conflicts over the girls' responsibility to the family.

Lillian is willing to act as the translator but must leave in 30 minutes to get to work; she can't be late. After her mother's last hospital admission, the hospital staff had suggested Mrs. Trang be placed in a nursing home, but Lillian believes that it is her responsibility to take care of her mother. Lillian recalls some issue with public health about her mother's pneumonia but mentions she has a hard time understanding "all that medical stuff." Usually someone is always at home, but occasionally the daughters don't come home from school and Mrs. Trang is at home alone. The neighbors try to keep an eye out for Mrs. Trang and watch over her if she wanders around outside. However, this rarely happens since Mrs. Trang doesn't like the cold or snow and is afraid to go out into the neighborhood in the summer.

The team has only a partial medical chart, which indicates that Mrs. Trang and her family received care from a couple clinics within different health systems. There is a record of her last admission to the county hospital for pneumonia, and her outpatient chart from her county clinic admissions.

Her past medical history includes:

- systolic hypertension
- hypercholesterolemia
- COPD
- cigarette smoker with a 50-year, 1 pack/day history
- Blood pressure in clinic has been reported as 140-200/80 - 95 mmHg
- Cholesterol blood values 180 - 240 (nl)
- FEV1: 50 - 85% predicted (nl $\geq$ 80% predicted)
- ABG: pH 7.3- 7.4, pCO2 40 - 60, pO2 50 - 70 (values representative of severe COPD)

Her hospital discharge diagnosis was Vancomycin-resistant enterococcus pneumonia: a 7-day hospital course; two cultures were negative before discharge. MMSE on admission was 13/30 with use of interpreter. Medications are amlodipine 4 times daily; simvastatin; albuterol inhaler -- 2 puffs 4 times daily or as needed; ipratropium inhaler -- 2 puffs 4 times daily; prednisone 20 mg once in the morning X 10 days; antibiotic.

Mrs. Trang's lungs sound clear. Her temperature is normal and there is no shortness of breath. Her blood pressure is 180/95. Before the examination is concluded, Lillian confesses that she has a hard time getting her mother to take her medications. Mrs. Trang believes that, at best, Western medicine doesn't do any good and, at worst, may be harmful. She prefers alternatives, especially herbal medicines from Vietnam.

TASK: It is now team rounds and time to develop a plan of care for Mrs. Trang.

Faculty Information Only: Mrs. Lin Trang

TEACHING POINTS:

The purpose of this case is to help team members:
critically examine, from the perspective of all professions on the team, their own notions on symptom self-care, particularly as it is shaped by cultural and family values.
work together efficiently to achieve an assessment and care plan that addresses the reasons for client noncompliance, appreciate client beliefs about self care, and incorporate patient and family values in negotiating a plan and goals that the patient and family will follow.

1. What is the overarching goal?

Patient: Appears to want to maintain symptom self-care through traditional Vietnamese medicines.
Family: Daughter appears to want her mother to be compliant with the prescribed conventional medications and to support her mother at home.
Team: To develop a health care plan that 1) maintains the patient in a safe environment and promotes patient self-care, 2) motivates the patient to be compliant with the prescribed regimen, and 3) respects the client's cultural and family traditions.

2. Patient's problems:

a. Noncompliance — failure to take prescribed medications; cultural attitudes appear to make patient resistant to the prescribed treatment.
b. Public health hazard — tends to remain at home, with family; not often in public
c. Safety issues — older house may present safety problems.
d. Safety issues — lack of adequate supervision.
e. Family dynamics may make for a social environment not conducive to care; social resources may be overtaxed.
f. Medical records are incomplete — nursing home admission is recommended.
g. Possible financial problems may prevent purchase of needed medications, maintenance of safe environment.
h. Differences in culture and language may lead to overall problems in communication of information, mistrust, and values conflicts; these may also make determination of decisional capacity difficult.

3. What is the impact of each problem on the patient's health and quality of life?

The patient's continued noncompliance (medications) may adversely affect her health as well as expose others to Vancomycin-resistant enterococcus pneumonia. Lack of supervision and an unsafe physical environment may also place her in harm's way. On the other had, if the client is decisionally capable, she has a right to give/withdraw consent. However, a care plan that respects her cultural values and traditions while meeting her medical needs may enhance her compliance.

4. What strengths and resources does the patient have for addressing each problem?

The patient appears motivated to medical self-care, although from a different cultural perspective. Her daughter is concerned about her care and family values appear to be supportive; several family members live within same household and may be available to help with supervision, although other issues such as financial needs and generational differences, may drain family resources. As a member of an ethnic group that has recently immigrated to the United States, the patient may also have a tight knit community and benevolent societies upon which to draw.

5. What additional information is needed?

Mrs. Trang's medical records are incomplete and it is unclear why it was recommended that she seek admission to a nursing home. Her decisional capacity needs to be assessed now that she is no longer acutely ill. Mrs. Trang's own interpretation of her illness and her willingness to manage her symptoms are not known, other than from a brief comment by her daughter. There is little information on the family system and its resources — emotional and financial — with which to help Mrs. Trang manage her medications and supervise her activities. We know little about the patient's physical environment and other safety issues when she is alone at home.

Little information is given on Mrs. Trang's personal attitudes toward medical care. It is important to discuss that the team should start with learning the individual's personal understanding and values, rather than stereotyping her with "cultural traditions." On the other hand, to the extent that cultural differences become apparent, the team might want to assess its own capacity/skills for dealing with this patient. Would she be better served through a community clinic that has links with the Hmong community and has, for example, Hmong social workers? Some clinics employ acupuncturists who work closely with physicians, nurses, and social workers from the community, and village elders (e.g., Community-University Health Care Center) Or, in working with the patient, the team might consider building support for the health care plan by engaging the assistance of a Hmong mutual assistance association. Many of these have respected community leaders and elders who are supportive of conventional as well as traditional approaches.

Terms:

Social Work:

Medical Assistance (MA). Minnesota federal/state program that pays acute and long-term health care costs of eligible persons. Since older adults are typically covered by Medicare, MA mainly pays for long-term care costs. Residents of nursing homes also receive personal needs allowance of $63 (April, 1997). Allowances are also made to allow non-institutionalized spouse retain specified monthly assets and monthly income

Hmong American Partnership for Information and Referral. Nonprofit agency that provides information and referral, family programs, and a crisis hotline.

Preadmission Screening (PAS). A county-administered program that evaluates a person's self-care abilities and resources to determine whether nursing home care is needed. Required for all Minnesota nursing home applicants. See also *Alternative Care Grant.*

Refugee Medical Assistance. Refugees who do not qualify for the state medical assistance program may qualify for Refugee Medical Assistance (administered by county economic assistance offices).

See also Financial Assistance Glossary

6. **Plan of care:** See Plan of Care Attachment.

7. **Expected outcomes:**

   Patient to remain at home following health care regimen that includes both conventional and alternative medications; supervision to be shared by family, especially the three daughters, with emergency assistance from neighbors; if functional status warrants, home stay supplemented by adult day care.

Plan of Care Attachment -- Complex Case #10: Mrs. Lin Trang

Problems	Suggestions/ Interventions
Incomplete records	• general physical and multidimensional assessment, using daughter as translator.
Noncompliance with medications/health care plan	• determine patient's decisional capacity barriers towards noncompliance (i.e., impairments, complexity, financial, relationships with providers), patient's attitudes towards the prescribed medications, her understanding of her illness and symptoms, attitudes towards self-care and traditional remedies. • explore use of other supports such as Hmong social worker/community elder to support an approach that draws on both western and alternative care. • evaluate interaction among conventional and natural medicines/herbs that might be part of a care plan. • determine need for support and management of medications/health care plan; those in family who might help.
Safety issues	• negotiate plan with patient and family. • evaluate home for potential safety problems; check out potential home maintenance aid, if problems. • assess and help family negotiate responsibilities for supervision.
Financial issues	• assess financial needs; if necessary explore sources of financial aid, particularly as might relate to alternative medications not covered by traditional programs. • explore possibility of Alternative Care Grant, especially regarding potential for assistance with day care.
Social issues	• family dynamics, stress, and problems with children — refer to Hmong mutual assistance programs for support intervention.

Complex Case #11: Ms. Tonita Brown

Ms. Tonita Brown is a 79-year- old African-American woman. She is a new patient in your clinic today. Ms. Brown used to live in New York but decided to move to Minneapolis to live with her son and his family. Her major concerns are getting a refill of her Halcion and finding a new doctor. She hasn't been able to sleep since she arrived in Minneapolis. She brought in her bag of medications and as you quickly look at these medications, you see that they are from different doctors, cities, and pharmacies. Her medical conditions listed on Dr. Tippert's 1996 medical report were:

- osteoarthritis
- hypertension
- gastritis
- COPD
- insomnia
- anxiety disorder

Medications

Drug/Dose	Doctor	Pharmacy
Relafen/1 gm q am	Dr. Fran	New York Pharm A
Maalox TC/1 tbsp as needed		Over the counter
HCTZ/25 mg bid	Dr. Tippert	New York Pharm A
Enalapril/5 mg bid	Dr. Tippert	New York Pharm A
Atenolol/40 mg qam	Dr. Fran	New York Pharm B
Baby aspirin/1 qam		Over the counter
Tagamet		Over the counter
Triazolam/0/125 mg as needed	Dr. Fran	New York Pharm B
Halcion/0/125 mg as needed	Dr. Tippert	New York Pharm A
Zantac/150 mg bid	Dr. Fran	New York Pharm B
Albuterol inhaler/2 puffs as needed	Dr. Tippert	New York Pharm A
Ipratropium inhaler/2 puffs 4 times daily	Dr. Tippert	New York Pharm B

The Halcion and triazolam bottles are empty. Most of the other bottles have about 5 - 10 pills in each. One bottle has white, yellow, and blue pills. Most of the dates on the bottles and inhalers expired over a month ago.

After recording all the medication information, you gave Ms. Brown back her medication bag. When Ms. Brown put her brown bag back into her purse, some other prescription bottles fell onto the floor. You asked Ms. Brown if you could see them, which she reluctantly agreed to. These were the medications in the additional bottles:

Additional Medications

Drug/Dose	Doctor	Pharmacy
Halcion/0/25 mg as needed	Dr. Tuggs	Local ER hospital pharm
Advil/200 mg		Over the counter
Triazolam/0.125 mg (Upjohn)	Dr. Bridge	New York ER hosp pharm

The Halcion and Triazolam bottles were 1/4 full. She states she takes her medications as ordered.

Review of Symptoms

unhappy with the generic Triazolam prescription and wants a Halcion prescription.
stated she is a very sick woman and will die if she doesn't get more Halcion, only thing that really helps her breathe.
walks about one-half block before she stops due to leg pain or shortness of breath, no walking assistance devices.
smokes 1 - 2 packs per day, 80 packs per year history.
spicy foods bother her stomach, OK if takes a Tagamet or Zantac, or both, before dinner.
wakes up 2 - 3 times a night if she forgets her Halcion, the real stuff. If she takes her Halcion she can sleep through the night.
takes a Halcion about 1 -2 times during the day if she gets short of breath.

Physical Exam

Weight: 50 kg Height: 5'5"
BP: 180/95 mmHg RR: 24 Pulse: 72 Temp 98.0
Gen: Restless woman breathing rapidly with minimal eye contact
HEENT: Pupils equal and reactive to light
Chest: diminished breath sounds throughout
Cardiac: regular rate and rhythm
Abdomen: soft, nontender, bowel sounds present, no masses
Extremities: stiff joints, decreased range of mobility with right knee, pain with flexion of left hip
Neuro: cranial nerves grossly intact
GU: deferred

Activities of Daily Living (ADLs)

intact

Instrumental Activities of Daily Living (IADLs)

Family does shopping, she doesn't drive, helps with some home maintenance.

Advanced Directives

None at this time, never thought about it or discussed it with a health provider.

Post-First Visit Plan

You decided to refill her blood pressure and COPD medications. She is to meet with the social worker in 3 days and return to clinic in 2 weeks. She is scheduled for next week's GITT evaluation.

Social Worker Visit

Ms. Brown would always agree to attend support groups for anxiety but never showed up. She knew with aging one's sleep needs decrease. Dr. Tippert had tried other anxiety medications but Ms. Brown said only Halcion worked. He kept her on the Halcion as needed for days with difficulty breathing. Since she only asked Dr. Tippert for the Halcion prescription renewal every 3 - 4 months he did not suspect abuse. Outside of a hospital admission every 12 - 18 months for pneumonia, she always seemed to be doing OK. Blood pressure was high sometimes. She came to clinic when she wanted, usually failing to show for her planned visits. She used the urgent care center quite frequently.

Dr. Fran did not know the patient was seeing another doctor for anxiety problems. Ms. Brown had exasperated her. They didn't suspect benzodiazepine abuse but suspected some alcohol abuse. She refused treatment for alcohol abuse and they never followed up with the pharmacy in terms of compliance.

TASK: It is now team rounds and time to develop a plan of care for Ms. Brown before her next clinic visit.

Faculty Information Only: Ms. Tonita Brown

TEACHING POINTS:

This case has a need for all the health care team members, as it deals the issues of substance abuse problems, polypharmacy, medication adherence issues, and lack of information about medical issues, and medication management. Within this case, conflict exists between patient and health care team goals.

1. What is the overarching goal?

Patient: To continue to receive Halcion prescriptions.
Family: No involvement yet, thus, to be determined.
Team: Manage underlying medical conditions with the fewest medications possible and develop a long-term professional relationship with patient. Determine if substance abuse is still a problem after resolving medical problems.

2. Patient's problems:

Big ticket items: Evaluate medical problems and develop a care plan that will increase her quality of life, decrease urgency/emergency care visits, improve medication use, and resolve any substance abuse problems

3. What is the impact of each problem on the patient's health and quality of life?

With multiple care providers and pharmacies, the patient is at risk for medication adverse reactions, drug interactions, and poor health. The financial considerations to her and society are substantial. Halcion can increase confusion and falls, which could lead to dependency. Patient is at risk for COPD exacerbation and infection.

4. What strengths and resources does the patient have for addressing each problem?

Currently lives independently within a larger family unit. Additional inquiry required to identify other strengths and resources.

5. What additional information is needed?

- Family perception of problems, evaluation of function, and mood.
- Family dynamics.
- Physical therapy evaluation to determine abilities and limitations with mobility and need for assistive devices.
- Further evaluation of alcohol abuse, perhaps neuro and/or psychosocial tests.
- Breathing evaluation such as pulmonary function testing.
- Evaluate inhaler technique.
- Identification of additional resources and strengths.
- Assess patient understanding of her medical conditions and medications.

6. Plan of care: See Plan of Care Attachment.

7. Expected outcomes:

- Establish positive relationship between client and health care team.
- Improve patient trust and loyalty to health care professionals and health system.
- Decrease need for benzodiazepine.
- Decrease alcohol intake.
- Cessation of smoking.
- Decrease number of medications, adverse effects, and drug interactions.
- Incorporate nonpharmacologic treatments for insomnia and anxiety.
- Improve medication compliance.
- Identify one pharmacy provider.
- Increase walking distance and decrease pain with walking.
- Improve breathing function.
- Control blood pressure .
- Establish advance directives

Plan of Care Attachment -- Complex Case #11: Ms. Tonita Brown

Problems	Suggestions/Interventions
Difficulty breathing	• obtain pulmonary function tests • obtain arterial blood gas • evaluate inhaler technique, re-educate if needed on inhaler technique • consider spacer for inhaler • improve compliance with ipratropium inhaler • use albuterol as needed for breathing difficulties versus Halcion • discontinue atenolol
Smoking cessation	• try nicotine patches, gum, or spray • enroll in a smoking cessation support group • provide educational materials on smoking cessation
Insomnia	• identify causes of insomnia • evaluate naps, food intake, habits, and sleep environment for alterations to improve sleep. • use albuterol as needed for breathing difficulties versus Halcion • wean off of Halcion after establishing a trusting relationship with patient • establish a sleep routine
Benzodiazepine addiction and potential alcohol abuse	• establish issues related to alcohol • enroll in a treatment program • wean off of Halcion after establishing a trusting relationship with patient and increasing control of breathing problems • identify support systems • increase friends/socialization outside of family. • assess cognitive function • assess for anxiety disorder versus anxiousness with shortness of breath
High blood pressure	• evaluate blood pressure medications including adherence to prescribed schedule • discontinue atenolol, disease interaction with COPD • change HCTZ 25 mg qd as effective as 50 mg with less side effects • increase enalapril as needed or switch to benazepril if lower cost • monitor weekly • develop a plan for follow-up of blood pressure control and medication adjustment • increase exercise, if possible • check for orthostatic blood pressure changes
Decreased mobility	• conduct a home safety assessment • stop medications associated with falling • physical therapy assessment for assistive devices and increased mobility • evaluate neighborhood for safety for a walking program
Osteoarthritis	• evaluate pain and limitations • try acetaminophen 650 mg 3 times daily to 4 times daily and wean off Relafen (may be causing gastritis) • re-evaluate pain and mobility and determine need for Relafen in future • exercise program to increase muscle strength • evaluate need for assistive aids
Gastritis	• evaluate triggers for and severity of gastritis • determine relationship to Relafen • switch Relafen to regularly scheduled acetaminophen • if Relafen needed take with food, consider misoprostol or H2 blocker • take baby aspirin with a full glass of fluids

Problems	Suggestions/Interventions
Medication compliance	• decrease number of medications (potentials Halcion, atenolol, Relafen, Advil, Tagamet or Zantac) • educate about medications and importance of compliance • establish one pharmacy provider • use a pill box or some type of compliance aid • keep medications out of reach of children • bottle of ipecac and poison center number • evaluate use of over the counter medications • encourage Ms. Brown to discuss over-the-counter medications with a health care provider • determine if financial issues exist with payment for medications
Health care team relationships	• listen to patient needs • show compassion and caring • frequently assess relationship • adequate clinic visits and time
Family relationships	• determine safe, positive home environment • engage family in patient's care
Advance directives	• establish advance directives when a positive relationship has been established

Glossary Of Social Work Terms

GERIATRIC INTERDISCIPLINARY TEAM TRAINING

Note: *The following terms are based on the state and local rules, regulations, and programs available to the Minnesota GITT Program. Faculty should be aware of similar terms and programs in their area and edit this list as appropriate for the cases and the local context.*

Adult Day Care (ADC). A program of social, recreational, and health activities and services in a group setting. Some programs offer extended and/or weekend hours and provide transportation, usually for an additional fee. Health monitoring, nursing care, and personal care assistance are also offered at some centers. ADCs that serve more than five participants must be licensed by the Minnesota Department of Health and the Department of Human Services.

Adult Foster Care/Home Plus. Single-family homes or other living arrangements that provide a place to live as well as assistance with Activities of Daily Living to older adults. Providers are licensed by the Minnesota Department of Human Services for up to five persons.

Adult Protection Services (APS). County units that, under the Vulnerable Adult Reporting Law, are responsible for investigating reports of abuse and neglect of vulnerable adults (18 years or older) and for providing services such as home nursing, homemakers, money management counseling, legal aid, guardianships. In Ramsey and Hennepin counties, APS serves as a Common Entry Point (CEP) for vulnerable adult maltreatment reports. APS collects the information, screens, and dispatches for protective services, as appropriate. See V*ulnerable Adult*, *Maltreatment*, *Mandatory Reporting*.

Advance Care Planning. The process of considering and communicating treatment preferences for end-of-life care that precedes and may lead to an advance directive.

Advance Directives. Directions that people give about the kind of health care they wish to have or not have if they lose the ability to make decisions for themselves. Advance directives include living wills, durable power of attorney for health care, and informal advance directives.

Alcoholics Anonymous. A 12-step program to help recovering alcoholics maintain sobriety.

Alcoholism, Late/Early Onset. Although alcoholism begins at a younger age for most seniors, about one-third has late onset alcoholism. This type, thought to develop in response to stress/loss, is more responsive to treatment.

Alternative Care Grants (ACG). County-run programs financed by federal, state, and county funds for persons 65 years and older who, through preadmission screening, are determined to require services in order to remain in the community and not enter a nursing home. Eligibility includes being a current Medical Assistance (MA) beneficiary or being eligible for MA within 180 days of entering a nursing home. Services include case management, home health aide, homemaker, adult day care, adult foster care, personal care, respite care, and equipment. See *Preadmission Screening*.

Alzheimer's Association. A support association for families who have a member with Alzheimer's disease. Services include education and training, caregiver, and family support groups.

Assisted Living Facility (ALF). Offers residents an independent living option, while providing services and support with daily living activities. In Minnesota, ALFs may be comprehensive, offering a continuum of care; or they may provide a menu of services to be purchased. Services may include laundry, meals, housekeeping, personal care/nurse, emergency response, transportation, and social activities.

Boarding Care. Provides a lower level of care than a nursing home. Services may be limited to room, meals, laundry, personal care services, supervision, administration of medications, and a program of social and recreational activities. Medicare does not pay for boarding care homes. Must be licensed if serving more than five persons.

Board and Lodging. There are two types. *Board and Lodging only* includes a room, three daily meals, and linens. Must be licensed if it serves five or more people; operates on a month-to-month lease. *Board and Lodging with Special Services* includes the above but also offers assistance with social services and/or health supervision. Must be licensed.

Chemical Health Seniors Project. Programs in both Hennepin and Ramsey Counties that provide support, such as outreach, support groups, I&R, to seniors with chemical health problems.

Congregate Housing. Housing that provides meals and some supportive services to residents who are 62 years of age and older and/or disabled. Usually involves a high-rise setting.

Conservatorship. See *Guardianship.*

Deafness, Education and Advocacy Foundation. Private foundation that provides adult educational programming, phone relay services, advocacy, and information and referral services. Services are free.

Decision-making Capacity. Term referring to a person's ability to make decisions in a general rather than legal sense. Involves the evaluation of a person's capacity in three distinct areas: understanding, communicating, evaluating.

Durable Power of Attorney (DPA). A legal document that gives competent adults the ability to choose a person to act on their behalf in property or business transactions. The adult can specify the transactions or powers that he/she is vesting in the DPA.

Durable Power of Attorney for Health Care (DPAHC). A legal document that gives competent adults the ability to choose a person to act on their behalf in medical matters if they become incapacitated or unable to make their own health care decisions.

Emergency Life Line. A type of emergency alert system linking a client to a central emergency response system.

Energy Assistance. A program for households with incomes at or below 135% of federal poverty guidelines. Provides financial assistance for energy bills as well as for energy-related emergency repairs. Referrals are made to the Minnesota Department of Energy Weatherization Program.

Exploitation. *See Maltreatment.*

First Call for Help. A directory of community social services published periodically by the United Way. The agency descriptions include address, phone, intake information, fee structure, and services provided. The directory is arranged by subject matter and title of agency.

Food Stamps (FS). Low-income persons receive coupons or electronic benefit transfers (EBT) to purchase food. Eligibility based on household income that is within 160% of federal poverty guidelines for older adults.

Foster Grandparents Program. Persons 60 years of age and over meeting income requirements are trained to provide companionship and services to children in state institutions, residential centers, in-home placements, etc.

Genogram. Describes family systems by diagramming family structure and relationships.

Guardianship or Conservatorship. An appointee is vested by the court with the power to make decisions for someone who is incapacitated/unable to make personal and/or financial decisions. Under Minnesota law, guardianship and conservatorship are similar. In general, conservatorship tends to be preferred, since guardianship more severely limits a person's rights. It is possible to nominate a conservator prior to incapacity by completing and signing a written document witnessed by two persons.

Home-Delivered Meals. Programs, such as Meals on Wheels, providing hot meals in the home to homebound persons (special diets often available). Some programs are free; others vary in price from $2.50 to $3.50.

Incompetence. Term referring to the legal status of a person who, based on evidence presented in court, has been declared incapable of managing his/her affairs.

Licensed Social Worker (LSW). A social worker with a BSW degree who has passed the Board of Social Work basic competency examination. Persons must be licensed to practice social work in Minnesota (except for designated settings such as county and state agencies).

Licensed Independent Clinical Social Worker (LICSW). A social worker with an MSW degree and at least 2 years of supervised clinical practice who has passed the Board of Social Work clinical examination. Medicare and other insurance programs may authorize clinical social workers as primary providers, allowing them to independently claim reimbursements.

Licensed Independent Social Worker (LISW). A social worker with an MSW degree and at least 2 years of supervised generalist practice who has passed the Board of Social Work advanced examination.

Licensed Graduate Social Worker (LGSW). A social worker with an MSW degree who has passed the Board of Social Work intermediate level examination.

Lifeline. A type of emergency alert system linking a client to a central emergency response system.

Living Will. An advance directive (legal document) that specifies the medical treatment one wishes/not wishes to have initiated, continued, or discontinued when one is in a terminal condition.

Maltreatment. Minnesota law identifies three categories of maltreatment: *Abuse* indicates assault; criminal sexual conduct; conduct producing pain or injury (e.g., physical abuse, hitting, slapping, kicking, involuntary confinement, deprivation); use of drugs to injure or facilitate a crime; promotion of prostitution; staff-patient sexual contact unless there was a pre-existing consensual sexual relationship. *Neglect* includes failure to provide for basic needs (e.g., food, shelter, health care supervision), either by the caregiver or the vulnerable adult. *Financial exploitation* involves the unauthorized expenditure or the failure to expend a vulnerable adult's resources resulting in detriment to the vulnerable adult. In the absence of legal authority it involves the willful use, withholding of, or disposal of a vulnerable adult's funds, or obtaining control of a vulnerable adult's funds by fraud, coercion, harassment. See also *Vulnerable Adult*.

Mandatory Reporting. Health care professionals are mandated reporters and must report when they have reason to believe a vulnerable adult is being or has been maltreated; or have knowledge that a vulnerable adult has sustained a physical injury that is not reasonably explained. They must make an oral report to the Common Entry Point (CEP). The CEP varies from county to county. In Hennepin and Ramsey counties, the CEP is Adult Protection Services.

Medicare, Part A. Hospital insurance benefits for those eligible for the Social Security or Railroad Retirement programs. Pays for acute care and rehabilitative care. Deductibles and copays may be covered for low-income elderly by the Qualified Medicare Beneficiary (QMB) program. See *Qualified Medicare Beneficiary (QMB)*.

Medicare, Part B. Medical insurance coverage available for a monthly premium to those eligible for Social Security or Railroad Retirement programs. Premiums and copays may be covered for low-income elderly by *Service Limited Medicare Beneficiary (SLMB)* program. See *Service Limited Medicare Beneficiary (SLMB)*.

Medical Assistance (MA). Federal/state program that pays acute and long-term health care costs of eligible persons. Since older adults are typically covered by Medicare, MA mainly pays for long-term care costs. Residents of nursing homes also receive a personal needs allowance of $63 (April, 1997). The program allows the non-institutionalized spouse to retain specified monthly assets and monthly income.

Medigap Insurance. Private insurance plans available for covering part or all of the costs of deductibles and copays for Medicare. For low-income groups, deductibles and copays may be covered by public programs. See *Qualified Medicare/Beneficiary and Service, Limited Medicare Beneficiary*.

Metro Mobility. Provides door-to-door transportation for persons with disabilities, using accessible and nonaccessible vehicles. Fees vary; rider certification is required.

Minnesota Supplemental Aid (MSA). Stated-funded monthly cash assistance for persons who are 65 years or older, blind, or permanently disabled. Individuals with SSI and MSA may receive up to $545/mo (April, 1997). Income and assets test. Administered by county economic assistance offices. See also *Supplemental Security Income (SSI)*.

Ombudsman, State Office. State office that is responsible for complaint investigation and resolution, mediation, and advocacy for nursing/boarding home residents, as well as Medicare beneficiaries using hospital services.

Preadmission Screening (PAS). A county-administered program that evaluates a person's self-care abilities and resources to determine whether nursing home care is needed. Required for all Minnesota nursing home applicants. See also *Alternative Care Grant*.

Qualified Medicare Beneficiary (QMB). Elderly/disabled who are within 120% of federal poverty guidelines and who have limited assets are eligible for payments of Medicare Part A premiums, deductibles, and co-insurance. Administered by county economic assistance offices.

Refugee Medical Assistance. Refugees who do not qualify for the State Medical assistance program may qualify for Refugee Medical Assistance (Administered by county economic assistance offices).

Representative Payee. Programs administered by federal agencies such as Social Security, Civil Service Retirement, and Veterans Benefits, can designate a representative payee to receive benefits on behalf of a person who is determined by the agency to be incapable of managing the benefit. This action is usually initiated by someone who believes a person is no longer able to manage his/her affairs.

Retired Senior Volunteer Program (RSVP). A program that provides persons 60 years of age or older with opportunities for volunteer services in service organizations and day-care settings (administered by Senior Resources).

Rule 36 Facilities. Group homes for persons with serious and persistent mental illness (SPMI). Behavioral approaches are often used when working with the residents.

Senior Companion Program. Low-income companions over the age of 60 years receive a stipend to visit older adults to provide socialization.

Senior Center. A gathering place for seniors, often serving congregate meals, as well as providing recreational senior, social, and educational programs.

Senior Partners Care. A health care program for seniors who are not eligible for Medical Assistance but cannot afford supplemental insurance. No monthly charges, premiums, co-pays, or deductibles. See *Qualified Medicare Beneficiary* and *Service Limited Medicare Beneficiary.*

Service Limited Medicare Beneficiary (SLMB). A program that pays premiums for Medicare Part B; it is limited to people enrolled in Part A and enrolled or eligible for Part B. Targeted to those 120% or less of federal poverty guidelines. Administered by county economic assistance offices.

Services for the Blind. Agency that serves (e.g., vocational rehabilitation, talking books, Braille State instruction, counseling) persons who are blind or have failing vision that limits their ability to do work, housework, live independently, attend school, or read. Services are free.

Senior Linkage Line. A toll-free, statewide information and referral system that links callers with local information and referral units for assistance on community services. (1-800-333-2433).

Share-a-Home. A program that matches senior homeowners with persons who can help with household duties for reduced or free rent.

State Services for the Blind. Agency that serves (e.g. vocational rehabilitation, talking books, Braille instruction, counseling) persons who are blind or have failing vision. The failing vision must limit the ability to do work, housework, live independently, attend school, or read. Services are free.

Subsidized Senior Housing. Includes public housing and privately owned apartment buildings developed with federal funding. Most housing requires applicants to be 62 years of age or older or to be handicapped/disabled. Residents are required to pay about one-third of their income toward rent. There are often long waiting lists.

Substance Abuse. The DSM-IV term applying to alcoholism that includes: 1) continued use (despite having persistent or recurrent social or interpersonal problems) caused/exacerbated by the substance, or recurrent use in situations that are physically hazardous; and 2) symptoms of the disturbance which have persisted for at least 1 month or have occurred repeatedly over a long period of time.

Supplemental Security Income (SSI). Individuals who have permanent disabilities, are blind, or age 65 years and over may receive federally funded assistance if they meet income and assets test. Maximum grant for a qualified individual is $484/month (April, 1997). Administered by county economic assistance offices. *See also Minnesota Supplemental Aid (MSA)*.

Telephone Reassurance. A program that provides daily/periodic telephone checks with persons living alone. There are several in the Twin Cities metro area, including programs by Abbot-Northwestern Hospital, Senior Resources.

Vulnerable Adult (VA). Vulnerable adults are persons, 18 years of age or older, who fall into one of two types: *categorical* VAs are facility residents, recipients of services from licensed facilities, recipients of licensed home health care services, or of care from MA-funded personal care attendants; *functional* refers to adults with a physical, mental, or emotional infirmity that impairs care for basic needs and impairs ability to protect self from maltreatment.

Social Work Glossary

List of Applicable Terms by Case

CASE 1: Mrs. Emma Cook

Adult Day Care (ADC)

Advance Care Planning

Advance Directives

Congregate Housing

Durable Power of Attorney (DPA)

Durable Power of Attorney for Health Care (DPAHC)

Emergency Life Line

Guardianship or Conservatorship

Home-delivered Meals

Living Will

Metro Mobility

Senior Center

Senior Companion Program

State Services for the Blind

CASE 2: Miss Bertha Larson

Advance Care Planning

Advance Directives

Decision-making Capacity

Durable Power of Attorney (DPA)

Guardianship or Conservatorship

Incompetence

Living Will

CASE 3: Mr. Jim Rich

Alcoholics Anonymous

Alcoholism, Late/Early Onset

Chemical Health Seniors Project

Decision-making Capacity

Genogram

Incompetence

CASE 4: Mrs. Rose Carmine

Abuse

Adult Day Care (ADC)

Adult Foster Care/Home Plus

Adult Protection Services (APS)

Energy Assistance

Food Stamps (FS)

Maltreatment

Medical Assistance (MA)

Medicare, Part A

Medicare, Part B

Qualified Medicare Beneficiary (QMB)

Service Limited Medicare Beneficiary (SLMB)

Substance Abuse

Supplemental Security Income (SSI)

Vulnerable Adult (VA)

CASE 5: Mrs. Gertie Treat

Adult Protection Services (APS)

Advance Care Planning

Advance Directives

Durable Power of Attorney (DPA)

Durable Power of Attorney for Health Care (DPAHC)

Guardianship or Conservatorship

Living Will

CASE 6: Ms. Clara Germaine

Services for the Blind

CASE 7: Mr. Roger Anderson

Alternative Care Grants (ACG)

Alzheimer's Association

Energy Assistance

Food Stamps (FS)

Medical Assistance (MA)

Medicare, Part A

Medicare, Part B

Qualified Medicare Beneficiary (QMB)

Service Limited Medicare Beneficiary (SLMB)

Supplemental Security Income (SSI)

CASE 8: Mrs. Josie Wells

Alzheimer's Association

Deafness, Education and Advocacy Foundation

Life Line

Metro Mobility

Senior Center

Senior Companion Program

Services for the Blind

Substance Abuse

CASE 9: Mrs. Betsy Jones

Adult Day Care (ADC)

Alternative Care Grants (ACG)

Energy Assistance

Food Stamps (FS)

Genogram

Medical Assistance (MA)

Medicare, Part A

Medicare, Part B

Qualified Medicare Beneficiary (QMB)

Senior Center

Service Limited Medicare Beneficiary (SLMB)

Supplemental Security Income (SSI)

CASE 10: Mrs. Lin Trang

Energy Assistance

Food Stamps (FS)

Medical Assistance (MA)

Medicare, Part A

Medicare, Part B

Preadmission Screening (PAS)

Qualified Medicare Beneficiary (QMB)

Refugee Medical Assistance

Service Limited Medicare Beneficiary (SLMB)

Supplemental Security Income (SSI)

<u>CASE 11: Ms. Tonita Brown</u>

Chemical Health Seniors Project

Incompetence

Rule 36 Facilities

Senior Center

Glossary For Medical Issues[9]

GERIATRIC INTERDISCIPLINARY TEAM TRAINING

Mini Mental State Exam (MMSE). A widely used mental status screening exam. It is useful in quantitatively estimating the severity of cognitive impairment, but is not intended to provide a diagnosis. The exam includes orientation questions, registration and recall of three words, attention and calculation testing, and testing of language skills.

Scores on the MMSE range from 0 (most impaired) to 30 (intact). Generally, MMSE scores are used to classify the severity of cognitive impairment into levels:

24 (or 25)-30 as cognitively intact
18-23 as mildly impaired
11-18 as moderately impaired
0-11 as severely impaired.

CASE 1: Mrs. Emma Cook

Geriatric Depression Scale (GDS). A screening tool developed specifically for use in the elderly. Other depression scales often included somatic complaints that skewed data in elderly who had these complaints as a part of other chronic diseases. The GDS long form contains 30 items and the short form has 15 items. The tool is written in a simple Yes/No format, which makes it possible to use even in individuals with some cognitive impairment.

Scores on the GDS long form range from 0 (not depressed) to 30 (severely depressed). A point is given for each response that matches the “yes” or “no” highlighted after the question. A score of 10 or 11 is usually considered the threshold to separate patients into depressed and non-depressed groups. Scores on the GDS short form range from 0 to 15. (See attached form, page 5). Scores of 1-5 points are considered normal (not depressed), 6-10 points are mild to moderate depression, and 11-15 points are very depressed.

3/6 systolic ejection murmur: Systolic ejection murmurs are actually quite common in the elderly. The 3/6 means that this is a rather loud murmur and can be associated with congestive heart failure.

Fine rales at bases means that there are lung sounds indicative of fluid in the lower part of the lungs on both sides. These sounds can mean several things but are commonly associated with congestive heart failure or pneumonia.

Hepatojugular reflux is another indication of excess fluid, a sign of congestive heart failure

HgbA1C is a lab test used to determine how elevated the blood sugar has been over a longer period of time. A result of 11% indicates that this patient’s blood sugar has been very poorly controlled.

Jugulovenous distension means that the patient’s neck veins are distended, indicating some excess fluid, another sign of congestive heart failure.

Mean Blood Glucose of 280 to 300 indicates that the average blood sugars for this patient are fairly high. The normal blood sugar range is 70 to 150 for elders. Even in elderly persons with diabetes, you would want to try to achieve a mean blood glucose of 150 - 180.

Case 1 Summary: In general, these findings mean that this patient is not managing her diabetes very well, which puts her at risk for increased infections and increased confusion. Also, her congestive heart failure is not very well controlled, so she is going to have fairly poor endurance with activity.

CASE 2: Miss Bertha Larson

Subdural hematoma: This indicates a collection of blood beneath the dura mater (which is the outer membrane covering the brain). This like a bruise underneath the membrane that is just inside the skull. Large hematomas can cause pressure on the brain and increase confusion. They are sometimes evacuated (cleared out) in hopes of reversing a sudden change in mental status.

Case 2 Summary: There is no guarantee that evacuation of a subdural hematoma will necessarily ensure a return to previous status. It may be difficult to reasonably predict whether this patient will recover back to her baseline cognitive status after this procedure. If discussion gets caught up whether or not she could get back to her previous normal pleasantly demented state, you might want to point out this uncertainty and refocus back to patient wishes.

CASE 3: Mr. Jim Rich

Absence of toe hair: Again, this is a sign of poor circulation to the feet.

Diminished distal pulses: This means that the pulses in his feet are more difficult to feel. This is a sign of poor circulation to the feet and is a common finding in chronic smokers.

Mild rubor: This means a discoloration or redness of the area. In this case, another sign that this man has vascular problems to his remaining foot.

Case 3 Summary: These exam findings should lead a GNP/MD to be concerned about the future of skin breakdown and the risk for infection in this patient's remaining foot. Routine foot exams and appropriate referrals to podiatry for nail care should be part of the care plan.

CASE 4: Mrs. Rose Carmine

BP 188/98 is a high blood pressure reading. It is important that the students not dismiss this as a single reading that's unimportant. She has a history of hypertension and has two medications prescribed that should help lower blood pressure. Since the daughter indicates that getting her to take medications is extremely difficult, the students should not try to add new drugs to her list without some determination of where her BP would be if she takes the ones prescribed currently. Simplifying the medications to the least possible would help a patient like this. They should include some routine monitoring of her BP.

1+ pitting edema means that she has swollen feet. It can be another sign of congestive heart failure but it can also be a sign of poor venous return of fluid in elders. Usually compression stockings (TED hose) are recommended.

***See Case 1** for the description of the **systolic ejection murmur**, **jugulovenous distension,** and **hepatojugular reflux**. These are signs of congestive heart failure.

CASE 5: Mrs. Gertie Treat

Aspirated means that she took fluids or foods into her lungs.

CASE 6: Ms. Clara Germaine

Rule 36 Facilities. See social work glossary

CASE 7: Mr. Roger Anderson

No applicable terms

CASE 8: Mrs. Josie Wells

CP. Abbreviation for chest pain.

Blood pressure: 160/80 would be considered borderline systolic hypertension. A mild increase in her Vasotec, (or even in the diuretic, Lasix) might easily get this under better control.

No rales, rhonchi, or wheezes essentially means that there were no sounds in the lungs that would make you suspicious of extra fluid or congestion in her lungs.

3/6 SEM best heard at both the RUSB and LLSB means she has a moderately loud systolic ejection murmur (a common heart murmur in elderly), that is best heard along either side of her sternum.

Occasional ectopy. Occasional irregularity of the heart rhythm.

No S3 or S4: S1, S2, S3, and S4 are heart sounds. S1 and S2 are the most distinct sounds (that normal lubb, dubb). S3 and S4 may or may not be present. It is considered a normal finding not to hear S3 and S4.

Hbg 11.2, Hct 33.0 means the hemoglobin is 11.2 and the hematocrit is 33.0. These tests are done to check for anemia. These levels are at the low end of normal for women.

Fasting serum glucose 312: This is a high blood sugar. In elderly patients with diabetes, it is important to try to keep blood sugars in the 110 to 180 range.

Hbg A1C: is a lab test used to determine how elevated the blood sugars has been over a longer period of time. A result of 11% indicates that this patient's blood sugar has been very poorly controlled.

Case 9: Mrs. Betsy Jones

MS. . . no increased warmth: MS is the abbreviation for the musculoskeletal part of the exam. The "no increased warmth" appears to be referring to the patient's knees, which are enlarged. Increased warmth often indicates an acute inflammatory process.

Case 10: Mrs. Lin Trang

Forced expiratory volume in 1 second (FEV1). A test that is used to determine pulmonary (lung) function.

Arterial blood gases (ABG). Her pCO2 of 40 to 60 is an indication that she's retaining carbon dioxide, which is common in people with chronic lung disease.

CASE 11: Ms. Tonita Brown
No applicable terms