



Interprofessional Geriatric Case Competition Manual

Saint Louis University

Gateway Geriatric Education Center



Gateway Geriatric Education Center Project Team

Directors

John E. Morley, MB, BCh
Marla Berg-Weger, PhD, LCSW

Interprofessional Education

Milta O. Little, DO
Helen W. Lach, PhD, RN

Contributing Faculty:

Julia Henderson-Kalb, OTD, OTR/L
Kelley Hawthorne, PT, DPT, GSC
Jill Fitzgerald, PT, DPT, GCS, CEEAA, CSCS
Whitney Postman, PhD, CCC-SLP
Melissa Ramel, PhD, MS, RD
Susan Tebb, PhD
Cara Wallace, PhD, LMSW
Max Zubatsky, PhD, LMFT

Administrative Support:

Kathleen Leonard

Contact: aging.slu.edu

Acknowledgements

The Interprofessional Geriatric Case Competition was adapted by the Gateway Geriatric Education Center with permission from AT Still University's Case Collaboration program.

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1QHP28716 Geriatrics Workforce Enhancement Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Materials may be copied and used for educational purposes.

How to Use this Manual

Included in this manual is general information about planning and organizing an interprofessional Geriatric Case Competition (GCC) as well as handouts for participants, flyers, cases, sample slides, and evaluation materials.

Table of Contents

Introduction.....	4
GCC Planning Guide and Schedule.....	5
Recruitment Flyers.....	8
Sample Schedule.....	12
Participant Handouts.....	13
Evaluation Forms.....	22
Sample Cases.....	26



Introduction

The interprofessional Geriatric Case Competition brings together teams of health professions students to work together on a complex geriatric case. They attend an orientation and work together and with a faculty coach over one month to design and present a plan of care to address the issues from the patient case. An interprofessional panel of judges rates the presentations and prizes are awarded for best team presentations.

The goal of the case competition is to help students begin to develop competencies in geriatric interprofessional practice. The team approach is a hallmark of care in the fields of geriatrics and gerontology, providing the best outcomes for older patients and their care partners. Many older adults present to the health care system with complex conditions with intertwined medical, psychological, and social problems. These problems are best managed by a variety of health professionals, each with their own skills, expertise, and lens on the patient's care, working as a team. We hope this experience will pique students' interest in future work with this population, or at least gain appreciation of the complex nature of geriatric care. The Interprofessional Education Collaborative¹ (IPEC; 2016) identified the following core competencies for interprofessional teamwork, which serve as a framework for this educational activity:

1. Work with individuals of other professions to maintain a climate of mutual respect and shared values.
2. Use the knowledge of one's own role and that of other professions to appropriately assess and address the healthcare needs of patients and to promote and advance the health of populations.
3. Communicate with patients, families, communities and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.
4. Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.

1. Interprofessional Education Collaborative. Core Competencies for Interprofessional Collaborative Practice: 2016 update. Washington, DC: Interprofessional Education Collaborative, 2016.

GCC Planning and Schedule

Outline of Events

Ideally, planning a GCC should begin 3-5 months prior to the program start. This allows time to recruit students and faculty and make all the arrangements needed for a successful program. The GCC itself occurs in a little over a month. We found the fall semester to be a good time for the program, with students participating from late September till the end of October or early November.

Students

Students attend an orientation, work with their group on developing the team care plan, present their plan, and later attend a reception to announce winners. The target participants for the GCC are health professions students from any discipline. Many of these will be graduate students depending on the discipline, but upper-level undergraduate students can be successful participants. Students with some clinical experience may have the most to contribute to teams, but we have had students who are early in their training or in non-clinical disciplines, and levels up to doctoral students. Participants have included medicine, nursing, social work, physical therapy, occupational therapy, speech therapy, communication sciences, dentistry, biomedical engineering, public health, psychology, and medical family therapy. Attrition has occurred but has been minimal.

We recommend that you recruit student participants through all channels available including faculty in geriatrics and gerontology, program directors, newsletters, flyers and word of mouth. Students from any local schools may be recruited as desired. Student volunteers have enjoyed the GCC and given positive feedback, and nearly all have completed their participation. We do not recommend making the GCC required for students, unless it is a strong fit with their field of study or it is a mandatory part of the curriculum for all of the student participants. Building incentives into courses for students to participate has been successful, for example extra credit, credit for clinical hours, or offering participation as a replacement for a different assignment. We developed a video of student comments from the first competition that has been helpful when presenting in classes and at student events (see <https://www.youtube.com/watch?v=VIK9A54P-Yk&feature=youtu.be>)

Student presentations are 20 minutes, with accompanying slides. All team members are expected to take part in the presentation. After the presentation, there is a 10-minute question-and-answer period. Students do not attend other student presentations, although we have examples from prior years which can be reviewed on our web site at <https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/>

Faculty

Faculty volunteers participate in the GCC as coaches and/or judges for the final presentations. Each team is assigned a faculty coach who serves as a resource for the team. Ideally, faculty participants have training or an interest in geriatrics/gerontology and interprofessional teamwork. Faculty from any of the health professions and faculty from other institutions can be recruited. Faculty can serve as both coaches and judges but should not judge the team they coached.

Coaches typically attend the orientation and then assist their team based on student-initiated requests. Teams have been varied in their desire and need for coaches. Some teams want the coach to meet with them, others have not used the coaches at all. Coaches may be contacted for references or resources if the team needs these. We encourage coaches to review the team presentation and give tips for improvement, some meet with teams for a practice session. Coaching has not required a large investment of time in our experience. When we have a shortage of coaches, some faculty agree to coach 2 teams. Of note, we have included senior doctoral students who are in the field as coaches and judges, particularly if they participated as students earlier in their training.

GCC judges are asked to spend about 4 hours for evaluating presentations. We have conducted presentations in the evening from about 5-8 P.M. We provide a judge orientation on the case and scoring rubric. at 4:30 and have included a box dinner. Then judges are assigned to rooms to view and evaluate 3-4 team presentations (5 is possible but does fatigue judges). A list of students and their discipline and team is provided to judges. We strive to assign at least 4 judges of different disciplines to each room and are usually able to include 5 judges. At the end of the presentations, judges complete their evaluations, and rate the teams from high to low in case of a tie in scores. We have assigned a winner from each room for prizes, in case of judging differences, although we have found high similarities in scoring across judges. We typically record the team presentations with a lecture/capture software that is in our classrooms. This could be used to later compare winners to determine an overall winning team.

A reception is held a week later for all participants, to give out prizes and celebrate the student's work. We have provided snacks, given out awards and faculty and students mingle. This could be a time to get evaluations or student reflections and give some feedback to student groups. Some groups plan to go to dinner following the reception.

Cases

GCC cases are designed to be complex and include a broad range of issues that would be of interest to many health professions students. Topics include caregiving, elder abuse, and end-of-life and family issues; each with multiple medical, functional and psychosocial issues. The manual includes 4 sample cases developed or adapted from other sources. You can use these or develop your own cases. Other options can be found on the web, for example the Portal of Geriatrics Online Education

(<https://www.pogoe.org/>) or the National League for Nursing Advancing Care Excellence for Seniors (<http://www.nln.org/professional-development-programs/teaching-resources/ace-s>). The cases have background, family and social issues and excerpts or notes for different team members. The details for each are variable, and some redundant information is removed -so excerpts are not always exactly like what students would see in an actual patient record. Enough details are given to identify a variety of issues for the care plan.

Evaluation

We have used several methods for program evaluation. Students are asked to complete an evaluation form at the end of the program to provide feedback about the experience (see forms). This includes questions about the process, and questions related to the IPEC competencies noted earlier. Coaches and judges complete a similar evaluation from their perspective. Evaluation data is entered to a spreadsheet to compile results. An online evaluation that students could complete from their phones make increase the response rate. We did not initially examine changes in student perceptions from pre-post GCC. However, in the last GCC, we added a measure of confidence in interprofessional teamwork.¹

Supplies

Supplies needed for the GCC include handouts for students, coaches and judges. We have provided folders with materials. It is helpful to provide snacks and water for students for the orientation and presentation events as well as the reception. Box dinners are helpful for judges the night of the presentations. Classrooms are ideal for meetings and student presentations, as these usually have capability for projecting slides and recording sessions.

¹ Dow AW, Diaz Granados D, Mazmanian PE, Retchin SM. An exploratory study of an assessment tool derived from the competencies of the Interprofessional Education Collaborative. *Journal of Interprofessional Care*. 2014 28(4);299-304.

Planning Schedule

Timeframe	Activities
Pre-GCC	
3-5 months	<ul style="list-style-type: none"> • GCC Leaders meet to plan schedule • Secure rooms for orientation, presentation day, and reception • Identify contact/e-mail for students/faculty • Send flyers/information to faculty and sites to begin recruitment process (i.e. faculty who might build incentives into courses) • Send request for faculty coaches and judges
2 months	<ul style="list-style-type: none"> • Continue recruiting • Post/distribute flyers • Select/create case
1 month	<ul style="list-style-type: none"> • Continue recruiting as needed • Review and update materials
2 weeks	<ul style="list-style-type: none"> • Begin assigning students into groups
1 week	<ul style="list-style-type: none"> • Revise student groups • Send reminder e-mails to students and coaches • Compile packets for students/coaches
GCC	
Orientation	<ul style="list-style-type: none"> • Introduce competition • Break into teams for meet and greet • Teams meet coach and make plan for work
Team meetings	<ul style="list-style-type: none"> • Teams meet on their own • Coach serves as resource as determined by team needs/requests • Assign judges/rooms
Presentation day	<ul style="list-style-type: none"> • Judge orientation • Ensure that students know prior to this date that they may reserve space for rehearsal of presentation • Set up computers for slides and to record presentations • Student deliver presentations • Judges score and rate presentations • Plan to compile scores to determine winners
Reception	<ul style="list-style-type: none"> • Snacks • Collect student reflections • Announce winners and award prizes
Post GCC	
Evaluation	<ul style="list-style-type: none"> • Compile student, coach and judge evaluations • Compile brief feedback for teams • GCC leaders meet to debrief and plan future GCCs

Interprofessional Geriatric Case Competition

Flyers and Handouts





Sample Flyer (faculty/recruiting)

4th Annual 2018 Interprofessional Geriatric Case Competition

**Students from ALL health-related programs are
invited to participate**

Schedule:

Orientation: Monday, September 24, 2018, 5:00 PM
Presentations: Monday, October 29, 2017; 5:00 pm – 8:00 pm
Award Ceremony: Monday, November 5, 5:00 pm – 6:00 pm

Each student will:

- ✓ Collaborate with a team of 4-5 health professions students and a faculty mentor on a geriatric-based case focused on creation of a care plan for an older patient with multiple, chronic health challenges
- ✓ Create an innovative 20-minute electronic case presentation
- ✓ Compete against other teams for the opportunity to win prizes

Time frame:

- 1) 8/27/18 - 9/20/17, register for the case competition
- 2) By 9/21/18, receive team assignment
- 3) Orientation session at 5:00 pm on 9/24/17
- 4) Meet with team as needed to develop plan of care
- 5) Presentations beginning at 5:00 pm on 10/29/17
- 6) Awards Presentation /Reception at 5:00 pm on 11/05/2017

To register, email aging@slu.edu with:

- ✓ Your name, University, and email Address
- ✓ Discipline and year/program level

We will contact you by email with a confirmation and team assignment. Most activities will take place at the Saint Louis University Learning Resources Center on Caroline Mall.

Sample Flyer (students)

Opportunity for Health Professions Students

Students from ALL health-related programs
are invited to participate in the 2018



Interprofessional



Geriatric Case Competition

Each student will:

- ✓ Collaborate with a team of 4-5 health professions students
- ✓ Create a plan of care for a complex older patient with multiple, chronic health challenges
- ✓ Create an innovative 20-minute case presentation
- ✓ Compete against other teams for the opportunity to win prizes

Schedule of Events

Orientation: Monday, September 24, 2018, 5:00 PM

Presentations: Monday, October 29, 2018; 5:00 pm – 8:00 pm

Team meetings: Determined by the team

Award Ceremony: Monday, November 5, 2018 5:00 pm – 6:00 pm

To register, email aging@slu.edu with your name and
discipline/program and year.

Saint Louis University Gateway Geriatric Education Center

Interprofessional Geriatric Case Competition

2018

Sample Schedule of Events

Date/Time	Event/Location	Description
9/27/2018 5:00- PM	Orientation Learning Resources Center, Saint Louis University Rooms 112-113 3545 Vista Ave. St. Louis, MO 63104	Meet team and coach and get orientation.
10/24/2018 5:30 PM	Presentations Learning Resources Center ** Judges orientation – 4:45 Room 112	<i>Team Presentations</i> Sign in 30 minutes prior to presentation. Presentations Room 112: Team 1 5:30-6:00 Team 2 6:00-6:30 15-minute break Team 3 6:45-7:15 Team 4 7:15-7:45 Presentations Room 111: Team 4 5:30-6:30 Team 6 6:00-6:30 15-minute break Team 7 6:45-7:15 Team 8 7:15-7:45 Presentations Room 110: Team 9 5:30-6:00 Team 10 6:00-6:30 15-minute break Team 11 Team 12
11/2/2018 5:00 PM	Reception Allied Health Multipurpose Room 3437 Caroline Mall, Room 3040 St. Louis, MO	Winner will be announced, and prizes distributed. Light refreshments. Student groups may plan to go out after!

Interprofessional Geriatric Case Competition

Student Handout

Your team is about to take over the care of a complex geriatric patient. The details of the case are included in this packet.

Your task is to:

1. Create an interprofessional team to care for this patient that includes your team and other health professionals you deem needed.
 - Identify the roles and responsibilities of those who ideally should be involved
 - Plan for how you will ensure effective teamwork and communication among team members
 - Assure that you place the interests of the patient/family at the center of health team
2. Develop a comprehensive plan of care to address the patient/family geriatric problems
 - Conduct a case analysis and build a list of problems and/or differential diagnoses based on the materials provided
 - Develop potential interventions to address these problems
 - Identify community resources appropriate to the case
 - Identify how you will plan for quality improvement and patient safety
 - Describe how you would evaluate the outcomes of the plan of care
 - Use geriatric literature to support your plans (4-6 references expected)
 - Finances should be considered, but should not constrain the plan of care

During this orientation, you will learn about the competition and how it works, get schedules, meet your team and coach, review the case, and develop a plan for working together (see Program Planning Worksheet below).

The case includes:

- Background information on the patient and family
- Information that should suggest a variety of health professionals who may have taken part in this patient's assessment or would be helpful in providing care

You will present your plan of care to an interprofessional panel of faculty judges in one month who will evaluate your plan and presentation to evaluate how well you have developed as an interprofessional team. They will also assess the quality and depth of the plan, use of disciplines, and innovative ideas used to meet the needs of the patient/family. See the attached grading rubric for key points the judges will use to grade your presentation and plan of care.

A coach is assigned to your team who can assist you as needed in developing your plan of care. You will meet with the coach during orientation and we encourage at least one additional time or more as needed. Your coach can guide you to resources or references or answer questions. They may help you practice your presentation if you wish. Let your coach know what you need. You are also welcome to contact practitioners in the field or community resources to provide information as you develop your plan of care.

Team Presentations

Each team will have 20 minutes to present the results of their case analysis and their recommendations. Students will use slides to support the verbal presentation. The judges will be familiar with the case, so your team does not have to present too many details of the case before beginning the discussion of the case analysis and plan of care. You can see examples of presentations online, but your presentation should show originality- judges have seen the online presentations.

Key components of the plan will include:

- A brief case introduction and summary
- Goals for care
- Interventions and resources to help patient/family meet goals and needs
- Use of appropriate interprofessional team members to address needs
- Organized, readable, and professional visual aids

Teams are expected to complete their presentations within the timeframe. A silent 5-minute warning will be given to the team at the 15-minute mark. Each team member must participate in the oral presentation and the question and answer period immediately following the team presentation. Presentations will be followed by a 10-minute question and answer period with the judges. You will not be allowed to watch the other team presentations on the day of the competition.

Each judge will complete a scoring sheet for each team presentation. An average score will be calculated for each team. Teams will be provided with their team score and brief feedback after the results of the competition are compiled. Prizes will be awarded to winning teams.

NOTE: If a team member withdraws from your team, please contact your faculty coach right away to let them know.



Interprofessional Geriatric Case Competition

Student Project Planning Worksheet*

=

Group Member Assigned	Task	Due date for completing the task for the CCC to review
	Plan for communicating during project	<i>Orientation</i>
	Set up group -mail/chat	<i>Orientation</i>
	Set time for first group meeting	<i>Orientation</i>
	Introduce yourselves to your teammates and share about your discipline	<i>Orientation</i>
	Review the case and discuss one thing your discipline might do for this case based on what you have read	<i>Orientation</i>
	Assign tasks to team members	
	Perform research on assigned topics and writing it up for team members to review	
	Draft the PowerPoint presentation	
	Make sure everyone meets assigned deadlines for tasks.	
	Proofread and editing the Power Point	
	Submit the PowerPoint on date requested	
	Other:	
	Other:	

*Adapted from AT Still University

Interprofessional Geriatric Case Competition Grading Rubric

Date _____

Team # _____

Judge Initials _____

Content Area	Expectations	Score (Circle)	Comments
A. Described an interprofessional patient care <i>team</i> needed to provide patient-centered care in this case to meet patient/family needs, and communicated clearly professional roles and responsibilities	1. Identified an extended list of professions to contribute to this patient's care (nursing, physician/PA, OT, PT, SW, speech and language, etc.)	1 – 2 – 3 – 4 - 5	
	2. Described the expected role and contributions of each involved profession and addressed overlap of roles	1 – 2 – 3 – 4 - 5	
	3. Identified the patient and family as part of the care team; used humanistic language (e.g. referred to the patient by name versus "the patient"); case is patient-centered	1 – 2 – 3 – 4 - 5	
B. Developed a targeted plan of care that clearly illustrates how the interests of the patient/family are the center of interprofessional health care delivery (use knowledge of one's own role and other professionals to address healthcare needs)	1. Identified patient/family goals to guide the plan of care	1 – 2 – 3 – 4 - 5	
	2. Completed analysis of case and identified appropriate problems	1 – 2 – 3 – 4 - 5	
	3. Identified appropriate interventions and resources to address the patient's needs	1 – 2 – 3 – 4 - 5	

	4. Included patient/family education (address potential issues such as health literacy, cultural diversity, cognitive issues, etc.)	1 – 2 – 3 – 4 - 5	
	5. Presented potentially innovative ideas that could increase the quality of care delivery	1 – 2 – 3 – 4 - 5	
C. Described how the student team worked together and demonstrated effective interprofessional practice (IP) teamwork (climate of mutual respect, communication)	1. Identified and described IP team process used to develop plan (e.g. team meetings, communication, etc.)	1 – 2 – 3 – 4 - 5	
	2. Discussed reflections on the team process and lessons learned	1 – 2 – 3 – 4 - 5	
D. Presentation Skills	1. Effective and organized introduction and case summary	1 – 2 – 3 – 4 - 5	
	2. Organized, readable, and professional visual aids	1 – 2 – 3 – 4 - 5	
	3. Professional dress and manner	1 – 2 – 3 – 4 - 5	
	4. Appropriate eye contact, posture, and facial expressions with clear audible voices	1 – 2 – 3 – 4 - 5	
	5. All members of the team contributed to the presentation	1 – 2 – 3 – 4 - 5	
Team Total Score:			
Additional Comments:			

*Adapted from AT Still University

Interprofessional Geriatric Case Competition

Coach Handout

WHAT IS INVOLVED:

A coach is assigned to each student team to serve as a resource person to assist them in developing their plan of care and presentation for the case competition.

Key Points:

1. Coaches will attend the team orientation and meet with their teams to help them get started.
2. Coaches will encourage the team to develop a quick plan at the orientation of how they will function, how they will communicate with each other, etc.
3. Encourage team members to share their background and discipline and where they are in their training.
4. We encourage coaches to meet at least one additional time with their team, or additionally as mutually determined by the team and coach.
5. Teams should send their presentation draft to their coach, and if they wish, the coach can help them schedule a rehearsal.
6. The coach can assist the team by:
 - Encouraging them to set their first meeting
 - Keeping the team on track
 - Helping the team remain focused on the collaborative competencies
 - Advise the team regarding available resources (e.g. personal contacts, journal sources, books, individuals from other professions, etc.)
 - Encouraging the team to work together collaboratively
 - Helping teams set up a presentation rehearsal and offering feedback if they wish

It is important for Faculty coaches to allow students to do their own research, develop their own recommendations, and create their own presentation for the case competition.



Interprofessional Geriatric Case Competition

Judge Handout

WHAT IS INVOLVED:

Judges will view the student presentations, score the presentations using a standardized rubric, and provide feedback for student teams. Judges need to be available to attend student team presentations and hopefully, to attend the reception with teams the following week.

Key Points:

1. Review the case information provided.
2. A team of 4-5 students from different professions are asked to develop comprehensive, interprofessional plan of care for the patient in this case to care for this patient and plan for discharge back to the community. The team has one month to meet, work together, conduct research, and devise the plan of care they will present to you.
3. Their presentation should meet the criteria laid out in the case Grading Rubric – you will be given copies to fill out during the presentations.
4. At the completion of the presentations in your room, the judges should rank the presentations (based on scores) that can be used in case of a tie in scores – at least the top presentation.
5. We will provide an orientation prior to the presentations (food will be provided). This orientation is useful as you will get a brief overview of the case and be ready to just (as well as dinner).

General Comments on judging:

- Some students are undergraduates or are at the beginning of their discipline-specific professional education and have little experience in clinical settings. You can adjust your expectations accordingly and do not need to worry about the quality of the details or discipline-specific information.
- Students may “get things wrong at times,” but should show evidence of reasonable rationale for planned actions
- We tell students to consider financial issues but not to let that constrain their ideas
- We hope to see from the team presentations have a good attempt at:
 - Adequate analysis of the information provided to identify patient problems.
 - Clear evidence that the patient and care partners were the focus of care
 - Recommendations for care interventions and creativity
 - Evidence of developing interprofessional collaboration– working together as a team, valuing their own and others contributions, respectful teamwork, communication, values and ethics
 - Ideally teams will come up with some innovative strategies for managing challenges of care and teamwork in caring for the patient and family.
- The presentation should indicate that there was intentional/deliberate interprofessional collaboration

- Evidence that team members learned about each other and additional disciplines as they prepared their plan
- Evidence of self- and team- reflection on challenges and rewards of a variety of viewpoints and strengths on team and collaboration.

Rubric Areas

1. Described an interprofessional patient care *team* needed to provide patient-centered care in this case to meet patient/family needs, and communicated clearly professional roles and responsibilities
2. Developed a targeted plan of care that clearly illustrates how the interests of the patient/family are the center of interprofessional health care delivery (use knowledge of one's own role and other professionals to address healthcare needs)
3. Described how the student team worked together and demonstrated effective interprofessional practice (IP) teamwork (climate of mutual respect, communication) .
4. Presentation Skills



Sample Student Orientation Slides



Gateway Geriatric Education Center



Orientation to Case Competition

- Key skill for geriatric care is teamwork and interprofessional collaboration
- Improves patient safety and outcomes to meet triple aim of health care
- Case competition provides an opportunity to work with team of professionals from different disciplines in fun and challenging activity



Geriatric Case Competition

- Sets of interprofessional (IP) teams
- Each assigned to develop and prepare to present a plan of care for the patient/family in the case presented
- Faculty coaches available for consultation
- 1 month to meet and develop plan



Goals for Orientation

- Meet team and coach
- Begin to learn about each other's focus and expertise
- Review case
- Develop plan to meet and work on project (See project planning worksheet)
- Ask questions and clarify process



Competencies for Interprofessional Teams

- Work together in climate of mutual respect and shared values
- Use knowledge of own roles and that of other professionals to appropriately assess and address health care needs of patients
- Communication with others
- Apply relationship-building values and principles of team dynamics



Competencies Self-Assessment

- Complete the team self-assessment
- Put date and last 4 digits of your cell phone (for matching with post assessment)



Directions to Get Started

- Review the case
 - There should be something for team members in any discipline!
- Create Interprofessional team (yourselves and others as appropriate)
- Place patient/family at the center of the team
- Begin to identify medical, functional, and psycho-social problems



Care Plan

- Develop comprehensive care plan
- Analyze case and create list of problems
- Identify interprofessional team members
- Explore potential interventions
- community resources
- Plan evaluation for care plan



Presentation

Will take place in 1 month

- 20 minutes presentation – 10 minute Q & A
- Everyone participate
- Present summary, plan, reflections
- Interprofessional team of 4-5judges will score each team using the rubric



Geriatric Case Competition

- Scoring based on their meeting the criteria on rubric
 1. Not at all
 2. To a small extent
 3. To some extent
 4. To a great extent
 5. Consistently and expertly
- The highest scoring team will win! Prizes!!



Geriatric Case Competition

- Key Areas for Scoring
 - Describing the composition of the team/roles you create
 - Evidence of patient-centered care
 - Targeted plan to meet patient/family goals
 - Evidence of meeting IPE competencies, collaboration on plan and presentation
 - Identifying key problems, innovation in plan
 - Insightful reflections on how team worked together



Geriatric Case Competition



Sample Judge Orientation Slides



Gateway Geriatric Education Center



Geriatric Case Competition

- Adapted from a model from AT Still University
- This is the 4th Competition
- Offered through the Gateway Geriatric Education Center, funded by the HRSA Geriatric Workforce Enhancement Program
- Focus of the GEC is to improve geriatric health care by educating students and health professionals
- Improve skills in teamwork and collaborative practice



Goal: Improve Geriatric Skills and Interprofessional Collaboration

Based on Interprofessional Education Collaborative (IPEC) Competencies

- Work together in climate of mutual respect and shared values
- Use knowledge of own roles and that of other professionals to appropriately assess and address health care needs of patients
- Communication with others
- Apply relationship-building values and principles of team dynamics



Geriatric Case Competition

- Students recruited from local health professions programs
- 2018 includes 11 Interprofessional teams!!
- Each team assigned faculty coaches who were available for consultation
- Orientation then 1 month to meet and develop plan
- Presentations judged for prizes



Process for the Teams

- Introduced to the case 9/24
- Met other team members and coach
- Instructions:
 - Develop a team with group (and others as appropriate)
 - Create a plan of care for the patient as presented
 - Place patient and family at center of team
 - Plan for effective teamwork and communication



Care Plan

- Conduct a case analysis and list of problems
- Determine disciplines and roles
- Identify potential interventions and community resources
- Describe evaluation plan
- A few references



Case Overview: Family Feud JoAnn and George Galloway

- Married couple moving to St. Louis
 - Living in Florida
 - Second marriage for both
 - She has dementia and he is challenged to provide care
 - Each have children from prior marriages who are worried their own parent won't get their individual needs met – hence the potential feud



Wife: JoAnn Galloway (78)

- She has fractured hip and is in rehab
- Memory problems for a while – SLUMS score 14
- Anticipate she will need help/supervision with ADLs
- Low weight
- GDS score 9/15
- Atrial fib, HTN, Back pain, urinary urgency, dental caries, cataracts, skin cancers, hyperlipidemia



Husband: George Galloway (80)

- Generally healthy and functional
- HTN, Prostate enlargement, Insomnia
- SLUMS 27
- GDS 3/15
- Caregiver Stress
- Needs to make decision on where to live here in St. Louis



Other Potential Issues

- Dementia (no real diagnosis) and needs for her
- Caregiving role for him
- Different options for living situation may yield different supports or outcomes for each
- Medication issues – polypharmacy, supplements and vitamins
- How to get family members on board for plan and who should decide what?



Geriatric Case Competition

Considerations in judging

Higher scoring teams will provide:

- Evidence of patient-centered care
- Evidence of meeting IPE competencies
- Evidence of collaboration on plan and presentation
- Address key problems from case
- Innovation in plan
- Insightful reflections on how team worked together



Presentation Expectations

- Brief introduction and summary
- Goals for care
- Interventions and resources
- Include appropriate interprofessional team members
- Discussion of lessons learned
- Organized, readable and professional visual aids and presentation



Judges

- Review 3-4 presentations
- Assign a timekeeper for the room to keep students to 20 minutes
- Use rubric to score on each section
- Circle the score and make any pertinent notes to the team
- Total scores
- At the completion of the presentations, rank the presentations you observed (for use in case of tie in scores)



Geriatric Case Competition

- Considerations in judging
 - Range of students and experiences (may not have identified ALL of the issue we put into this case)
 - 1 month preparation time
 - Goal is not that they get all details right, but have good rationale for their recommendations
 - Don't worry about details of unique profession-specific issues that other professionals would not know
 - Told to consider finances but not to constrain the plan



Key Areas of Rubric

- Described appropriate IP team, roles, patient centered
- Develop appropriate plan – problems, goals, interventions, patient/family education
- Describe how team worked together
- Presentation skills – organized, professional, clear, all members participated
- Scores should differentiate groups (5= highest score; 1 = lowest score)



Geriatric Case Competition



Interprofessional Geriatric Case Competition

Sample Table of Student Team Assignments

Team	Name	E-mail	School	Discipline	Year	Coach	
1	Kelley P	xxx@gmail.com	xxx	Medicine	3 rd		
1	John			PT	1st		
1	Jenny			SW	2 nd MSW		
1	Jorge			Nursing	MSN 2nd		
2				Nutrition	Senior		
2				OT	2 nd Grad		
2				Medicine	2nd		
2				Nursing	BSN Senior		
2				Med/Family Therapy	2 nd Grad		
3				Medicine	2nd		
3				Nursing	MSN- 2nd		
3				SW	2 nd MSW		
3				OT	2 nd Grad		
3				Speech/ Language	1 st Grad		
4				Pharmacy	5th		
4				NP	2nd		
4				SW	2 nd Grad		
4				PT	2 nd Grad		

Interprofessional Geriatric Case Competition

Student Evaluation

Please circle your answer:

What is your Discipline?		
Medicine	Occupational Therapy	Social Work
Medical Family Therapy	Physical Therapy	Other (please specify)
Nursing	Psychology	
Nutrition/Dietetics	Speech/Language	

Please indicate your answer with a check mark:

Please rate each of the following:	Excellent	Good	Average	Fair	Poor
Orientation					
Timeline and Schedule					
Email notifications and reminders					
Expectations for the competition					
Faculty participation/support					
Overall rating of experience					
Please rate how the team worked together on the following aspects:					
1. The work climate was respectful					
2. I was able to provide expertise from my discipline to address the patient problems					
3. I learned from other disciplines new information to address the patient's problems					
4. Team members had a commitment to collaborating on this case					
5. Team members communicated well with each other					
6. Team members shared the work for this project					
Comments about how team worked together:					

What did you think was the most helpful aspect of the Geriatric Case Competition and what should we be sure to keep in?

What would you recommend that we change for next year?

Please circle your answer:

Would you recommend this program to other students?	Yes	No
---	-----	----

If you answered "No" to either of the previous questions, please explain:

Interprofessional Geriatric Case Competition

Coach/Judge Evaluation

Please circle your answer:

What is your position/role?	What is your Discipline?	
Faculty	Medicine	Psychology
Other, please specify:	Medical Family Therapy	Social Work
	Nursing	Speech/Language
	Nutrition/Dietetics	Other (please specify):
	Occupational Therapy	
	Physical Therapy	

Please indicate your answer with a check mark:

Please rate each of the following:	Excellent	Good	Average	Fair	Poor
Orientation					
Timeline and Schedule					
Email notifications and reminders					
Faculty/coach participation/support					
Overall rating of experience					
Please rate how well the students overall met the Interprofessional objectives for the competition.					
1. Work with individuals of other professions to maintain a climate of mutual respect and shared values.					
2. Use the knowledge of one's own role and that of other professions to appropriately assess and address the healthcare needs of patients and to promote and advance the health of populations.					
3. Communicate with patients, families, communities, other professionals in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health/ prevention/ treatment of disease.					
4. Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/ population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.					

What did you think was the most helpful about the Geriatric Case Competition and what should we be sure to keep in?

What would you recommend that we change for next year?

Please circle your answer regarding participation in the GCC:

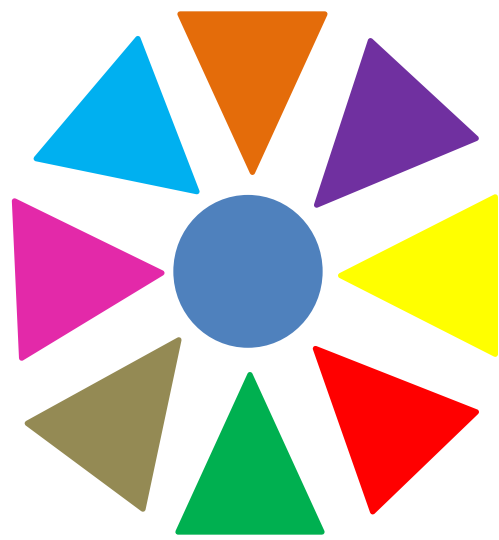
Would you recommend this program to other faculty members?	Yes	No
Would you recommend this program to students?	Yes	No

If you answered "No" to either of the previous questions, please explain:

\

Interprofessional Geriatric Case Competition

Cases



Sample Case 1

Interprofessional Geriatric Case Competition

A Stroke of Luck: Dorothy Johnson Case*

Overview:

Dorothy Harris Johnson is a 77-year-old African American female who lives with her son and granddaughter in a small house in a lower middle-class neighborhood in St. Louis. Mrs. Johnson had a mild stroke six months ago, which left her with some mild disability. She was brought to the Emergency Department (ED) by her granddaughter, Talia, because of slurred speech and inability to get up out of her chair this afternoon. After a workup in the ED, Talia is told that her grandmother may not have had a stroke and may just be dehydrated and has an infected wound on her leg. However, there are questions about some features of her condition that warrant further evaluation, and she is admitted to the hospital. She will probably be discharged within a day or two at the most, once evaluations are complete and a plan in place. The following provides a history of the patient and excerpts from her medical record that includes assessments done by a variety of disciplines that saw her in the hospital.

Case History

Family History:

Mrs. Johnson's father died at age 72 of a stroke. Her mother had Type II Diabetes and died in a car accident at age 63. She was married twice – to James Harris when she was 18 (divorced later); and to Michael Johnson later and widowed in 2012. Mrs. Johnson grew up in Pennsylvania and moved to St. Louis with her first husband in 1957. She owns the home, in which she has lived for 40 years.

Mrs. Johnson has two sons, Bruce and Michael Harris, from her first marriage and three grandchildren. Bruce and his family live out of town. Until six months ago, she lived alone. At that point, her younger son, Michael (divorced), moved in with her to help. His 17-year-old daughter, Talia, lives with Michael and his mother. He had lost his job in Bakersfield, California, and was able to make the change to provide her with needed help.

Social History:

Mrs. Johnson is a private person, with limited social contacts and little interaction with her neighbors at this time. She is a retired elementary school secretary and her primary social group consists of church friends. Mrs. Johnson had been seeing them for monthly meetings and luncheons but has not participated since her stroke. Mrs. Harris considers her religion an important part of her life but has not attended church services in recent months.

Mrs. Johnson owns a car but has not driven it since her stroke. Her license expired and she has no plans to renew it. This decision was prompted, in part, by her son who insists on driving and handling tasks such as shopping and running errands. Mrs. Johnson has appreciated her son's assistance since she has been concerned about her vision, particularly when driving at night and her functional problems. Along with some

church activities, Mrs. Johnson had enjoyed attending some bingo and exercise sessions at the local senior center. Since she no longer has access to her car, she has stopped participating in these activities.

Past Medical History:

- Poorly controlled hypertension for 25 years
- Type II Diabetes for 15 years with diabetic chronic kidney disease
- Osteoporosis, no history of fracture
- Urinary Incontinence, urge
- Macular degeneration
- Osteoarthritis of knees and hands
- History of falls – last visit to ER 3 months ago (no fracture, discharged home)
- Peripheral vascular disease

Medications:

- Hydrochlorothiazide 50mg daily
- Lisinopril 20 mg twice a day
- Atenolol 50 mg daily
- Metformin 1000 mg bid ♣ Glipizide 5 mg BID
- Amitriptyline 25mg for depression
- Alprazolam 1mg tid prn anxiety
- Oxybutinin 10 mg ER daily
- Calcium 500 mg BID
- Allergies: Penicillin-develops a rash

Family Members

Mrs. Johnson's oldest son, Bruce Harris, is 58 years old, married father of two, lives in Florida. He is a small business owner and has a wife who is physically disabled. Mrs. Johnson had been visiting Bruce and his family on an annual basis but found it increasingly difficult to maneuver travel the last few trips. Since it is difficult for Bruce to visit his mother, he has not seen her for more than three years. They talked on the telephone approximately once a month over the last year. Mrs. Johnson has appeared confused at times during these telephone conversations—forgetting her grandchildren's names; appearing less verbal; and ending the calls within a short period of time. Sometimes he is told she is sleeping or cannot talk.

The younger son, Michael Harris, is 48 years old, divorced and has one daughter, Talia, 17 years old. He is a college graduate in graphic design; worked in various IT jobs. He lost his most recent job in California six months ago and moved back to live with and assist his mother. He has had problems with alcohol abuse – history of DUIs and previous revocation of his driver's license in California. Currently, he has a part-time job at an IT call center. Michael has been taking on greater levels of care for his mother. He does all the shopping; has taken over payment of household bills; banking; etc. He can be short tempered with his mother and regularly reminds her of the sacrifices he has made to take over her care.

Granddaughter – Talia Harris is 17 years old. She is in high school. She has been close to her grandmother having spent many summers with her when she was younger. She goes to school and helps with some cooking and cleaning at home.

Excerpts from the Emergency Room and Medical Record

Emergency Room Note/ Physical Examination:

Slightly unkempt older woman with some stains on her blouse, smells of urine
Affect blunted and offers information only if questioned

Ht 62", Wt 48kg, BMI 19.2
BP 106/66, P 55, Temp 38, RR 16, O2 Sat 92%
Pain 2/10 in left lower leg
Skin Dry with some excoriations over areas she can reach
Circumferential bruising on her wrists and legs
Wound on left lower ankle

HEENT: arcus senilis; otherwise normal
Lungs clear
Kyphosis
Cardiac S1S2 no murmur regular rate and rhythm
Kyphosis
Abdomen active bowel sounds, normal liver size and non-palpable spleen
Extremities poor foot care, pulses not palpable in DP PT
Wound on left leg
SLUMS cognitive assessment - Score 23 out of 30
Geriatric Depression Scale - Score 10 out of 15

Labs:

BUN 30, Creatinine 1.9
HCT 35, Hgb 9, WBC 11.5 (slightly elevated with a left shift)
Albumin 2.2 (low)
Hgb A1c 9%
Vit D3 15 (low)
EKG and CXR unremarkable.
No evidence for osteomyelitis on left lower leg.

Nurses Admission Note

Patient admitted from ED with possible stroke. Son and granddaughter are at bedside and son answers questions for her. He is demanding and wants to know why she needs to be in the hospital if she did not have a stroke. He states that hospitalization is expensive, and he and his daughter can take care of her leg at home. Patient keeps reassuring him that she won't be a burden. Patient resting in bed. Patient complains of joint pain in knees, rating 5 out of 10.

Awake and alert, responds to questions appropriately. Lungs clear to auscultation. Skin intact except wound noted on left outside ankle, 2 x 1 1/2' with prurulent drainage. Patient states she has trouble with blood flow and legs tend to heal poorly. Bruising noted on both outside ankles and right knee. Bruising also noted on both wrists. Patient denies recall of source of bruises, stating "I'm just clumsy." Patient reports urgency when needing to void. Assisted to bathroom. Some difficulty with walking, shuffling gait. Patient encouraged to call for assistance getting to bathroom as soon as she feels the

need. Call light within reach. Fall risk band applied and falling star on door based on high risk for falls. Dinner tray ordered, although patient denies being hungry.

Attending Physician Progress Note

Hospital Day #1:

S: 77 y/o female admitted yesterday with complaints of slurred speech, now resolved. CT head negative. Overnight, no events. Patient this morning states is feeling better but still feels weak. Per nursing, slept well. No BM yet. Eating poorly. Granddaughter at bedside confirms. She is concerned because the ER told her that the patient was dehydrated.

O: VS BP 108/54 P 58 Temp 97.6 RR 20 O2 Sat 93% on RA

Gen: Alert, oriented to person, place, and time. Flat affect. No distress

HEENT: NC/AT, neck supple, temporal muscle wasting present, oropharynx clear, poor dentition with some missing teeth, dental caries, and white plaques over tongue.

Heart: regular, no M/R/G noted; pulses 2+ and equal radially, diminished pedal pulses, no carotid bruits

Lungs: clear b/l, no W/R/R

Abdomen: scaphoid, soft, non-tender, no HSM, BS hypoactive but present

Extremities: trace pedal edema with stasis changes present. Left leg with open ulcer on lateral shin with large amounts of yellow fibrous tissue. No purulent drainage. Mild surrounding erythema.

Neuro: CN II-IX grossly intact, Strength 4+/5 Left UE/LE and Right LE but 3/5 Right UE; Sensation diminished to vibration B/L feet to ankles, mild finger pass pointing on the right, no tremors or rigidity

Relevant labs:

BUN 30, Creatinine 1.9 (baseline around 0.8 based on last hospital stay)

Sodium 133, Potassium 3.3

HCT 35, Hgb 9, WBC 11.5

Albumin 2.2

Hgb A1c 9%

Vit D3 15 (low)

EKG and CXR unremarkable.

Social Work,/Psychology/ Counseling, and/or Gerontology Assessment

Mrs. Johnson was alert and oriented during assessment. Consistent with her earlier GDS score (10 of 15), Mrs. Johnson appeared lethargic, slow to respond, and reported that she feels sad and tired most of the time. Her granddaughter, Talia, was in the room with her during the visit but seemed reluctant to engage in the conversation. Mrs. Johnson is eager to go home and is confident that her son and granddaughter can take good care of her. She commented that Talia does "just everything" for her since her son, Michael, must be gone so much of the time and needs to rest when he is home. She is concerned about her financial situation but says that Michael is handling everything now, so she does not bother him with her worries. She misses her previous activities but indicates that Michael and Talia have too much to do and should not have to drive her. She is open to having help at home if it does not cost money.

Physical Therapy Assessment

Upon entering the room, Mrs. Johnson was sitting on the edge of the bed independently eating her lunch. She reports that she lives in a single-family home with one step to enter and 12 steps from first floor to second floor. No handrail is present outside but there are bilateral handrails inside. Mrs. Johnson performed sit to/from stand with minimal assistance and ambulated approximately 25 feet to bathroom with one hand-held assist. Mrs. Johnson presented with step to gait pattern leading with the left, wide base of support and increased stance time of left lower extremity. Patient had more difficult maneuvering around obstacles present in the room (side table, chair, trash can, etc.). Mrs. Johnson refused to use a wheeled walker for ambulation. Patient was dressed in hospital gown and hospital gripper socks. She refused to wear shoes for activities secondary to leg pain.

Mrs. Johnson requires moderate assistance for dynamic standing activities and minimal assistance for static standing activities. She can perform all sitting activities independently without loss of balance. Despite being right-handed, she tends to use her left side more often. Mrs. Johnson was compliant with physical therapy on this date. Mrs. Johnson's goal is to return home as independent as possible as to not rely on her son and granddaughter for activities of daily living.

Occupational Therapy Assessment Day Two

Subjective: Mrs. Johnson is hoping to return home soon and verbalizes that she doesn't want to be a burden on her family. Client mentioned that she would enjoy spending time with her friends from church or going to the senior center to play bingo, but she doesn't feel like she can do any of that anymore.

Objective: Initial ADL observations indicate that she needs moderate assistance with LB bathing at sink and dressing secondary to fatigue and balance impairment. While sitting in a manual w/c, she can complete UB bathing at sink, UB dressing, and all aspects of grooming with set-up assist only. Toileting requires minimal assist for transfers, moderate assist for hygiene and clothing management, mostly due to fatigue and balance impairments. During standing ADL activities, client verbalized pain in her knees of 5/10. Functional Reach Assessment: 7 inches with R hand (<10 in = fall risk, <7 in = limited mobility and ADLs). Client becomes SOB with <5 minutes of activity. She has full AROM in B UEs against gravity. UE MMT: B shoulder flexion/abduction is 3/5, B shoulder extension/adduction is +3/5. B elbow and wrist flexion/extension is -4/5. Per dynamometer testing, grip strength is 33# right hand, 37# left hand.

Speech – Language Assessment

Patient presenting with s/s of mild hypokinetic dysarthria w/out tremor, mild-moderate dysphonia, and mild-moderate oropharyngeal dysphagia.

Oral Neuro-motor exam: Sparse dentition; Minimal xerostomia (source unknown, potentially drug-induced); No asymmetry but global weakness with reduced speed and range of motion throughout orofacial and pharyngo-laryngeal mechanisms.

Speech evaluation: Overall impressions: Patient pleasant and compliant with all diagnostic tasks, no evidence of impaired comprehension during natural conversation,

however required moderate (>25% of occasions) visual-verbal cueing to maximize performance; Reduced verbal output overall; >90% intelligible in known contexts with environmental modifications (quiet room, close proximity) and moderate cueing to implement compensatory techniques targeting vocal intensity and breath support.

Swallow evaluation: Overall Impressions: Suppressed appetite. Unremarkable ingestion of thin liquid consistencies via cup sips. Patient responded positively to cues to alternate solids/liquids. Patient and family did report recent history of occasional complaints of globus sensation as well as self-restriction to softer textures and preferences for "sweets". Reduced endurance for complete meal ingestion, suspect d/t fatigue effects as well as reduced olfactory and gustatory sensations. <40% of Mechanical Soft/Thins tray ingested during this initial evaluation.

Prep Stage: Limited mandibular excursion and oral aperture (<36mm). Oral Stage: Lingual pumping; Inadequate bolus cohesion, resulting in scattered particles requiring visual/verbal cues for clearance via lingual sweeps and thin liquid washes; Prolonged oral transit time (>4 sec); Delayed bolus propulsion. Pharyngeal Stage: Delayed swallow reflex; Reduced force of pharyngeal wall contraction suspected d/t occasional spontaneous repeat swallows; No significant decline in vocal quality associated with swallows; Decreased laryngeal elevation/excursion (>3/4 inch on palpation); No reflexive coughs; Weak and mildly delayed throat clear in response to visual/verbal cues and clinician modeling.

Nutrition Assessment

77 yo AA female with hx of stroke and dysphagia, current LE wound.

Ht: 62", Wt: 48kg, (105.6#), BMI: 19.2
Estimated Energy Needs: ~1800 Kcal/day
Estimated Protein Needs: 58 g/day
Estimated Fluid Needs: ~1800 mL/day

Diet related behaviors: Mrs. Johnson lives at home with son and granddaughter. Son shops and cooks meals. Pt reports poor appetite and some difficulty swallowing/ chewing- choosing soft-textured foods. Pt doesn't drink much fluid throughout day. Pt used to enjoy visiting senior center and church, but no longer attends. Wt loss noted over the past 6 months (stroke).

Inadequate energy intake (NI-1.4) related to swallowing and chewing difficulty, <50% of meals eaten, and increased nutrient needs for healing as evidenced by weight loss over the past 6 months and LE wound.

Charge for the Case

The healthcare team will need to work with Mrs. Johnson to address her health issues and family challenges and provide them with resources and information to address this complicated situation so that they can find a solution they all can all live with.

*Case adapted from the Dorothy Johnson Case, University of New Mexico School of Medicine, posted on Portal of Geriatrics Online Education, 2014.

Sample Case 2

Interprofessional Geriatric Case Competition

Buried at Home: Susan Watson Case

Overview

Susan Watson is a 75-year-old Caucasian female who lives alone in a small two-bedroom rental property in a suburban neighborhood. She was recently hospitalized with pneumonia and during her hospital stay was referred to hospice care as part of her discharge plan. She was diagnosed with and treated for breast cancer 5 years ago with surgery and chemotherapy. She was in remission for four years but it has recurred and has spread to her lungs and bones. Over the last 3 months, she has been in the hospital three times (including the most recent hospital stay), twice for COPD exacerbation and pneumonia and once for gastroenteritis with dehydration. She has experienced a significant functional decline and is felt she would not tolerate further aggressive curative-intent treatments. Ms. Watson was adamant about returning home upon discharge, though there was some concern among the hospital team about her ability to manage her care independently on an ongoing basis. A representative from hospice met with Ms. Watson in her room and she was agreeable to enrolling in hospice, which will oversee her care once she returns home this afternoon. The admitting diagnosis for hospice is end-stage breast cancer, although she also has diabetes mellitus Type II, morbid obesity, essential hypertension, COPD, major depression, and OCD. She is now being admitted by hospice team members who are evaluating her to develop an ongoing care plan.

Case History

Family history:

Her mother died at age 50 of breast cancer and she also had long standing depression and anxiety. The father's medical history is unknown. She has one sibling, a sister, who has skin cancer, COPD and depression.

Social history:

Ms. Watson has never been married and has no children. She was raised by a single mother who died at age 50, also of breast cancer. She has always been very close with her sister, Delores, who lives in Chicago. Delores is recently widowed and has two adult sons and three young grandchildren. Ms. Watson and her sister were both born in St. Louis though her sister moved to Chicago early in her marriage. Due to her own health issues it is difficult for Delores to travel to visit, though Ms. Watson considers her a main source of support. Other than her two adult nephews, her only other living relatives are cousins who live across the country.

Ms. Watson worked as a receptionist at a dental office for nearly 35 years. She retired early as her health needs increased and her obesity became more difficult to manage. Now she has significant difficulty getting around. She does not have a car and mostly goes in a wheelchair to the places nearby (grocery store, fast food, and bank) in North county when she can, although this is becoming more difficult. She was previously attending a book club and knitting circle at the local community center, but this too has

become too difficult for her to attend. Her hearing was also an issue and she was having trouble hearing the conversations, so it was not as enjoyable of late.

Regarding her illness, Ms. Watson is very anxious about her worsening cancer and her multiple recent trips to the ER and hospital. She doesn't quite seem to understand the severity of her cancer and what is likely to happen, although she agreed to hospice care. She has lived in her current home for 10 years and wishes to remain there the rest of her life if possible. However, given the lack of a caregiver to help as she deteriorates, this may not be possible.

Ms. Watson relies a great deal on her friend, Sara, who visits several times a month and lives 15 minutes away. At one time they were neighbors and now remain close. Sometimes Sara will run errands for her or bring her lunch or dinner when she visits. Ms. Watson spends most of her time now watching television and shopping online. She talks often about her many collections and it brings her great pleasure to add to them. However, her home is extremely cluttered with stacks of boxes, dolls, and books, leaving paths through the center of each room to make walking. Her floors are also littered with trash from fast food restaurants and packaging from her online orders. When rooms get blocked from the piles of clothing or books, she often avoids bathing and addressing other hygiene issues. She receives great pleasure from the company of her three cats who come and go from the pet door at the front of the house. While she is not bothered by the clutter of the home, she is bothered by the bugs that seem to be escalating out of control as additional residents in her home.

Sara has mentioned this clutter problem to Ms. Watson on numerous occasions, where Ms. Watson has been very defensive about this topic. Just recently, a cable technician came into her home to address signal problems with her television. The technician could not get access to the back of the television to install a new cable box. Furthermore, the electrician noticed newspapers and other bills lying on top of Ms. Watson's stove. Being concerned about the situation, the technician contacting the housing authority about these safety issues. Although the housing authority did not make a personal visit to her home, they spoke to Ms. Watson over the phone about these safety issues. Ms. Watson has not yet addressed these issues in the home.

Family Members:

Ms. Watson's sister, Delores Smith, is 68 years old and lives in Chicago. Her husband of 42 years recently died of cancer. Delores has many health challenges of her own making travelling difficult for her. Her two sons are grown, Jack who is 40 and Jeff who is 36. Both are married and Jack has two children, ages 8 and 4, and Jeff has a two year old daughter. Jack is a software engineer and Jeff coaches high school football. Both lead very busy lives, but they have a special affinity for their aunt who used to keep them for a week or two every summer when they were children. The only other family Ms. Watson reports are her cousins who live in California and have families of their own. They are not in touch regularly.

Sara, Ms. Watson's former neighbor, is her closest friend. Sara is 60 years old and a school nurse at an elementary school in the next town. Her children are grown though her daughter still lives in the area with her three children. Sara spends a lot of time attending events to support their many activities. She also visits Ms. Watson several times each month.

Past Medical History:

- Stage IV metastatic breast cancer
- Hip and back pain
- Morbid obesity
- Chronic Obstructive Pulmonary Disease, not on oxygen at baseline
- Obstructive Sleep Apnea (non-compliant with CPAP)
- Poorly controlled Essential Hypertension
- Diabetes Mellitus Type II with Stage II CKD
- Major Depressive Disorder
- Obsessive-compulsive disorder
- Right arm Lymphedema
- Hearing loss (has worsened since her last chemotherapy regimen)

Medications:

- Carvedilol 12.5 mg BID
- Insulin glargine 26 units at HS
- Metformin 1000 mg BID
- Lisinopril 20 mg daily
- Amlodipine 10 mg daily
- Lasix 20 mg daily as needed for limb swelling
- Fluoxetine 80 mg daily
- Glipizide 5 mg BID
- Hydrocodone/Acetaminophen 5/235 mg PO q 6 hours PRN pain
- Aripiprazole 5 mg PO daily
- Tiotropium 18 mcg inhaled once daily
- Fluticasone furoate/vilanterol 100/25 mcg inhaled daily
- Ipratropium bromide/albuterol 0.5mg/2.5 mg per 3 mL q 4 hours PRN shortness of breath and wheezing

Primary Care Physician Progress Note

S: Patient seen for regular f/u of metastatic breast CA, HTN, DM, COPD. Patient recently saw oncologist, who told patient that she needs to come see me for a referral for therapy evaluation to get stronger before resuming chemotherapy. Patient notes that over the last week has been progressively more tired and sleeping “all the time.” Coughing up green sputum and feeling short of breath when walking to the bathroom now. Feels dizzy and occasionally gets the chills but didn’t check her temperature for a fever.

O: VS: BP 126/78 P 128 R 26 T 99.8 SaO2 86% on RA

Alert but appears ill. Mild conversational dyspnea.

HEENT: Oropharynx clear without exudates. No submandibular LAD

Heart: Regular, tachycardic, no murmurs noted. Pulses 1 + and equal radial, dorsalis pedis.

Lungs: Diffuse wheezing. Coarse crackles in left base. No e to a changes noted

Extremities: Non-pitting edema in right hand and forearm. Clubbing present in hands.

Trace pitting edema in LE to mid-calf.

No labs available since the last visit

A/P: Dyspnea, cough, low grade fever, and tachycardia. Suspect recurrent pneumonia and COPD exacerbation. Patient has poor supports in the home. Very tenuous clinical status given underlying metastatic malignancy. Patient wants to “keep going” with whatever treatments are available to her and hopes that she will be able to restart

chemotherapy soon. Will transfer patient to hospital for evaluation and management. Discussed with accepting hospitalist.

Hospital Discharge Summary

75 y/o female admitted directly from PCP office with fatigue, cough, and dyspnea. Found to have SIRS with sepsis due to left lower lobe pneumonia. WBC on admission was 12.8. Treated with IV ceftriaxone, azithromycin, and steroids. Also given 1 dose of IV Lasix 40 mg on admission for suspected fluid overload. On day 3 of hospitalization, steroids and antibiotics were switched to oral equivalents. Patient had slow improvement of symptoms. Hospital course complicated by respiratory distress on day 2 of hospitalization, stabilized with BiPap overnight. Improved with no need for intubation. Patient also had a drop in hgb to 6.5 and obtained 1 unit of packed red blood cells. Patient noted to have periods of anxiety throughout the hospital stay, improved with increase in antipsychotic. PT/OT consulted and recommended SNF stay. Patient refused to discharge to a facility. Palliative care consult obtained and patient has elected to d/c home with hospice.

Condition at discharge: Poor Discharge destination: Home with Hospice

Follow up -primary care MD

Medications at discharge:

Start the following medications, which you were not taking at home:

- Prednisone 40 mg daily for 4 days, then 30 mg daily for 4 days, then 20 mg daily for 4 days, then 10 mg daily for 4 days, then stop
- Levofloxacin 750 mg PO daily for 3 more days
- Omeprazole 40 mg PO daily
- Morphine sulfate 20 mg/ml solution. Take 0.5 mL = 10 mg PO/SL q 2 hours PRN pain or dyspnea
- Scopolamine transdermal 1 mg. Apply to skin every 3 days.
- Lorazepam 2 mg/ml solution. Take 0.5 mL = 1 mg PO/SL q 2 hours PRN anxiety

Start the following medications, which HAVE changed:

- Insulin glargine 26 units at HS
- Aripiprazole 10 mg PO daily

Resume the following medications, which have NOT changed:

- Carvedilol 12.5 mg PO BID
- Metformin 1000 mg BID
- Lisinopril 20 mg daily
- Amlodipine 10 mg daily
- Lasix 20 mg daily as needed for limb swelling
- Fluoxetine 80 mg daily
- Glipizide 5 mg BID
- Hydrocodone/Acetaminophen 5/235 mg PO q 6 hours PRN pain
- Tiotropium 18 mcg inhaled once daily
- Fluticasone furoate/vilanterol 100/25 mcg inhaled daily
- Ipratropium bromide/albuterol 0.5mg/2.5 mg per 3 mL q 4 hours PRN shortness of breath and wheezing

Excerpts from the Nurses Notes and Transfer Form

Ms. Watson was admitted severe pneumonia. She continues to have dyspnea and a productive cough. Respirations are shallow with rales, and productive cough. Her oxygen was discontinued. She is alert and oriented, but hard of hearing. Ms. Watson frequently requests medications for pain in her back and hips and is anxious about having worsening pain if her cancer progresses. Her mother died of breast cancer and she has bad memories of her mother's pain being poorly managed and her mother suffering. She is scared the same thing will happen to her.

Ms. Watson can transfer from her chair to bed and get to the bathroom but is easily fatigued and later in the day has difficulty. She is usually continent, but has some urgency and did have one accident due to slowness of getting to the bathroom. She has reddened areas under her breasts and some skin folds, which are hard to keep clean and dry, she has frequent diaphoresis.

One of the issues for Ms. Watson is lymphedema in her right arm. It is almost always swollen, and she frequently says to "ignore her extra arm" She wears a sleeve, but it is fairly loose. She cannot get a firmer sleeve on by herself, and the swelling is poorly controlled and causes discomfort.

Chaplain Note

The admission notes suggested that Ms. Watson was a lapsed Lutheran and had not been involved with a church. However, she did request to speak to a chaplain. I visited her on Tuesday to discuss her spiritual needs and wishes, and goals for quality of life as her disease progresses. Her biggest concern is comfort and staying at home as her cats provide so much comfort, and her friend lives nearby. While she talks about being on hospice, she does not have an idea about how long she may be sick, or the progression of her disease. She would like more visits to discuss her spiritual needs. She had not set her goals for end of life care or plans such as her last wishes.

Social Work/ Psychology/Counseling and/or Gerontology

Met with patient in her room after hospice order from physician. She was sitting up in bed and is alert and oriented. SW introduced self and role and explored patient's current concerns. Ms. Watson reports that she would really like to return home to her cats. She does not have any advance directive paperwork. SW provided and explained each form in detail (Power of Attorney, Living Will, and Out of Hospital DNR). She was open to this conversation and took the forms, but states she would like some time to consider them.

Discussed physician's order for hospice. Pt is skeptical of hospice care but seems more willing after a full description of the services that are offered. She also realizes that the additional help may allow her to remain independent at home. She has agreed to meet with several hospice representatives. SW will contact several hospices to arrange initial visits and will follow-up with patient after these visits.

Later note Pt is in upbeat spirits during visit as she is looking forward to a likely discharge tomorrow. She signed paperwork with ABC Hospice and they will begin overseeing her care upon discharge. SW provided support through active listening as patient talked about her life and her recent illness progression. Though patient has still not completed POA or Living Will, she did sign an Out of Hospital DNR for her transport

home. This was after much discussion. Pt expressed no further questions or concerns at this time and is looking forward to returning home.

Physical Therapy Home Assessment (Hospice Team)

Patient is currently performing transfers in home independently although fatigues easily. She has slow shuffling gait but walks independently. Patient c/o pin in back and hip occasionally, specifically with transfers. She also states back pain increases with prolonged sitting. Patient RR rate increases to 32 breaths/min and O2 drops to 84% with a noticeable increase in usage of accessory neck muscles for breathing when discussing her medical diagnosis. Recommend PT for palliative care and equipment assessment.

Occupational Therapy

Pt was seen by skilled OT for evaluation upon admission to the hospital. She is currently living alone in a one-story rental home with a ramp. Although she has visitors, she has no regular caregivers and is responsible for all her basic ADLs and IADLs. During her eval in the hospital, pt was set-up assist with UB dressing/bathing and mod assist with LB dressing/bathing due to lack of breath while trying to bend over. She is unable to don socks or shoes for the same reason and requires total A. She can complete all aspects of toileting with modified independence, however her O2 sats dropped to 80 during the activity, with pt using pursed lip breathing techniques afterwards. Nursing staff was notified. Pt is able to groom self from sitting position with modified independence. She can complete simple meal prep (i.e., microwave meal; sandwich). She is unable to use the vacuum herself, as it causes her to become too SOB. She can complete very small loads of laundry.

Per pt report, her social activity has been very limited in the last few months. Pt enjoys using the computer, watching tv, and playing with her cats. However, she did verbalize that she “gets lonely sometimes” and would like “to talk to someone more often.” Pt can get out of the house using a . Skilled OT recommends that pt go to a SNF after D/C from hospital. However, pt is currently refusing to do this.

Speech/Language

Cognitive-Communication Capacities: The patient presents with signs/symptoms of mild cognitive impairment. Patient reports occasionally feeling “in a fog” that that interferes with her safe and full participation in some activities. Analysis of elicited oral and written language samples indicate some reduced utterance length (suspect partially related to her in adequate breathing capacities) and syntactic complexity, occasional semantic paraphasias, and mild alexia and agraphia at single-word and short phrase levels.

Formal assessment via selected subtests of the Repeatable Battery for the Assessment of Neuropsychological Status Update (RBANS Update) and the Ross Information Processing Assessment - Geriatric (RIPA-G2) indicate mild impairments of auditory (note compensation for hearing loss during evaluation) and visuospatial capacities, and mild impairment of attentional capacities (suspect partially related to fatigue), situational knowledge judgement, problem solving, and planning.

Swallowing Capacities: Videofluorographic (FVG) analysis of swallowing revealed no evidence of oropharyngeal dysphagia. By contrast, interesophageal stasis (IES) was

observed as coating in aortic region of esophagus with liquid consistencies and semi-solid and solid textures. Suspect IES may underlie patient's report of globus sensation after ingestion of pill-form medications.

Nutrition Assessment

Consult received for poor appetite r/t increased pain and getting tired quickly. 75 yo Caucasian female admitted with SIRS due to pneumonia. Medical hx significant for Stage IV Metastatic breast CA, DM II with Stage II CKD, morbid obesity, HTN, COPD, major depression, hip and back pain, Rt arm lymphedema, hearing loss, and OCD. Consult for Hospice noted.

Ht: 64", Wt: 109kg (240#), BMI: 41.2

Diet Order: 1800 Cal ADA, Heart Healthy

Allergies: NKDA

Labs: BUN 48, Cr 1.8, Hct 24, Hgb 8.8, WBC 12.8,

Estimated Energy Needs: ~1850 Kcal/day (using Mifflin St. Jeor)

Estimated Protein Needs: 109 g/day

Estimated Fluid Needs: ~1850 mL/day

Diet related behaviors: pt lives at alone, states her limited capacity to prepare and shop for food, thus relies on convenience and fast food options or delivery most of the time. Pt states longtime friend Sara visits often and brings food. Pt doesn't follow any specific diet at home. Pt reports poor appetite and weight loss over the past 3 months; UBW (280#), 14% weight loss x6mo. 24hr recall reveals pt's usual intake at home ~ 1200-1500 calories, 60 grams of protein, and 1400 ml fluid per day, usual diet likely deficient in micronutrients based on recall. Pt is at risk for severe malnutrition as evidenced by significant weight loss, end stage cancer diagnosis, and poor intake.

Charge for the Case

The healthcare team will need to work with Ms. Watson to help her get the care she needs as her health declines.

Sample Case 3

Interprofessional Geriatric Case Competition Family Feud: JoAnn and George Galloway Case

Background

The Galloways were a happy couple. While they both lost their spouses in their early 60s to cancer, they met at a mutual friend's barbeque a few years later. After much encouragement, George asked Joann to dinner and they married. She was a stay at home mother and lived her whole life in St. Louis. George was recently retired from a high-level job. They got married and moved to Florida so they could travel, play golf, and enjoy the outdoors while they were still healthy and in good physical shape. The couple liked being active and wanted a warmer climate. Their children were not very happy with the situation. Both JoAnn and George's children had been close to their lost parents and had a hard time with replacements. And while they were glad their parents found some happiness, they each felt they had somewhat lost their remaining parent when the couple moved to Florida. The family dynamics had changed.

Their current situation is much different. George, 80, is still healthy. He has high blood pressure but is still able to play golf and do what he wants. However, JoAnn (78) has major health problems. She started showing signs of memory problems 3 years ago. Her condition progressed quickly, and now she is still mobile, but needs supervision with activities. George found pots burning up on the stove. She began to have trouble cooking and doing complex tasks. JoAnn's dressing was getting sloppy and she was not her usual neat self. George had her stop driving a year ago as she had a couple of minor car accidents.

JoAnn's needs were becoming challenging for George to manage. She was nervous and would get cranky when she had difficulty with things. When George left her alone, she would call her daughter or the neighbors to ask if he was there. Her children didn't think he should be going out and leaving her alone. He was frustrated because he had things he still liked to do. He was not sure he could take care of her much longer by himself, so he made the decision that they should move back to St. Louis where family still lives. They were here looking for a place to live when JoAnn fell and broke her hip. She is now getting rehabilitation at a nursing facility and it is not clear what level of function she will have, or what level of care. They are seeking help from the rehabilitation team to figure out what to do next.

The children from the two families are not close to each other, and never really spent time together with JoAnn and George. They would visit them in Florida, usually separately. They have very different ideas about what should happen next with this couple. George's children want him to place her in a nursing home and move into a retirement community. He is so stressed from trying to help her that they are worried about him. They want to be sure he can keep active and doing things. They don't think he should have to give up his life because she is declining.

On the other hand, JoAnn's children don't think she needs a nursing home, and they want her to keep her in a home setting. They are afraid her children will talk her into "dumping" her somewhere, so she doesn't have to worry about her. She doesn't seem that hard to manage. They also are willing to help with her care, although they have busy family lives themselves. Her children are not sure George (or his children) have JoAnn's best interests in mind.

When George talked to the facility social worker with both their daughters present, their comments showed they were at odds as to what he should do. The stage is set for a family feud that will present a challenge for the healthcare team.

Medical Overview

JoAnn Galloway

JoAnn was in the hospital for hip fracture repair and is now at the rehabilitation center. Her post-operative course was relatively uneventful except for a short period of agitated delirium related to urinary retention that resolved prior to discharge. She also required one-unit blood transfusion for post-operative anemia related to acute blood loss during surgery. Her blood counts have been stable since then. Skilled nursing facility rehabilitation was recommended by the hospital therapist due to her extreme weakness and loss of function following her fall and hip fracture.

Key Points from Patient History

JoAnn is a 78-year-old female and a poor historian. She says her health was fine till she "broke her darn hip" although she reports some "heart problems" and trouble needing to go to the bathroom "right away" but denies incontinence. She says she has some "issues" with her eyes, and a bad tooth. She has chronic back pain. She takes "lots of pills." JoAnn wants to go home with George and gets teary talking about this. Her affect seems to fluctuate, being a little animated when asked some questions, but then getting sad and teary when responding to other questions. She states that she does not need much help with her daily activities.

George reports a decline in her memory and thinking over a few years. She gradually gave up her outside activities. She did not want to play golf and cards, stating that she didn't feel up to it anymore. He could relate a few times where he thought things declined somewhat suddenly. She had the flu a couple of years ago and never seemed to get back to her old self afterwards. She also had a fall about a year ago, and though there were no injuries, she became very fearful of going out and became anxious about going out or him leaving her alone for very long. He has had to help her with her baths over the last several months and she must be reminded to change her clothes. He has taken over all the household chores, as well as driving and finances. He has taken her to her doctor regularly who had addressed her medical conditions but has not been very helpful in how to handle her memory problem except to prescribe medications. He states that she often loses control of her bladder but no stool incontinence. He denies any known history of heart attacks or strokes. She doesn't see any specialists in Florida. He reads a lot about complementary and alternative medications and has started several vitamins and supplements to help her.

Key Points from Medical and Rehabilitation Assessment

- Pleasant, somewhat confused female post hip fracture.
- Ht 62", Wt 105 Temp 98.7 BP 98/58 HR 56 RR 18 SaO2 98% RA

- Pain – unable to rate but says up and down
- Physical exam significant for irregularly irregular heartbeat without murmur, trace pedal edema, and clear lungs. Her muscle strength is equal on both sides, but she is noted to be weak.
- SLUMS mental status score: 14
- Geriatric Depression Scale (short form) – 9/15
- Functional Assessment (From rehab assessments)
 - ADLs
 - Needs assistance with bathing, dressing – can help with dressing, brushing teeth, but cannot pick out appropriate clothes or remember order to do tasks
 - Mobility -- needs assist of 1 with walker, transfers ambulation, getting to bathroom
 - Independent in eating
 - IADLS
 - Anticipate she will need assistance/supervision with all IADLs - full assistance/supervision with finances, shopping, meal preparation, housekeeping, someone to administer her medications
- Speech/Language
 - Mrs. G. presents with word finding difficulties, and reduced visuospatial capacities, impaired attentional capacity, as well as situational knowledge, judgement, problem solving and planning consistent with moderate cognitive impairment.
- Nutrition
 - Appetite is good, needs assistance with selecting meals and setting up food trays. BMI is low end of normal range (19.2) and husband reports she has been losing weight over past 3 years that may be related to her inability to cook (he doesn't cook much) and their reduced pattern of eating to only 2 meals/day. Recent dental pain limits her chewing meat.

Hospital Discharge Diagnoses

- Post intertrochanteric Hip fracture Right s/p intramedullary nailing
- Paroxysmal Atrial fibrillation – no anticoagulation per PCP due to fall risk
- Hypertension
- Dementia
- Hyperlipidemia
- Depression
- Back pain
- History of removal of multiple skin cancers
- Urinary urgency
- History of falls
- Dental caries
- Cataracts

Medications

- Namzaric 28 mg ER/10 mg IR daily at HS
- Atenolol 100 mg daily
- Amitriptyline 25mg daily at HS
- Oxybutinin 10 mg daily
- Calcium 500 mg BID (new from hospital)

- Alprazolam 1mg tid prn anxiety (new from hospital)
- Aspirin 325 mg daily
- Hydrocodone/APAP 5/325 mg Q4 hours PRN pain (new from hospital)
- Vitamin E 100 units daily
- Multivitamin daily
- Atorvastatin 80 mg daily
- Gingko biloba 60 mg TID
- Vitamin C 500 mg daily
- Fish oil 1000 units daily

George Galloway

Key Points from History

George was seen by the Nurse Practitioner at a local clinic to develop a new primary care relationship. He is a healthy 80-year old male with some chronic conditions, treated with medications.

The main issue for George is caring for his wife, who had a hip fracture here while visiting to plan a move to St. Louis. He has severe caregiver stress and does not know where they will need to go or if they can be together. He thinks she may have Alzheimer's disease but states he was never told the cause of her memory decline. He says he has gotten increasingly annoyed with her forgetting and clingy behavior and doesn't know what would be best for her. Their respective children are at odds with where they should move and are trying to influence him in different ways. He is staying with his daughter while trying to sort it out. He developed insomnia over the past year over her problems, and now it is worse.

Key Points from Medical Assessment

- Alert, pleasant male seeking new primary care provider.
- Ht 72", Wt 183, temp 97.8, BP 132/76, HR 78, RR 20, SaO2 99% RA
- Pain – n/a
- Physical examination was unremarkable
- SLUMS mental status score: 27
- Geriatric Depression Scale (short form) –3/15
- Functional Assessment (From rehab assessments)- fully independent in ADLs and IADLs
- Nutrition – BMI 24.89 within normal limits

Diagnoses

- Hypertension
- Prostate enlargement
- Insomnia

Medications

- Lisinopril 10 mg daily
- ASA 81 mg daily
- Tamsulosin 0.4 mg daily
- Ambien 10 mg daily
- Multivitamin daily
- Vitamin C 500 mg daily

- Vitamin E 1000 units daily
- Saw Palmetto 320 mg daily

Family Members

Rebecca Johnson and John Martin (JoAnn's daughter and son)

JoAnn was a model grandmother when her son and daughter had children. She helped frequently, including babysitting once a week while her daughter worked, and keeping her two sets of grandchildren on some weekends. They all missed her when she moved to Florida and they felt a loss. JoAnn came to visit some, and they went to Florida to visit, and they talked on the phone frequently. But they felt the distance. Her daughter especially noticed the changes in JoAnn's memory over the past year and she pushed George to find out what was going on. But JoAnn acted like everything was fine and George didn't want to push her. It wasn't until JoAnn had a couple of minor car accidents that he had to take some action. The memory problem continued to get worse.

Rebecca and John both live in St. Charles with their families. Rebecca is a teacher at a local school and has a daughter in college and a son in high school. John is an architect and works for a local firm. He has 3 children, ages 7, 10, and 14. They want George and JoAnn to move into a place that offers "some help" for JoAnn in St. Charles so they can see their mother as often as possible. They know they can also help George out so it will not be too much for him to manage, despite their busy lives. They acknowledge that she has a memory problem, but it doesn't seem that bad to them.

Theresa and Bob Galloway (George's daughter and son)

Theresa (divorced with 2 children ages 9 and 13 years) and Bob (wife Eileen, children 18 and 12 years) both have families and live in South St. Louis County. They have never felt that close to JoAnn, although they liked her and were glad their father found some companionship in his later years. But they always felt like they were truly stepchildren and that she favored her own children over them. They could never visit during spring break because her kids were always visiting, and photos of their children were barely evident around the house.

At this point, they don't want their Dad to give up the rest of his life to taking care of her, and they would like him to be nearby so they can enjoy his being back in town. They are hoping he will place her in a nursing home, where she will get full time care. Then he can go visit, but also be able to play golf and do some things that he enjoys while he is still able.

Charge for the Case

The healthcare team will need to work with this blended family to address the health care needs of JoAnn and George and provide them with resources and information to address this complicated situation so that they can find a solution they all can all live with.

Sample Case 4

Interprofessional Geriatric Case Competition

Trying to Catch his Breath: The Henry Williams Case*

Background

Henry Williams is a 69-year-old African American and retired rail system engineer who lives in a small apartment with his wife, Ertha in a small town. Henry and Ertha had one son who was killed in the war 10 years ago. They have a daughter-in-law, Betty, who is a nurse, and one grandson, Ty. Henry was admitted to the hospital last night after he called the doctor and told him that he could not catch his breath. Henry has several medical problems including COPD, hypertension, and high cholesterol. Henry is concerned about staying in the hospital because about Ertha is experiencing frequent memory lapses, and he is usually home to help her. Betty was able to take Ertha home with her, but this impacts her work and home life. Henry will be discharged when his breathing has stabilized for rehabilitation, but long-term plans are needed for when he is ready to go home.

Psychosocial and Family History

Details about Henry and his family are reported through a narrative interview during his hospitalization. His daughter-in-law Betty also provided an interview that outlines the challenges this family needs to address.

Henry Williams Narrative (in Hospital)

Hello, my name is Henry Williams (stops frequently during his story to breathe, O2 nasal cannula, coughs, appears hypoxic). Life sure has changed over the last two, three years, retirement just isn't what we thought it would be... we... that would be Ertha and me. I spent my life working for the Transit Department, as an engineer for the rail system. I'm pretty proud of this accomplishment. I was on the forefront of desegregation in college and the workplace.

Well, no one could tell me to stop smoking you know, especially when I was younger. I started smoking when I was a teenager, everyone smoked back then. I have had frequent bouts of colds, bronchitis, asthma and so forth but now they tell me it's COPD, whatever that means, but it sounds scary. I also have a little high blood pressure, but it's not too bad. I already take two pills for my high blood pressure and a cholesterol pill, aspirin and a breathing pill. Now they want to add inhalers and oxygen? What next? I hope my insurance will pay for all this stuff.

Ertha and I have always been active and independent, so we thought we would retire to this nice apartment and do some traveling since it's just the two of us. We haven't done much of this with my health and now Eartha's. We have adjusted to that OK, I guess. We lost our only son to the Gulf war – that really changed our lives as well; I don't think Ertha has ever been the same. He left us a lovely daughter-in-law, Betty and a grandson, Ty, but they live a couple of hours away in the city and it's hard for us to get there.

And now, Ertha is getting forgetful and it's hard to leave her. We go to the Baptist church regularly, but I can't let Ertha go alone to the ladies' stuff anymore. She used to go every Tuesday. I get so anxious now and I'm worried all the time about my wife, she is good some days and other days she can't remember things and she asks for Anthony, our son. That is so upsetting for both of us and she cries when I tell her he is gone.

I really lose my patience sometimes with Ertha. She forgets the stove is on, can't find her keys, forgets what day it is, and thinks Betty and Ty haven't visited us in years, when they were just here. I've had to watch her when she cooks, take her with me on walks. We just can't be apart and that gets frustrating.

Betty is a nurse, and she can take Ertha home with her while I am sick here in the hospital, but we need to think about a new plan so Ertha is cared for and I am too. I don't want a nursing home, but I hear there are some of those apartments where they help you some. Maybe that would be a good place for us.

The social worker lady said we might have to go on a waiting list before we can go into those apartments where they help you with a bath and some food. Ertha doesn't eat so well and can't cook so well anymore so help would be nice. I wonder if they help with the medications and baths. Ertha gets upset when I make her shower. We'll see! I have to rest now; you will have to ask me questions later.

Betty info Day 5: My goodness, how will Betty be able to keep up. She's already got her hands full with her career and her son, our grandson. Now she has to worry about helping us get settled. I'll be praying for her strength. Well, today they are getting me ready to move over to the rehabilitation center. I hope they know what they're doing. And I sure hope I get to see Ertha sometime soon. I miss her. I hope she doesn't have any trouble remembering me. I really do miss her.

Daughter Betty's Narrative

I'm Betty, Ertha and Henry's daughter in law. Their son Anthony was my husband who was killed overseas in the service. I've since been raising our son Ty on my own, he is now 12 years old. Ertha and Henry have been able to help me with Ty even though we don't live near each other. Since their health has declined it has been an uphill battle. Currently I have Ertha here with me in St. Louis as Henry has been in the hospital with an exacerbation of his COPD. I have had to take time off work to take care of her as she cannot be left alone very long--she gets really confused. Her surroundings here at my house are unfamiliar, unlike her own house where she seems to do better. She keeps asking for Anthony and even at times calls Ty Anthony 'cause she gets so confused.

Ertha is becoming very hard to deal with when it comes to her hygiene; it is a constant battle to get her to take a shower or even brush her teeth because she feels like she just did that. Just taking Ty to school has become a chore, and I've had to cancel several of his afterschool activities due to Ertha living here with us needing me full time to make sure she is safe and okay. The only time that I have to myself is at night, so I

have not been getting much sleep since that is when I normally get things done around here.

Looking to the future I am having a hard time and I am feeling very frustrated as I know it would be better for Ertha and Henry to stay in Poplar Bluff where they live and attend their church and those kinds of things. I do not attend church here in St. Louis. I think Ertha misses church when she's here and Henry has also expressed his desire to go to church. Poplar Bluff is very limited when it comes to assisted living and care homes and I think they might get separated and that would break their hearts. In many ways, St. Louis would be a better option as I would be able to visit them, keep in touch with my family, and keep "life" together, but again I think it would be better for them to be in their own environment. I'm at such a loss at this point and don't know what to do.

Physician/PA/NP Notes

Henry Williams was admitted to the ED with a three-day history of progressive dyspnea, cough, and increased production of clear sputum. He usually coughs up only a scant amount of clear sputum daily and coughing is generally worse after rising in the morning. He denies fever, chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. He treated himself with albuterol, but respiratory distress increased despite multiple inhalations. Upon arrival to the ED, there were few breath sounds heard with auscultation and the patient was so short of breath that he had difficulty climbing up onto the examiner's table and completing a sentence without a long pause. He was placed on 4L oxygen via nasal cannula and given nebulizer treatments. He participated in PT and OT to improve his function. His condition has stabilized, and he will be discharged for rehabilitation to improve his muscle strength and endurance, pulmonary rehabilitation.

PMH

HTN X 10 years

COPD diagnosed 6 years ago

Occasional episodes of acute bronchitis treated as outpatient with antibiotics.

History of TB, asbestos exposure, occupational exposure, asthma

Family History

Father died of lung CA

Mother is alive, age 80, also has COPD and is being treated with O2.

One sister, developed heart disease in her 50s.

Only son, deceased, good relationship with daughter-in-law Betty.

Social History

Married to Ertha for past 47 years.

2 pack/day Camel smoker for 37 years, has cut back to 5 cigarettes/day since he was diagnosed with COPD and is now willing to consider complete smoking cessation.

History of alcohol use, a social drinker for the past 15 years.

Significant findings on exam:

Skin: Cold and dry, poor turgor

HEENT: Normal, missing teeth

Neck and Lymph nodes: (+) mild JVD

Chest and Lungs: Use of accessory muscles at rest, barrel chest, poor diaphragmatic excursion bilaterally, percussion hyper-resonant, poor breath sounds throughout, prolonged expiration with occasional mild, expiratory wheeze; (-) crackles and rhonchi, (-) axillary and supraclavicular lymphadenopathy

Heart: WNL

Abdomen: (+) hepatosplenomegaly, fluid wave, tenderness, and distension

Genitalia and Rectum: Prostate slightly enlarged, but without nodules

Musculoskeletal and Extremities: cyanotic nail beds, 1+ bilateral ankle edema to mid-calf,

Neurological: WNL

Medications

- Advair Diskus 250 every 12 hours
- Albuterol 2 puffs as needed for acute onset of shortness of breath
- Crestor 20 mg every evening
- Lisinopril 12.5 mg oral daily
- Lopressor 50 mg daily
- ASA 81 mg daily
- Singulair 10 mg every evening
- Prednisone 40 mg for 2 more days , then 20 mg for 5 days, then 10 mg for 5 days and follow up in the clinic for further orders
- Albuterol 2.5 mg & Atrovent 0.5 mg in 3 cc NS q 4 hours and PRN (decrease frequency, as tolerated)

Occupational Therapy Notes (Excerpts)

According to the chart, pt. has dentures , wears bifocals, and has hearing aids, but complains they do not work well. Pt. is on O2, 2l per nasal prong and according to nursing notes has had sat rates generally around 90% at rest. Pt. views himself as generally independent but struggling to keep up himself, attend to his wife, and sustain the house, yard, and car. He revealed loss in other areas such as his church participation, reductions in volunteer activities, decline in previous leisure such as woodworking, and couples bridge. He states he has resorted to use of TV dinners most nights even though he knows he should not be making a habit of them, but Ertha seems to enjoy them more than anything else he makes. He worries because she is losing weight. Pt. complains that his house “is a wreck... my daughter is going to think I’ve become one of those hoarders you see on TV when she sees it.” He states his yard is “an utter humiliation...if you could have seen the gladiolas and marigolds I used to grow.”

Over the course of OT, pt. has made significant gains in knowledge about factors that will impact his SOB and fatigue. He required mod A and use of a bath chair and O2 at 2l. He was fatigued but able to sustain sat levels of 85-90% using recommended methods. Pt. was steady on his feet with no c/o dizziness OTR dressed him in hospital gown in bed after the shower and he was encouraged to rest with HOB elevated until breakfast tray arrives in approx. 45 mins. Pt. expressed pride that he has made some progress in his abilities today and hopes that someone can bring his wife up to visit him

today. OTR reminded pt. that his tray can be reheated, so he can rest until he feels refreshed.

Pt. functions best in ADL activities with less SOB earlier in the day. If pt. decides to return home with continued responsibilities for his wife, it may be best if they could hire a caregiver to come daily to deal with her care so that he still has enough reserve to engage in leisure or other activities. At times pt. is unable to fully recall events of the previous day, but it is unclear if this is actual cognitive impairment or a result of anxiety. It is difficult to determine if long term memory is fully intact as there is no one available to confirm accuracy of info he provides.

Physical Therapy Notes (Excerpts)

Assessment

Cognition/language: Alert, oriented to time, place and person. Consistently follows instructions.

Sensation: Light touch and kinesthesia intact LEs.

Motor: PROM WNL. Tone: WNL. Strength: 4/5 hip flexors and knee extensors; 4-/5 hip abductors; 4/5 ankle dorsiflexors and plantar-flexors. Balance: Independent sitting.

Modified Clinical Test for Sensory Interaction in Balance (CTSIB): Able to maintain standing eyes open and eyes closed on firm surface 30 secs without increased sway; able to maintain standing eyes open 30 secs on foam without increased sway; mild to moderate increased sway standing on foam eyes closed 10 secs. Functional Reach Test: 10 inches. Stands on one leg eyes open R LE 10.5 secs, L LE 10.8 secs. Stand on one leg eyes closed for 1 sec bilaterally.

Mobility: Independent bed mobility. Modified independent transfers moving between bed and bedside chair. Patient complained of mild dizziness when going from sit to stand, but this resolved quickly. Minimal assistance for walking to bathroom. Able to tolerate sitting for 30 minutes before requesting to go back to bed. Ambulation with 2 liters supplemental oxygen 100' level surfaces with minimal assistance, stopping 1 time momentarily to rest due to SOB. No loss of balance during walking. Slow gait speed. O₂ sats at 90% prior to ambulation, 88% immediately after ambulation, and then 90% after 5 minutes of rest at end of session, all on supplemental O₂. Stairclimbing/steps not assessed.

Discharge Note

Patient made progress toward goals during this admission. Continues to have impairments of LE weakness, limited endurance, and impaired motor and sensory strategies for balance. Has activity limitations of need for assistive device for walking and reduced gait speed. Needs continued therapy to progress toward goal of independent and safe mobility. Patient has been educated in safety precautions regarding decreasing episodes of orthostatic hypotension and how to walk safely indoors with the FWW. As he becomes more mobile, he will need to experience walking in a variety of environmental conditions and his need for assistive devices will need ongoing assessment. He needs continued balance assessment and intervention. He will need a home environmental assessment prior to D/C from the rehabilitation facility to ensure independence and safety in the home. Patient's wife has observed patient in therapy but is unable to assist Henry with mobility due to her cognitive impairment. Patient needs to progress to the level of at least modified independence with all mobility

in order to return to home. Patient has potential to progress to this level with intensive in-patient rehabilitation and will need to engage in life-long fitness activities as tolerated.

Charge for the Case

Long-term plans are needed for Henry and his wife Ertha to keep them safe and healthy. The healthcare team will need to work with this family to address this complicated situation so that they can find a solution they all can live with when Henry is discharged from the rehabilitation facility.

*Adapted from the Henry and Ertha Williams Case, ACES (Advancing Care Excellence for Seniors), National League for Nursing, <http://www.nln.org/professional-development-programs/teaching-resources/ace-s/unfolding-cases/henry-and-ertha-williams>