



CATCH-ON

CATCH-ON Evolving Cases:
Instructor Guide
August 2017

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www.catch-on.org

About This Instructor Guide

Purpose

This instructor guide provides an introduction to the CATCH-ON (Collaborative Action Team training for Community Health – Older adult Network) evolving cases.

These cases are designed to build upon and allow for integration and application of our online modules regarding normal aging, managing multiple chronic conditions (MCC), Alzheimer's Disease and Related Dementias (ADRD), and working in interprofessional teams. The series of 10-minute modules is available online for free for all health care professionals and students (<http://catch-on.org/hp-home/hp-online-education/>) along with a version for older adults and families (<http://catch-on.org/oaf-home/oaf-online-education/>). The cases can be used independent of the online modules, but it is recommended to use them together.

Structure

This instructor guide contains materials to aid you in facilitating the CATCH-ON evolving cases. Each case consists of an older adult evolving case description, discussion questions, teaching points, assessment questions, and links to related references and resources. Additional learning activities are included regarding related content.

Audience

This guide is designed for instructors of graduate level health profession courses.

These cases are designed for use in graduate level health profession courses or seminars. They may be used within individual discipline courses, though optimal learning may come from interprofessional groups of students. Each case meets different learning objectives and incorporates different physical, psychological, social, and environmental issues, so each of the cases can be fit into a variety of different course learning objectives.

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Brief Overview of CATCH-ON

Overview

Collaborative Action Team training for Community Health – Older adult Network (CATCH-ON) is a Health Resources and Services Administration (HRSA) funded Geriatrics Workforce Enhancement Program (GWEP). The 44 GWEPs across the US were funded to “support the development of a health care workforce that improves health outcomes for older adults by integrating geriatrics with primary care, maximizing patient and family engagement, and transforming the healthcare system.” Learn more about the GWEPs at <http://bhpr.hrsa.gov/grants/geriatricsalliedhealth/gwep.html>.

The overarching mission of CATCH-ON is to unify academic, health, and community organizations and resources to prepare a geriatric collaborative practice-ready health workforce optimizing health while serving and improving patient-centered health and wellness outcomes. CATCH-ON's primary objectives include:

1. Educate older adults, families, caregivers, direct care workers, health professions providers, students, residents, fellows, and faculty about normal aging, family and person-centered, culturally competent, interprofessional team management of multiple chronic conditions (MCC) among diverse older adults, especially those with cognitive decline, and Alzheimer's Disease and Related Dementias (ADRD).
2. Transform existing primary care systems to meet the needs of older adults with MCC and/or ADRD by implementing evidence-based programs that utilize provider, older adult and community resources. Critical innovations to achieve these aims include: interactive, universally accessible online modules for all learners, regional and statewide Learning Communities, Health Ambassadors for community health, and including Health Ambassadors in creation of the new CATCH-ON Community Health primary care model.

CATCH-ON Curriculum Enhancement

The older adult population is growing rapidly and all health care professionals must be prepared to meet the unique needs of older adults. Unfortunately, most graduate health education programs currently offer very little geriatric training, and adding courses to curriculum can be challenging. Further, most health education faculty have little geriatric training, and thus often do not include geriatric content in their courses. These evolving cases and associated learning resources were developed to offer faculty an opportunity to include geriatric content prepared by an expert interprofessional team of geriatric experts, and to become better prepared as instructors in the process.

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How to Use the Cases

About

These are evolving cases that can function as standalone narratives used in parts or in total, depending on the time available and learning circumstance. These cases represent a compilation of the authors' experiences, inspired by their work with older adults and their families. They are designed to help learners see older adults as individuals rather than compilations of symptoms. They highlight multiple social determinants of health that are critical to understanding and effectively treating older adults. The cases also highlight common presentations of illnesses and syndromes that are different from presentations in younger adults. Each section of the evolving case is accompanied by discussion questions designed to target a wide variety of health professionals; individual disciplines may choose to focus on some questions more than others. All disciplines are strongly encouraged to consider how other disciplines may view the same information.

Development

Consistent with Bloom's Taxonomy of Educational Objectives (Bloom et al, 1956: remember, understand, apply, analyze, evaluate, create), we developed our online modules to provide basic knowledge for learners to remember and begin to understand. With these cases, learners are able to expand knowledge, as well as to understand and apply the knowledge with each successive element in the cases and analyze similarities and differences with each additional case.

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Case Details

Learning Objectives Addressed	Mable Evans	Maria Martinez	Lawrence Kozlowski	Janice Kemp
1.1 Describe functional changes in later life.		X	X	
1.2 Incorporate appropriate tools and techniques to address the functional challenges of older adults.		X	X	X
2.1 Compare frameworks for managing MCC and individual conditions.		X	X	X
2.2 Demonstrate the ability to incorporate basic cognitive, psychological, functional, physical, and safety assessments in the older adult population with MCC	X	X	X	
2.3 Incorporate self-management strategies into the care plan for all older adults with MCC.		X	X	
3.1 Recognize the unique factors in managing older adults with MCC in the context of dementia.			X	X
3.2 Describe the assessment and approach for the hospitalized older adult with MCC/Dementia.			X	X
3.3 Describe strategies for medication management for the older adult with MCC/Dementia.			X	
4.1 Explain the role of the team in the care of older adults with MCC.	X	X	X	X
4.2 Incorporate strategies of effective communication with and within a team to improve quality of care and reduce caregiver burden.	X	X	X	

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	Mable Evans	Maria Martinez	Lawrence Kozlowski	Janice Kemp
Gender	Female	Female	Male	Female
Ethnicity	African American	Latina	Polish American	Caucasian
Medical issues	<ul style="list-style-type: none"> • Arthritis • Heart failure • Atrial fibrillation • Urinary incontinence • Shortness of breath • Weakness • Falls 	<ul style="list-style-type: none"> • Arthritis • Hypertension • Diabetes • Depression • Recent Stroke • Chronic pain 	<ul style="list-style-type: none"> • Diabetes • Hypertension • Hyperlipidemia • Arthritis • Emphysema • Vision problems 	<ul style="list-style-type: none"> • Diabetes • High cholesterol • Asthma • Arthritis • Dementia
Setting	Urban	Urban	Rural	Rural
Connection to community services/resources	X	X	X	X
Settings – start in formal setting (clinic/hospital/ED)	X	X	X	X
Transfer to different settings			X	X
Continuity of care across settings			X	X
Ageism	X			
Rural issues			X	X
Literacy	X	X		
Nutrition	X		X	
Finances	X	X		X
Support network	X	X	X	X
Ethnicity		X		
Mental/behavioral health		X	X	
End of life/palliative care				X
Decision making capacity			X	X
ADLs	X	X	X	X
IADLs	X		X	
Historical context – era raised in		X	X	
Family/caregivers	X	X	X	X
Substance use/abuse	X	X	X	

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Case Study: Mr. Kozlowski

Part 1:

Lawrence Kozlowski is a 75 year old, college educated, military veteran (served tours of duty in Korea and Vietnam), and retired business executive. He lives alone on the family farm where he was raised. He relocated to the farm after 30 years in the suburban home that he shared with his wife until her death 5 years ago. Mr. Kozlowski was physically active, playing golf and tennis and hunting for many years. He now occasionally plays golf with a few friends when the weather is good and they can get a golf cart. He gave up tennis about 10 years ago following a shoulder injury. Although he still has his rifle, he no longer hunts after the last of his hunting buddies and beloved hunting dog died a few years ago.

After graduating from high school, he enlisted in the Army. After 3 years, he returned home, worked in a coal mine and eventually entered college, which he finished in 4 years. He met his wife, Mary, while they were both in school. Mr. & Mrs. Kozlowski had three children: Anne, Marianne and Eugene. All three children went to college. Anne lives down state with her husband and their two children on a farm 90 minutes south. Anne also works as a nurse in a community long-term care facility. Marianne is on the fast track to partner in a high powered big city law firm about four hours away from her father. Eugene is the youngest and lives on the west coast with his wife Sarah, and their one child.

Setting:

Today, Mr. Kozlowski lives alone, and his sister Charlotte lives in the next town. He has hired help with the lawn and chores around the house. He does his own laundry, but is having increased difficulty getting up and down the stairs because of arthritis in his knees. For meals, he drives himself to a roadside restaurant or buys prepared food that he heats in his microwave.

He notices himself slowing down a bit and his daily activities are becoming more limited. He is having a hard time getting out and admits it is a little depressing being alone while seeing some of his friends pass away. When his children do visit, he states, "they make me feel like I am getting old."

He now notices that his vision is not as good at night. Although he has been told that he has diabetes, hypertension, hyperlipidemia, arthritis and emphysema, Mr. Kozlowski does not pay much attention to these, although he notices that he has more difficulty getting around and breathing when he forgets to use his inhaler.



Discussion Questions

What non-medical services would be beneficial for Mr. Kozlowski?

Teaching Points

- ✓ Connecting to local community Area Agencies on Aging (to identify local resources)
- ✓ Elder Care Locator: <http://www.eldercare.gov>
- ✓ Benefits Check-up: <https://www.benefitscheckup.org>
- ✓ Homemaker service
- ✓ Meals on Wheels
- ✓ Participation in Area Agencies programming, services
- ✓ Self-management supports - Chronic Disease Self-Management program, Matter of Balance
- ✓ Senior Health Insurance Program (SHIP) Counselor for help with Medicare
- ✓ Neighbors, Friends, Church community, Clergy / Chaplain
- ✓ Role of the children in long distance caregiving
- ✓ Home and community based care program offered through the Veteran's Administration.

What health care disciplines should play a role in Mr. Kozlowski's care at this point?

Teaching Points

- ✓ Social Worker for care management
- ✓ Physical Therapy
- ✓ Ophthalmology
- ✓ Primary Care Physician

What role do social determinants of health play in this situation?

Teaching Points

- ✓ Health and health care:
 - Health education could also improve awareness of health conditions and improve health literacy.
 - Access to health care and primary care could include a more comprehensive assessment, targeting multiple chronic conditions (MCC), functional assessment, and access to community resources to support his care.
 - Limited access (or non-clinician access) to health care for prevention, management and treatment of chronic conditions may be a reality in rural communities.
 - Rural providers are more likely to accept Medicare coverage than Medicaid or no insurance.

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- ✓ Education:
 - Mr. Kozlowski is a high school graduate with a bachelor's degree. Advanced education is associated with higher health outcomes.
- ✓ Economic stability:
 - Mr. Kozlowski has a stable pension from his years of working.
 - Stable housing is available via the farm and associated assets.
 - Food security is possible through access to farm produce.
- ✓ Social and community context:
 - Social isolation places older adults at risk for poor health outcomes, depression, cognitive decline and financial abuse.
 - Civic participation helps serve as a protective factor.
 - Mr. Kozlowski's social network is aging and less likely to be available for support
 - Family lives at a distance and may not recognize growing problems.
 - Transportation may be an issue if a rural home dweller does not have family/friends to drive and they are no longer able to drive.
- ✓ Neighborhood and build environment:
 - Country living provides access to health organic foods.
 - Crime and violence are lower in rural environments as compared to urban centers.
 - Rural contexts subject people to lower environmental toxins and pollutants.

Question 1

The health of rural older adults is impacted by:

- A. Limited access to health care for prevention, management and treatment of chronic conditions
- B. Abundant access to help with activities of daily living
- C. Easy transportation to medical appointments
- D. Higher levels of education among rural adults.

The correct answer is A

Question 2

Health care outcomes for rural older adults, are influenced more by:

- A. Social position and insurance status
- B. Clinician access and economic status
- C. Geography
- D. A, B and C

The correct answer is D

Part 2: 12 months later

Over the past few months, Mr. Kozlowski's friends have seen him driving erratically. On one recent foggy night while driving home from church, he hit a stop sign. While he

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escaped injury, the car's front end was damaged. He called his daughter. Anne drove ninety minutes north to check on him.

While visiting, Anne noticed that the garbage had not been taken out for a few weeks and that there were stacks of unopened mail on the dining room table. Mr. Kozlowski told her that the cleaning person had back surgery a few months ago and had not been back. He had not considered finding a new housecleaner. Anne scolded him about the mess and told him to look in the local newspaper or call the church to find a new housecleaner. She also told him to be more careful driving at night and not to go out in bad weather. On the drive home, Anne thought about what she and her siblings would do when their dad could no longer live alone. "Thank goodness we're a few years away from that," she thought.

During his annual visit to his primary care physician, Dr. Patel, Mr. Kozlowski reported that he was worrying more about the future and having trouble sleeping at night. Dr. Patel noticed that Mr. Kozlowski was wearing a stained and wrinkled shirt with dirt-caked shoes and had lost 15 pounds since his last wellness check. He spent a little more time asking Mr. Kozlowski about how things were going for him all alone on the farm. When asked about his diet, Mr. Kozlowski said, "I keep pot pies in the freezer. I heat those up in the microwave or I just make a sandwich. Dr. Patel wondered aloud about Mr. Kozlowski's remembering to take all his medication every day. "Don't worry, Doc," Mr. Kozlowski said. "I keep my medicine all lined up on the kitchen counter and I take it at the same time every day. I don't forget my medicine, no sir!"

Dr. Patel did a complete physical and neurologic examination. Other than his lungs (which show signs of COPD resulting from his days as a coal miner) and signs of arthritis, the physical exam was normal for his age. Dr. Patel told Mr. Kozlowski that in addition to his lungs, he was concerned that Mr. Kozlowski was having increasing difficulty in caring for himself and may be developing memory loss. He was concerned and wanted to do a more extensive work-up to determine what help Mr. Kozlowski may need.

Discussion Questions

What are your medical and social concerns for Mr. Kozlowski?

Teaching Points

At this point, the primary care physician has identified concerns and should implement a more structured formal assessment of the older adult with Multiple Chronic Conditions and functional decline.

- ✓ Medical illness: comprehensive physical and neurological exam, targeted labs and imaging
- ✓ Medications: thorough review, adherence, reconciliation); pharmacy check or referral

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- ✓ Impaired driving: formal driving assessment
- ✓ Impaired vision/hearing: eye exam, ophthalmologist and audiologist referral
- ✓ Poor nutrition: unintentional weight loss is associated with multiple adverse outcomes, so refer for formal nutrition assessment by dietitian, weight loss, dentition
- ✓ Hygiene: Occupational Therapy referral for assessment of Activities of Daily Living (ADL's) and Instrumental Activities of Daily Living (IADL's)
- ✓ Impaired memory, getting lost: labs, imaging, Mini-Cog, neuropsychological evaluation if available
- ✓ Pain: pain inventory
- ✓ Social isolation (poor prognostic indicator)
- ✓ Home safety/Environment: referral to home health care and/or referral for home safety check by Care Coordination Unit and/or Occupational Therapy
- ✓ Emotional status: administer PHQ-4; if positive, administer PHQ-9; if positive, refer to mental health specialist
- ✓ Balance/Gait/Falls: orthostatic blood pressure, fall risk evaluation, gait evaluation
- ✓ Urinary incontinence (UI) check: if patient has lost urine >5 times in past year
- ✓ Advance Care planning: Health Care Power of Attorney, Durable Power of Attorney (finances, property), estate plan

What services would be of use to him right now?

Teaching Points

- ✓ Vision: Low Vision Program and resources
- ✓ Transportation
 - Transportation assistance
 - Suggest to participate in the "55 Alive" class at the local Senior Center
- ✓ Nutrition
 - Meals on Wheels or meals at the Senior Center
 - PeaPod or other food delivery service
- ✓ Senior Center
- ✓ Home health evaluation
- ✓ Confirm medication adherence with pharmacy; arrange home delivery and/or a referral to the Parish Nurse program at his church to help organize his medications
- ✓ Technology
 - ✓ A cell phone with GPS in case he gets lost
 - ✓ A computer with a camera for face time chats with family and friends; assure that he knows how to use this or can access assistance with using them
- ✓ A comprehensive assessment by the Community Care Program for homemaker services which can help get trash out and clean even if he needs to pay privately for services

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- ✓ Referral to the AARP Volunteer Money Management program to help with mail and paying bills
- ✓ Medical alert system (consider since lives alone and no local checks and balances)
- ✓ Referral/consultation with an Elder Law/Estate planning attorneys
- ✓ Home and Community Based care programs coordinated by the Veterans Administration network, or subcontracted through VA through the Community Care Programs.

How would you go about identifying those services?

Teaching Points

- ✓ The Illinois Network of Centers for Independent Living (INCIL)
 - <http://www.incil.org/>
- ✓ The State and Area Agency on Aging:
 - http://www.aoa.gov/AoA_programs/OAA/How_To_Find/Agencies/find_agencies.aspx
- ✓ Eldercare Locator: <http://www.eldercare.gov>

What are the barriers to receiving these services and how will each of you try to address these?

Teaching Points

- ✓ Insurance or financial qualifications for certain services:
 - Prior authorization for services: assure appropriate referrals
 - If services are not covered, seek other services or approximation of services. For example, if the older adult has exhausted their physical therapy benefit, look for a Matter of Balance class at a local senior center
- ✓ Transportation to appointments with medical, financial, social services
- ✓ Coordination of care: direct calls with case management, documentation
- ✓ Rural location/isolation- transportation, adult day center, friendly visitor program
- ✓ Willingness and adherence of older adult to recommendations: align services with the older adult's goals
- ✓ Availability of specialty services due to location (rural) or waiting list
- ✓ Uncertain family involvement

What are transportation options are available to rural dwelling older adults?

Resources

- ✓ National Rural Transit Assistance Program Directory of State RTAP Managers: www.nationalrtap.org (This resource provides a directory of state, regional and local programs)
- ✓ Locally, one should check with the county or region to decide what additional programs may be available.

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- ✓ Uber services are becoming increasingly available in specific rural communities for transportation assistance,
- ✓ Local area Veteran's Administration (VA) hospitals may have transportation services available to their constituents.

When should someone stop driving?

Teaching Points

- ✓ Required adequate function for driving: vision, attention, reaction time, executive function (judgment, problem-solving, planning) physical strength, flexibility
- ✓ Functional decline related to conditions associated with aging does not affect all drivers at the same rate or in the same way. Some of the specific abilities needed to drive safely discussed above may decline as we age. However, the rate of change varies greatly across the older adult population. Risk begins to increase at age 70 and is greatest for those over 85. Learning new or compensatory strategies, or by training on adaptive equipment, many older adults can continue to drive safely. Providing information about alternative transportation, communities also can help older adults make smoother transitions away from driving.

Resources

- ✓ <https://nihseniorhealth.gov/olderdrivers/howagingaffectsdriving/01.html>
- ✓ https://www.cdc.gov/motorvehiclesafety/older_adult_drivers/

Discuss your discipline's role in deciding this and how you work together as a team to provide options if driving is restricted.

Teaching points:

- ✓ Consultation with primary care provider, ophthalmologist
- ✓ Driving evaluation through a rehabilitation program, often involve occupational therapy and/or neuropsychology
- ✓ Social work/case management: identifying transportation alternatives
- ✓ Physician: can report driving revocation to the state's Department of Motor Vehicles
- ✓ National Highway Traffic Safety Administration Drive Well Toolkit: Promoting Older Driver Safety and Mobility in Your Community.
<https://www.trafficsafetymarketing.gov/get-materials/older-drivers/drivewell-toolkit>

What types of food programs are available for rural dwelling older adults?

Teaching Points

- ✓ The Child & Adult Day Care Food Program (CACFP) is a federal program providing healthy meals and snacks to adults receiving day care

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- ✓ The Senior Farmers' Market Nutrition Program (SFMNP) is offered through the USDA Food and Nutrition Service to provide low-income seniors with coupons that can be used at farmer's markets, roadside food stands and community-supported agriculture programs to promote the consumption of fresh fruits and vegetables.
- ✓ The Eldercare Locator (<http://www.eldercare.gov>) for information about local Congregate and Home Delivered Meal programs

Discuss the specific role your discipline plays in the care plan, and how your role integrates with other disciplines on the team involved in his care plan.

Teaching Points

- ✓ Older adult: critical to include the older adult at the center of the team - personal goals and preferences must be prioritized
- ✓ Family/caregiver: involved in the process to the extent possible and desire by the older adult
- ✓ Team: work toward an integrated care plan
- ✓ Physician, Physician Assistant, Nurse Practitioner: Physical examination, cognitive screening, mental health assessment
- ✓ Nurse: care coordination, patient education, ADL/IADL screening, assessment tool screening
- ✓ Pharmacist: medication review/reconciliation, [patient education, access, adherence, monitoring
- ✓ OT: ADL/IADL assessment driving and home safety checks, fall assessments
- ✓ PT: mobility, strength, upper extremity assessments and strengthening
- ✓ Psychologist:
 - Neuropsychological assessment provides detailed information about cognitive strengths and weaknesses. It can be incredibly helpful in diagnosis and treatment planning to identify which elements of cognitive functioning (e.g., memory, executive function, speed of processing) the older adult is performing consistently with those their age, and which are impaired.
 - The psychologist can also provide mental health diagnostic assessment, psychotherapy, and health behavior intervention
- ✓ Social Work: psychosocial assessment, individual and family counseling, self-management support

What psychological issues need to be addressed? Discuss your discipline's role in this situation and how you work together as a team to address this.

Teaching Points

- ✓ Progressing dementia
- ✓ Decision-making capacity for health care, finances, legal issues
 - See APA/APA Capacity evaluation tools: <http://www.apa.org/pi/aging/programs/assessment/>

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- ✓ Increased risk of depression, anxiety, grief
 - Adjusting to a chronic illness
 - Autonomy and independence
 - Caregiver/family education

What social determinants of health need to be considered in this case and how do they play a role in this case situation?

Teaching Points

- ✓ Neighborhood/environment: Uncertain family contact/support
- ✓ Education: Higher levels of education ensure better health outcomes. Mr. Kozlowski does have a bachelor's degree, which may be an asset in the situation.
- ✓ Health care, vision, memory, medications, etc. may be compromised if there is a lack of access to health care and primary care. Health Literacy may also be an area of concern related to how concern for health issues are addressed by Mr. K.
- ✓ Economic stability - food security, housing stability, management of finances
- ✓ Social and community context - social cohesion, civic participation and the ability to access community resources or opportunities.
- ✓ Health and healthcare - access to health care and primary care, transportation
- ✓ Neighborhood - isolated, cannot cook/chooses not to cook, housing aid

Question 1

The safety of the older adult driver depends upon seeing traffic and road conditions and:

- A. Recognizing what they see
- B. Processing what they see and decide how to react to it
- C. Performing the physical movement required to control the vehicle
- D. All of the above

The correct answer is D.

Question 2

Unintentional weight loss among older adults is:

- A. Associated with adverse health outcomes
- B. Rarely associated with increased mortality
- C. Associated with increased functional ability
- D. Defined as a decrease of greater than 2% over 6 to 12 months

The correct answer is A.

Part 3: 24 months later

For his 76th birthday, Mr. Kozlowski's son and daughters gave him a shepherd collie to keep him company. The collie learned the way home and so, if Mr. Kozlowski got a little confused about the route, he could follow the dog back to the house. Sleep remained a

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problem and Mr. Kozlowski started drinking a shot or two of vodka before bed every night, which worked.

Then one night, Mr. Kozlowski got up to go to the bathroom and tripped over the sleeping dog. As he hit the floor, he heard a sickening crack and he could not move. The phone was out of reach. He never wore that alert button the kids gave him. It seemed like too much trouble. The next morning, Anne made her regular morning telephone call. There was no answer to multiple calls. Anne jumped in the car and raced towards Sesser. Within minutes, her cell phone rang. It was the homemaker calling to let her know that she was at the house and had found Mr. Kozlowski on the floor. He was awake and in a lot of pain. The emergency medical service was on the way. Anne drove to the hospital, where she met her father in the emergency department.

The emergency department physician called the orthopedic surgeon who admitted Mr. Kozlowski for hip surgery the next day. Post-operatively, Mr. Kozlowski was awake on and off throughout the day and night. He referred to his daughter Anne as his mother. He complained of “dogs barking outside of the room.” His recovery was slow. His children came together and debated next steps with each other and the medical team. They worried that he would not return to his baseline due to dementia. Mr. Kozlowski told his family that he planned to go back to the farm. An occupational therapy evaluation suggested that Mr. Kozlowski was currently able to function independently as long as he had people checking in on him every day. Mr. Kozlowski’s children wanted him to move to an assisted living facility (ALF). For Mr. Kozlowski, it was not an option.

Discussion Questions

What concerns do you have for Mr. Kozlowski at this point?

Teaching Points

- ✓ Decisional capacity: assessment and documentation in medical record should occur
- ✓ Cognitive impairment:
 - Mr. Kozlowski’s symptoms are consistent with delirium, most likely due to anesthesia, though infection and post-operative medications must also be evaluated
 - Risk factors for delirium: dementia, advanced age, MCC, sleep deprivation, immobility, pain, sensory impairments, recent hospitalization/surgery
- ✓ Physical safety at home: environmental assessments by occupational therapy are recommended
- ✓ Depression and suicide risk: depressed mood, loss of interest, weight loss, insomnia, feelings of worthlessness, recurrent thoughts of death
- ✓ Nutrition: continue assessment of food intake for adequate nutrition
- ✓ Social isolation: be aware of loss of interest and/or inability to engage in activities

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- ✓ Medication adherence: post-operative medication regimen is more complex, and may be difficult to self-manage
- ✓ Risk for elder abuse (inadequate caregiving, financial stress, isolation, depression, malnutrition, living arrangements inadequate for older adult needs, stressful family situations)
- ✓ Alcohol misuse (consider assessment and contribution to prolonged recovery)

What services should be included in his post-hospital treatment plan?

Teaching Points

- ✓ Follow up appointments with the primary care provider, orthopedic surgeon, ophthalmologist
- ✓ Social worker or nurse to coordinate care
- ✓ Homemaker
- ✓ Home physical and occupational therapy; assistive devices
- ✓ Meals on Wheels or another meal delivery service
- ✓ Transportation services
- ✓ Discuss removal of alcohol and the gun from the home with Mr. Kozlowski
- ✓ Support from friends, if possible
- ✓ Regular visits from the local Parish Nurse Program
- ✓ Continue to discuss residence options (senior housing, ALF, residential care, continuous care, palliative care, hospice care as needed in the future)
- ✓ Referral to legal services to assist with developing a trust to deal with Mr. Kozlowski's assets and Power of Attorney.

What are Mr. Kozlowski's rights in determining where he will live after his rehabilitation?

Teaching Points

- ✓ Recognize and address ageism. Age does not determine mental status.
- ✓ Decisional capacity is task and situation specific. In the event that this is a long term concern, a Power of Attorney may need to be in place.
- ✓ Diminished capacity may be reversible and temporary, such as during delirium
- ✓ Although Mr. Kozlowski is currently able to live on his own with intermittent daily supervision, this is not necessarily a long-term solution.
 - The team must encourage both Mr. Kozlowski and his family to prepare a backup plan for the time when Mr. Kozlowski can no longer live alone.
 - Least restrictive environment is an important concept to keep in mind when helping the person age in place. Supports to help him remain in his chosen environment are also important to consider.
 - Even if a decision seems like a bad decision to the health care team, where Mr. Kozlowski lives is his choice as long as he has decisional capacity.

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- ✓ The appearance of friends from the past who offer help may be a welcome relief for a worried family. It is important to remain alert to the possibility of financial abuse or undue influence.
- ✓ The health care team will need to communicate closely with each other, including Mr. Kozlowski and his family

Question 1

Adults over the age of 65 with decisional capacity have the right to:

- A. Drive
- B. Drink alcohol
- C. Choose where they live
- D. All of the above

The correct answer is D

Question 2

Risk factors for delirium include:

- A. Dementia and age
- B. Multiple medical illnesses
- C. Dementia, age, medical illnesses, depression and alcohol
- D. Depression and alcohol

The correct answer is C



Case Study: Mable Evans

Part 1: Emergency Room Visit

Mrs. Mable Evans is an 84 year old African American woman with history of multiple chronic conditions including arthritis, heart failure, atrial fibrillation, and urinary incontinence. She has had multiple emergency department visits due to shortness of breath (SOB), weakness and falls. Her primary care physician elected not to continue treating her due to the patient not following the physician's recommendations. The emergency room physician determines that Mrs. Evans would benefit from a more team-based approach to her care.

Discussion Questions

What are your initial concerns about this patient?

Teaching Points

- ✓ Multiple hospital admissions lead to high healthcare utilization and higher risk of infection for older adults
- ✓ Multiple chronic conditions (MCC) + age + geriatric syndrome = high level of complexity
- ✓ Falls
- ✓ Primary care physician relationship
 - Was the patient actually fired?
 - Was there an appropriate referral and handoff?
 - Does she have a primary care provider?
 - What does this mean to the patient regarding trust, medical care?
- ✓ Nonadherence to medical treatment plan
- ✓ Living situation – is her home safe if she is falling often?
- ✓ Self-management of chronic conditions
- ✓ Functional mobility for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)
- ✓ Cognitive status
 - Age + cardiovascular medical conditions + falls + not adhering to treatment plan suggests potential cognitive and mental health issues

Resources

- ✓ Older adults with MCC are more likely to be hospitalized than younger adults without MCC. Hospitalization costs of older adults with MCC are approximately 20% more expensive than those who are younger without MCC.
 - *Trends and Projections in Hospital Stays for Adults with Multiple Chronic Conditions: 2003-2014* <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb183-Hospitalizations-Multiple-Chronic-Conditions-Projections-2014.pdf>

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- ✓ Poor quality improvement outcomes and rising healthcare costs are frequently noted to be the challenge of taking care of patients with MCC. Patients living with MCC have a lower quality of life with increased mortality and higher rates of functional decline (disability). There is a direct correlation between the number of MCCs and increased healthcare utilization costs (i.e. outpatient visits, hospitalizations, home health care use, prescription drug use).
 - *Quality of Care for Patients with Multiple Chronic Conditions: The Role of Comorbidity Interrelatedness*
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3930789/>
- ✓ Annually, nearly 50% of community dwelling adults will sustain a fall. Falls are associated with increased mortality and morbidity and are a key indicator of frailty.
 - *Falls in the community dwelling older adult: A review for primary care providers* <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686332/>
- ✓ Nonadherence to medical treatment plans results in poorly managed MCC. Treatment nonadherence is due to many various factors, including poor patient-physician relationship, poor communication, lack of patient understanding of own medical condition(s), undiagnosed cognitive impairment, alcohol or drug dependence, socioeconomic and cultural issues.
 - *Factors affecting therapeutic compliance: a review from the patient's perspective* <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2503662/>
 - *Working with the Noncompliant Patient*
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2912714/>
- ✓ Poor caregiver support, increased assistance with ADLs, solitary living, female sex, and advanced dementia are all risk factors for nursing home placement.
 - Andel R, Hyer K, Slack A. 2007. Risk factors for nursing home placement in older adults with and without dementia. *J Aging Health*. Apr;19(2):213-28. DOI: 10.1177/0898264307299359

What sort of information would you want to know about the patient?

- ✓ Living situation
- ✓ Social supports
- ✓ Insurance
- ✓ Medicines: access, adherence, medical events
- ✓ Self-perception of health
- ✓ What prevented Mrs. Evans from adhering to the treatment plan?
- ✓ Literacy
- ✓ Health literacy

In any of your answers, do you notice any bias towards the patient? Is she being labeled as a “difficult patient?”

- ✓ Do we assume that nonadherence is exclusively the responsibility of the patient?
- ✓ What responsibilities does the provider have?
 - Explaining to patient

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- Provide referral and warm handoff
- How could other team members help to balance this load?
- Involve the patient in the treatment planning to assure that all are on the same page about the plan
- Identify barriers to treatment adherence
- ✓ Does Mrs. Evans have the same relationship with different providers? Are there parts of the treatment plan or providers' plans that she is adherent to?

What are some barriers to treating complex older adults in primary care?

- ✓ Time
- ✓ Health literacy
- ✓ Fragmentation: poorly coordinated care
- ✓ Access to services
- ✓ Bias among providers
- ✓ Lack of geriatric training
- ✓ Lack of awareness of community resources
- ✓ Administrative burden
- ✓ Lack of awareness of other team members who could contribute to care

Resources

- ✓ Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions
 - <https://pcmh.ahrq.gov/page/coordinating-care-adults-complex-care-needs-patient-centered-medical-home-challenges-and>

Test Bank

Question 1:

Which of the following is TRUE about nonadherent behavior?

- a. Nonadherent behavior improves medical outcomes
- b. Medication side effects improve patient adherence
- c. A patient-physician relationship with good communication improves treatment and medication adherence
- d. Cognitive impairment decreases nonadherent behavior

The correct answer is C:

Reference: Factors affecting therapeutic compliance: a review from the patient's perspective <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2503662>

Question 2:

Which of the following is/are barriers to treating complex older adults? (*select all the correct answers*)

- a. Patients possess knowledge of community resources
- b. Lack of adequate transportation to clinic appointments
- c. Lack of geriatric training among different specialty healthcare providers

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d. Low healthcare literacy and education

The correct answer is B, C, and D

Reference:

1. Issues affecting the health of older citizens: meeting the challenge

<http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume82003/No2May2003/OlderCitizensHealthIssues.html>

2. Traveling towards disease: Transportation barriers towards health care

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/>

Part 2: Visit 1 in Primary Care

Mrs. Evans arrives 20 minutes late for her initial appointment with you. Her son dropped her off at the entrance. She tells you she just wants her hips and knees to stop hurting her. She has been having increasing difficulty doing her own household chores; she is no longer cooking as it hurts her to stay on her feet too long. She relies on her son to do the grocery shopping, and often he buys TV dinners and canned goods. She does not talk with anyone other than her son who lives with her. She would like to move somewhere else, but her family relies on her to help pay the rent and frequently asks to borrow money from her.

Discussion Questions

What concerns do you have about the patient?

Teaching Points

- ✓ Social isolation
- ✓ Lack of support
- ✓ Possible elder neglect/financial exploitation
- ✓ Poor nutrition, especially salt with heart failure
- ✓ Pain management
- ✓ Deconditioning – functional status, mobility
- ✓ Self-care
- ✓ Health literacy
- ✓ Environmental safety and cleanliness
- ✓ Mood

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What assessments would you consider doing during your initial encounter with Mrs. Evans?

Teaching Points

Attend to the patient's primary concern and choose from these assessments (these measures can all be found on the CATCH-ON website: <http://catch-on.org/hp-home/hp-catch-on-community-health/asures/>):

- ✓ Functional assessment
 - Timed Up and Go (TUG) test
 - ADL/IADLs
- ✓ Nutritional health checklist
- ✓ Cognitive screen
 - MiniCog
 - MOCA
 - SLUMS
- ✓ Depression/Anxiety
 - PHQ-2, PHQ-9
 - GDS
 - GAD-7
- ✓ Pain scale
 - Visual analog / 1-10
 - Faces
- ✓ Medication
 - Adherence: Morisky – 8
 - Safety: BEERS screen
(https://static1.squarespace.com/static/569418a269a91a5371ed8b4e/t/57d437d5c534a520cf50dacb/1473525718855/Guide+JGS_13701_Rev_EV.PDF)
- ✓ Comprehensive Geriatric Assessment (CGA) is a more thorough evaluation of an older adult. Besides the traditional elements of a standard physical exam, the CGA focuses on elements with particular importance to older adult care (orthostatic vital signs, vision, hearing, gait, cognition and mood). Additionally, a thorough medication review, evaluation of functional status, social support and discussion regarding Durable Healthcare Power of Attorney and Advanced Directives is also included. CGA can uncover geriatric syndromes and medical conditions that could have been potentially missed and undiagnosed.

Resources

- ✓ The geriatric assessment is a multidimensional, multidisciplinary assessment designed to evaluate an older person's functional ability, physical health, cognition and mental health, and socioenvironmental circumstances.
 - *The Geriatric Assessment* <http://www.aafp.org/afp/2011/0101/p48.html>

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Who should be part of Mrs. Evans care/support team?

- ✓ Team members
 - Physician Assistant (PA) – Follow up on health issues, and primary care needs
 - Home care nurse – medication management
 - Occupational therapy – functional assessment at home
 - Dietician – healthy food choices and strategies to reduce sodium
 - Case manager/Social Worker to coordinate care and connect to resources
 - Homemaker to assist with home management, IADLs/ADLs
 - Family members; may need education about how to engage in care
 - Physical therapy – falls prevention
- ✓ Interdisciplinary teamwork provides effective care of patients with MCC. Assignment of duties by the PCP to team members ensures patients are connected with the appropriate clinic and support services to aid them in the management of their MCC. Successful teams are those that utilize a variety of multiple disciplines such as pharmacist, nurses, case managers, therapists, etc., focusing on the medical and behavioral problems of the patient and helping them access appropriate community resources.
 - The Role of Patient Care Teams in Chronic Disease Management
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117605/>

What non-medical interventions can you offer Mrs. Evans to address her concerns?

- ✓ Nutritional counseling (malnutrition vs high BMI)
- ✓ Physical and Occupational Therapy for home safety assessment and DME evaluation
- ✓ Transportation assistance
- ✓ Health coach/Community Health Worker
- ✓ Housing alternatives

What potential outcomes do you hope to accomplish with these interventions?

- ✓ Decrease frequency of falls
- ✓ Improve nutritional intake (decreased salt intake) will result in decreased frequency of Congestive Heart Failure (CHF) exacerbation
- ✓ Improve access to appointments with patients healthcare team

Test Bank

Question 3:

Patients benefit from a comprehensive geriatric assessment by:

- a. Ignoring the disability patients experience as a result of MCC
- b. Focusing on elements of the history and physical exam such as incontinence, falls, weight loss, vision and hearing problems
- c. Increasing the mortality and morbidity rates older adults experience

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- d. Excluding members of the interdisciplinary team from working with the patient and the caregiver
The correct answer is B.

Reference:

The Geriatric Assessment: <http://www.aafp.org/afp/2011/0101/p48.html>

Part 3: Second visit 3 months later

Mrs. Evans returns for a follow up appointment. She is accompanied by her homemaker, Anna, who now is helping Mrs. Evans with grocery shopping and low salt meal preparations. She has not fallen since her last visit. She was discharged from home health nursing and physical therapy services one month ago. She reports improved balance and increased endurance. Anna encourages Mrs. Evans to perform her physical therapy exercises, which she does 3 times per week. The nurse taught Mrs. Evans how to fill the pillbox for the week to help keep track of her medications. Despite that, Mrs. Evans admits to skipping dose of her water pill, "It makes me pee too much." She is also embarrassed about her urinary incontinence.

Mrs. Evans tells you she cannot afford to buy all her medications; it is also difficult for her to go to her pharmacy to pick up the prescriptions. She wonders if she is eligible for any assistance programs since she has Medicaid.

Discussion Questions

What assessments would you consider doing at this time?

See resource list before for more on each of these:

- ✓ Patient Incontinence Impact Questionnaire
- ✓ DIAPERS mnemonic (evaluation of urinary incontinence):
 - Delirium/confusional states
 - Infection-urinary (symptomatic)
 - Atrophic urethritis/vaginitis
 - Pharmaceuticals
 - Psychological, especially depression
 - Excessive excretion (i.e., CHF, hyperglycemia)
 - Restricted mobility
 - Stool impaction
- ✓ STOPP/START – evaluation of potentially inappropriate prescriptions and whether any other medications need to be prescribed that are missing from patients medication list
- ✓ BEERS List Criteria – evaluation to eliminate potentially inappropriate prescriptions

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Resources

- ✓ Alappattu, M., Neville, C., Beneciuk, J., & Bishop, M. (2016). Urinary incontinence symptoms and impact on quality of life in patients seeking outpatient physical therapy services. *Physiotherapy theory and practice*, 32(2), 107-112.
- ✓ Thom DH, Nygaard IE, Calhoun EA: Urologic diseases in America project: urinary incontinence in women – national trends in hospitalizations, office visits, treatment and economic impact. *J. Urol.* 173(4), 1295–1301 (2005).
- ✓ Hill-Taylor, B., et al. "Effectiveness of the STOPP/START (Screening Tool of Older Persons' potentially inappropriate Prescriptions/Screening Tool to Alert doctors to the Right Treatment) criteria: systematic review and meta-analysis of randomized controlled studies." *Journal of clinical pharmacy and therapeutics* 41.2 (2016): 158-169.
- ✓ Chen, L. L., et al. "The 2012 Updated Beers Criteria in Falls Related Hospitalization in Older Adults." *Value in Health* 19.7 (2016): A824.

Discuss social and medical factors that can lead to a patient's social isolation.

- ✓ Incontinence
- ✓ Urinary frequency
- ✓ Declining functional status
- ✓ Lack of transportation
- ✓ Depression

Resources

- ✓ Nicholas R. Nicholson. A review of social isolation. *J Prim Prev.* 2012;33(2-3):137-152.

How can you improve her current lack of additional help and support at home?

- ✓ Department on Aging Homemaker evaluation
- ✓ Attempt to improve patient's own functional status with participation in physical and occupational therapy
- ✓ Increase socialization opportunities via Adult Day Services Programs, local community outreach groups aimed at seniors
- ✓ Senior Housing

Resources

- ✓ City of Chicago Family & Support Services
https://www.cityofchicago.org/city/en/depts/fss/supp_info/help_in_your_home.html
- ✓ Functional Decline in Older Adults <http://www.aafp.org/afp/2013/0915/p388.html>

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



What other interventions can you offer the patient in regards to her prescriptions and urinary problems?

- ✓ Community Care Program (CCP)
- ✓ Mail Order Prescription Plan
- ✓ DME Prescription for bedside commode and incontinence supplies
- ✓ Bladder Training Program – i.e. Timed Voiding, Kegel exercises

Resources

- ✓ Treatment of overactive bladder and incontinence in the elderly
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1476020/>
- ✓ Examination of the link between medication adherence and use of mail order pharmacies in chronic disease states
<http://www.jmcp.org/doi/full/10.18553/jmcp.2016.22.11.1247>
- ✓ List of community resources for older adults:
<https://www.eldercaredirectory.org/state-resources.html>
- ✓ Illinois Department on Aging: <http://www.illinois.gov/aging/Pages/default.aspx>

Part 4: Third Visit 4 Months Later

Mrs. Evans returns for a follow up visit with her homemaker Anna. Anna pulls you to the side and tells you she is concerned about Mrs. Evans' alcohol intake. She was recently seen in the emergency room for falls, where she sustained a forehead laceration and cut her hand. Anna tells you it is because Mrs. Evans has been drinking almost daily.

The clinic social worker has been in regular communication with Mrs. Evans since her last visit with you to encourage her to attend Adult Day Services or to consider a volunteer to come to her home for additional social interaction. Mrs. Evans declined both suggestions.

Mrs. Evans was also recently hospitalized for heat exhaustion. Her electricity was turned off after failure to pay her bills for 6 months. She admits that her children are asking her more frequently for her social security check and becoming verbally abusive if she says no.

Discussion Questions

What concerns do you have about Mrs. Evans?

- ✓ Safety – falls, lack of electricity
- ✓ Medication interactions
- ✓ Physical and mental well-being due to alcohol use resulting in physical injuries
- ✓ Isolation
- ✓ Financial exploitation/vulnerability
- ✓ Depression

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What should be done to address her alcohol consumption?

- ✓ Alcohol dependence is impairing her safety (falls, decision-making) and wellbeing
- ✓ Re-assess for depression; coping skills/resources
- ✓ Level of safe alcohol drinking limits for older adults
- ✓ Potential interaction of blood thinner and alcohol
- ✓ AUDIT-C; MAST-G
- ✓ Elder Abuse Suspicion Index (EASI)
 - <https://www.mcgill.ca/familymed/research-grad/research/projects/elder>
- ✓ Assess readiness for changing her alcohol intake

Resources

- ✓ AUDIT-C: http://www.integration.samhsa.gov/images/res/tool_auditc.pdf
- ✓ MAST-G: <http://www.sbirtraining.com/printpdf/1711>

What concerns do you have about her relationship with her children?

- ✓ Financial exploitation is a form of elder abuse
- ✓ Verbal abuse
- ✓ Safety risk given social isolation, unpaid bills
- ✓ Consider report to Adult Protective Services
- ✓ Provide elder abuse screening tools

Resources

- ✓ Volunteer money management program (part of Older Americans Act, Adult Protective Services)
- ✓ Detecting Elder Abuse and Neglect: Assessment and Intervention
<http://www.aafp.org/afp/2014/0315/p453.html>

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



Case Study: Mrs. Kemp

Part 1: Meet Mrs. Kemp

Mrs. Kemp is a 73 year old English-speaking woman who lives with her husband in a small rural town. The Kemps have been married 51 years and raised two daughters (Sarah and Sally), who still reside in the state. The Kemps moved about four years ago into a smaller house that was closer to their daughter Sarah and allowed them to see their grandchildren more often. Mrs. Kemp is in good general health, but also has a history of diabetes, high cholesterol, asthma, and arthritis in her knees.

Recently, Mrs. Kemp intended to drive to the bank to make a transaction, but forgot where she was going and made a wrong turn. She ended up driving the wrong direction on a one-way street. She was alone in the car and fortunately, no one was on the road, but a police officer pulled her over and called Mr. Kemp. Mr. Kemp noticed his wife had some ongoing forgetfulness, especially when she could not remember things they had done earlier together in the day, but he dismissed it. After all, Mrs. Kemp could often recall many things they did together in earlier years and she was still able to care for herself.

Mrs. Kemp has always kept the bank accounts and paid the family bills, but the bank contacted Mr. Kemp recently and said there was an overdraft of the accounts. Thinking about the driving, the bank account, and the memory changes he noticed, Mr. Kemp realized that it was time to look into it. Although he was not sure exactly what was wrong, he knew something was not right. Mr. Kemp called Sarah to explain what he noticed to see if she had noticed anything similar. Sarah had noticed some changes, but thought it was just mom getting older. After learning of the recent incidents, Sarah encouraged Mr. Kemp to call their primary care provider to get an evaluation and said she would reach out to a friend she knew who is a geriatric specialist.

Mr. Kemp called the office to schedule a doctor's appointment. After Mr. Kemp described Mrs. Kemp's changes, the office nurse provided some strategies that Mr. and Mrs. Kemp could begin now since the next available appointment was 4 weeks away.

The nurse reviewed Mrs. Kemp's medications over the phone and explained how Mr. Kemp could help organize and track Mrs. Kemp's medications and schedule. Mr. Kemp was also encouraged to go with Mrs. Kemp to get some labs drawn so that the doctor can review them at their appointment.



Discussion Questions

What concerns do you have about Mrs. Kemp?

Teaching Points

- ✓ Multiple domains of cognition affected
 - Mrs. Kemp is having difficulty with day to day functioning (executive function) and short term memory, while long term memory is intact
- ✓ Multiple medical concerns to rule out (acute illness - silent myocardial infarction, urinary tract infection, delirium, high or low blood sugars; medications – antihistamines).
 - Various acute illness manifest differently in the older adult and some medications may exacerbate symptoms
- ✓ Normal aging vs. Disease – some small cognitive changes are normal, but going down a one way street in an environment that the person is familiar with and was previously able to navigate, and losing the ability to effectively manage finances are not considered part of normal aging

Resources

- ✓ 10 Warning Signs of Alzheimer's Disease - <http://alz.org/10-signs-symptoms-alzheimers-dementia.asp?gclid=ClnYi7Slv84CFQ6naQodSjcNBg>

What are some examples of next steps for Mr. Kemp to help his wife?

Teaching Points

- ✓ The likely progressive nature of cognitive decline will impact Mrs. Kemp's daily functioning, supports to help Mr. Kemp will be important
- ✓ Mr. Kemp keeping track of symptoms/medications/safety
- ✓ Mr. Kemp minimizing Mrs. Kemp's activities alone, but encouraging her independence whenever possible
- ✓ Checking with family/corroborating with different members to see if they notice any changes
- ✓ Mr. Kemp receiving support services as a caregiver

Resources

- ✓ Alzheimer's Disease and Education and Referral (ADEAR) Center - <https://www.nia.nih.gov/alzheimers/publication/caring-person-alzheimers-disease/about-guide>
- ✓ Alzheimer's and Dementia Caregiver Center: Daily Care - <http://www.alz.org/care/alzheimers-dementia-daily-plan.asp>
- ✓ Alzheimer's and Dementia Caregiver Center: Care and Support - <http://www.alz.org/care/overview.asp>

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Test Bank

Question 1

Which condition is associated with an increased risk of dementia?

- a. Arthritis
- b. Diabetes
- c. Asthma
- d. Gastroesophageal reflux disease (GERD)

The correct answer is B.

Reference: https://www.alz.org/national/documents/topicsheet_diabetes.pdf

Question 2

Each of the following is a dementia warning sign EXCEPT:

- a. Withdrawal from social activities or work
- b. Trouble understanding visual images and spatial relationships
- c. Writing down information in order to remember it
- d. Misplacing things and losing the ability to retrace steps and find them

The correct answer is C.

Reference: <http://www.alz.org/10-signs-symptoms-alzheimers-dementia.asp>

Part 2: Evaluating Mrs. Kemp

Four weeks later, at the doctor's office, Mr. Kemp described things that he had noticed about his wife over the past 3-4 years --her difficulty in managing the checkbook, some of her emotional outbursts, and when she would argue with him about something that was not correct. He also found that he needed to prepare her medications each morning, otherwise, she would forget to take them or get mixed up in getting them ready.

Her primary care doctor, Dr. Jones, then met with Mrs. Kemp alone and asked her basic cognitive screening questions using the Montreal Cognitive Assessment (MoCA). He asked her if she had any concerns about her health and she said, "No." When Dr. Jones asked who brought her to his office, she said, "George, my husband," and then she said, "and Sarah? Or no, it was Sally who came with us" (it was actually their daughter Sally). Dr. Jones asked the family to meet with him again and said that it appeared as though Mrs. Kemp may have some type of dementia but he would like to continue to get more information about her symptoms.

Two weeks later, Dr. Jones met with Mr. and Mrs. Kemp and their daughters to summarize the exam results, which included a physical exam, cognitive screening (Montreal Cognitive Assessment - MoCA), a neurological exam, laboratory tests, and a MRI:

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- Other than Mrs. Kemp's cognitive impairment for the past 4 years, she was in good health. She recently drove down a one-way street in the wrong direction and was no longer able to manage the family finances. Her primary risk factor for dementia was that her mother died in a nursing home at age 79 with similar symptoms. Mrs. Kemp did not have symptoms of depression.
- Her Montreal Cognitive Assessment score was 18/30, including her difficulty in remembering 3-items after a 5-minute delay.
- Her neurological exam showed no parkinsonian features or evidence of a stroke.
- Mrs. Kemp's laboratory results were normal and her MRI scan of the brain showed moderate diffuse cerebral atrophy. He said that given these results she has probable Alzheimer's disease. He asked if they had further questions. When they did not, he suggested that they spend the rest of their time talking about what they see as the next steps.

What are some examples of next steps for the family?

Teaching Points

- ✓ Including family in the discussion of her care plan
- ✓ Accessing community and educational resources
- ✓ Redefining family roles as they transition to caregivers
- ✓ Ensuring that Mr. Kemp receives adequate support services as a primary caregiver
- ✓ Engage in advance directives planning including completing Health Care Power of Attorney and Durable Power of Attorney paperwork
- ✓ Work with a financial advisor and elder lawyer to begin planning for the possibility that Mrs. Kemp may need long-term care at some point, or to prepare if Mr. Kemp is no longer able to care for Mrs. Kemp.
- ✓ Keep Mrs. Kemp engaged in activities she enjoys, modifying them as needed to match her abilities.

Resources

- ✓ *Giving Someone a Power of Attorney For Your Health Care: A Guide with an Easy-to-Use, Multi-State Form for All Adults* from the American Bar Association http://www.americanbar.org/content/dam/aba/administrative/law_aging/2011_aging_hcdec_univhcpaform.pdf
- ✓ Estate planning – Durable Power of Attorney: http://www.americanbar.org/groups/real_property_trust_estate/resources/estate_planning/power_of_attorney.html
- ✓ Go Wish Game: a card game to help families talk about what is most important near the end of life (cards to purchase or play online for free) - <http://www.gowish.org>
- ✓ Alzheimer's Disease Education and Referral (ADEAR) Center - <https://www.nia.nih.gov/alzheimers/topics/caregiving>

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- ✓ Area Agency on Aging - <http://www.n4a.org/caregivers>

Who should be part of Mrs. Kemp's care team (now and in the future)?

Teaching Points

- ✓ Teams are critical for older adults with multiple chronic conditions and dementia, and each member plays an essential role. There may be differences in team make-up base on rural v. urban settings, given what providers are available.
- ✓ Health care team members (for more information on specific roles of team members please view the 'Teams Module')
 - Mrs. Kemp
 - Mr. Kemp
 - Sarah
 - Sally
 - Geriatrician
 - Neurologist
 - Physician Assistant
 - Social Worker
 - Registered Nurse
 - Pharmacist
 - Community agency staff

What other resources might be useful to the Kemp family for services and support?

Resources

- ✓ Alzheimer's Association – www.alz.org – The Alzheimer's Association is the leading voluntary advocacy organization in Alzheimer's care, support and research. They provide a 24/7 hotline offering information and advice, provide caregivers and families with comprehensive online resources and information, help people find clinical studies and more.
- ✓ Eldercare Locator – <http://www.eldercare.gov> – search for services for older adults and their families
- ✓ Family Caregiver Alliance, National Center on Caregiving – www.caregiver.org – a community-based nonprofit organization in the country to address the needs of families and friends providing long-term care for loved ones at home.
- ✓ AARP Caregiving Resources – www.aarp.org/home-family/caregiving – provides resources for caregivers on many different topics.

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



Test Bank

Question 1

Each of the following is a step to receiving a dementia diagnosis EXCEPT

- a. History
- b. Cognitive testing
- c. Physical and neurological exam
- d. Sleep pattern

The correct answer is D.

Reference: http://alz.org/alzheimers_disease_diagnosis.asp

Question 2

Each of the following treatable conditions can cause problems with memory EXCEPT

- a. Thyroid problems
- b. Temperature
- c. Depression
- d. Vitamin deficiencies

The correct answer is B.

Reference: http://alz.org/alzheimers_disease_steps_to_diagnosis.asp

Part 3: Mrs. Kemp's Behavior

Five years after an evaluation confirming a dementia diagnosis, Mr. Kemp and his daughters have started to share the responsibility of caring for Mrs. Kemp. Sarah and Sally alternate watching Mrs. Kemp during the week to give Mr. Kemp a break. They also alternate who stays with their mother and who goes with Mr. Kemp to a caregiver support group. It is Sally's turn to care for Mrs. Kemp. Late one morning, Sally thinks that her mom might enjoy a walk around the neighborhood on such a beautiful spring day. Sally recalls her mom has always enjoyed flowers and goes to the bedroom to see if Mrs. Kemp would be interested. Upon entering the room, Sally finds Mrs. Kemp pacing anxiously in her room, wringing her hands, and murmuring. As Sally surveys the room, she notices the newspaper ripped to shreds on the floor around the bed. When Sally asks what is going on in an exasperated voice, Mrs. Kemp becomes startled and angrily yells, "You had better get out of here or I'll call my daughter!" Mrs. Kemp then throws her slipper at Sally and goes into the bathroom, slamming the door.

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



Discussion Questions

What concerns do you have AT THIS POINT about Mrs. Kemp?

Teaching Points

- ✓ This behavior change is an indication of disease progression, which affects Mrs. Kemp's safety and well-being, as well as her daughter and other family members.
- ✓ Perceptions from the perspective of the person living with dementia are critical and approaches/tones can be perceived differently triggering behaviors.
 - Safety, harm to self or others
 - Approach, tone - approaching an individual with dementia with an angry or exasperated tone may be frightening, increasing the likelihood of defensive behavior. Approaching with a calm voice and a smile regardless of the situation decreases the likelihood of negative or dangerous emotional and behavioral response

Resources

- ✓ National Institute on Aging - <https://www.nia.nih.gov/alzheimers/topics/caregiving#behaviors>
- ✓ National Institute on Aging - <https://www.nia.nih.gov/alzheimers/publication/coping-agitation-and-aggression>

What are some common antecedents for behavioral changes in dementia?

Teaching Points

- ✓ Delirium – learn more here: <https://www.guideline.gov/summaries/summary/43920/delirium-in-evidencebased-geriatric-nursing-protocols-for-best-practice>
- ✓ Unmet physical or psychosocial needs such as hunger, isolation, or pain
- ✓ Overstimulation – too much input for an impaired brain to manage
- ✓ Pain
- ✓ Fear – not recognizing environment or people
- ✓ Environmental factors (excessive noise, bright lights, new/unfamiliar environment)
- ✓ Medication side effects
- ✓ Infection
- ✓ Time of day (sundowning: increased confusion and agitation in the evening)

Resources

- ✓ Family Caregiver Alliance - <https://www.caregiver.org/caregivers-guide-understanding-dementia-behaviors>

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



- ✓ Vermeiren, Yannick, et al. "Brain Serotonergic and Noradrenergic Deficiencies in Behavioral Variant Frontotemporal Dementia Compared to Early-Onset Alzheimer's Disease." *Journal of Alzheimer's Disease* 53.3 (2016): 1079-1096.
- ✓ Woods, Diana Lynn, et al. "Detecting and Characterizing Patterns of Behavioral Symptoms of Dementia." *Discovering Hidden Temporal Patterns in Behavior and Interaction: T-Pattern Detection and Analysis with THEME™* (2016): 125-142.

As healthcare providers, how do we support team members like Sally?

Teaching Points

- ✓ Recognize the added stress of behavioral manifestations to the role of caregiver, and the continuous demands of the role. The first time a family member is not recognized by the individual with dementia can be highly distressing.
- ✓ Provide behavioral manifestations education (hallucinations, aggression, agitation, depression) and strategies for managing them
- ✓ Shared caregiving with other family members or with professional caregivers
- ✓ Some health care providers might offer anti-anxiety or anti-psychotic medication to manage Mrs. Kemp's behavior, should it become chronic. Medication should never be the first choice in managing behavior of individuals with dementia; managing the environment and the behavior of those around her to help her feel safe and comfortable must come first.

Resources

- ✓ National Institute on Aging - <https://www.nia.nih.gov/alzheimers/publication/medical-side-ad/medicines-treat-ad-symptoms-and-behaviors>

What other resources might be useful to the Kemp family?

Teaching Points

- ✓ Caregiver Support Groups
- ✓ Clarify Mrs. Kemp's personal preferences about her healthcare (person-centered care); depending on stage of the disease, this may need to be provided by those who know Mrs. Kemp best
- ✓ Geriatric psychiatrist referral
- ✓ Pharmacist to watch Mrs. Kemp's medications for any potential contributions to acute changes

Resources

- ✓ Family Caregiver Alliance - <https://www.caregiver.org/making-choices-about-everyday-care-families>
- ✓ Providers - learn more about caregiving: <http://gerocentral.org/clinical-toolbox/clinical-issues/caregiving/>

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



- ✓ Alzheimer's Association -
http://www.alz.org/apps/we_can_help/support_groups.asp

Test Bank

Question 1

Each of the following increases the risk of behavioral problems in dementia EXCEPT:

- a. Pain
- b. Constipation
- c. Hunger
- d. Exercise

The correct answer is D.

Reference: http://www.alz.org/professionals_and_researchers_14310.asp

Question 2

Each of the following statements correctly describes dementia caregivers EXCEPT:

- a. Caregivers often quit or decrease work hours on their paid job in order to care for a loved one with dementia.
- b. Medicare provides financial compensation for family caregivers
- c. Many dementia caregivers suffer from depression
- d. A majority of dementia caregivers are women

The correct answer is B.

Reference:

<http://www.alz.org/facts/>

<https://www.caring.com/articles/medicare-home-care>

Part 4: Mrs. Kemp's Hospitalization

About two years after the confirmed dementia diagnosis and the frightening behavioral episode with her daughter Sally, Mr. and Mrs. Kemp leave the kitchen after a light lunch. While returning to the family room, Mrs. Kemp falls after misjudging a step. At the Emergency Department, while Mr. Kemp is speaking with a triage nurse, Mrs. Kemp is seated and looking around warily at the bright lights, numerous people, and noisy monitors/telephones.

When Mr. Kemp returns with the triage nurse, Mrs. Kemp clutches his arm. The nurse grabs Mrs. Kemp's other arm and places a blood pressure cuff around it. Simultaneously, she places a pulse oximeter on Mrs. Kemp's finger. As the blood pressure cuff begins to inflate and the pulse oximeter beeps, Mrs. Kemp begins to squirm. The nurse then removes both, tells Mrs. Kemp to "take some deep breaths," and proceeds to listen to her lungs using a stethoscope. Mrs. Kemp shrieks "no!" and pleadingly insists to Mr. Kemp, "I need to go home." The triage nurse tells Mr. Kemp

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that his wife's oxygen level is low and she seems to be short of breath. The nurse would like to start her on oxygen and get her a breathing treatment. Mr. Kemp tries to reassure Mrs. Kemp, but it is obvious she is upset. He realizes that any additional treatment Mrs. Kemp will need may be challenging.

Discussion Questions

What concerns do you have AT THIS POINT about Mrs. Kemp?

Teaching Points

- ✓ Environment, overstimulation/frightening – New environments, especially those with high levels of stimuli like emergency rooms, are difficult for individuals with dementia to manage. Because there is so much incoming information, an individual with dementia is more likely to experience cognitive overload, become emotionally distressed, and act in ways to protect themselves. These behaviors may actually be less safe for them and others nearby. In these situations, individuals with dementia may be more likely to be unable to recognize familiar people.
 - If possible, move a person with dementia to a low-stimulus area for any interactions with hospital personnel.
 - Anyone with dementia should be approached slowly, calmly, and with a smile. Explain who you are and what you are going to do, then explain what you are doing while you do it, then explain what you just did. Explain the sounds of the machines and what they mean. Slowly. Calmly.
- ✓ Recognize the unfamiliarity of the new environment and the importance of routine and structure as well as their impact on safety.
 - An unfamiliar environment may pose different risks to the person with dementia – tubing, clutter, overstimulation may precipitate wandering behavior
- ✓ Recognize that persons living with dementia also frequently have multiple chronic conditions in tandem with a dementia diagnosis

Resources

- ✓ Alzheimer's Disease Education and Referral (ADEAR) Center - <https://www.nia.nih.gov/alzheimers/publication/acute-hospitalization-and-alzheimers-disease>
- ✓ Jing, Wenbo, Rosalind Willis, and Zhixin Feng. "Factors influencing quality of life of elderly people with dementia and care implications: A systematic review." Archives of gerontology and geriatrics 66 (2016): 23-41.

How do we support team members like Mr. Kemp?

Teaching Points

- ✓ Recognize the necessity of involving the family as part of the health care team.

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



- ✓ Caregiver engagement – it is important to listen to any concerns of Mr. Kemp. As the primary caregiver and spouse of 51 years, he knows more about Mrs. Kemp than the health professional in the narrow window of assessment.
- ✓ Inquire about how caregiving is going, how are things being managed at home, does he have help? Recognize the fact that many dementia caregivers are themselves older and/or dealing with their own health/psychosocial challenges.

Resources

- ✓ Caregiving in the U.S., 2015:
<http://www.aarp.org/content/dam/aarp/ppi/2015/caregiving-in-the-united-states-2015-report-revised.pdf>
- ✓ Caregiver Burden Screen:
<http://gerontologist.oxfordjournals.org/content/31/1/76.full.pdf>
- ✓ Alzheimer's Association, Alzheimer's and Dementia Care Center:
<https://www.alz.org/care/>
- ✓ Relieving Stress & Anxiety: Resources for Alzheimer's Caregivers:
<https://www.nia.nih.gov/alzheimers/relieving-stress-anxiety-resources-alzheimers-caregivers>

What are some common reasons for hospitalization in dementia?

Teaching Points

- ✓ Recognize that there are many reasons that would bring a person living with dementia into the hospital, but the main three for a person with dementia are:
 - Multiple chronic conditions (MCC)
 - Injuries such as falls
 - Infections

Reference: Phelan, Debnam, Anderson, & Owens (2015). A systematic review of intervention studies to prevent hospitalizations of community dwelling older adults with dementia. *Medical Care*, 53(2), 207-213

Resources

- ✓ Nurses Improving Care for Healthcare System Elderly (www.nicheprogram.org) – Recommend
- ✓ Alzheimer's Disease Education and Referral (www.nia.nih.gov/alzheimers) - Recommend
- ✓ Alzheimer's Association (www.alz.org) - Recommend
- ✓ National Institute on Aging (www.nia.nih.gov) – Option
- ✓ Geriatric ED (Hwang . 2013 – Transforming Emergency Care for Older Adults; Hwang and Morrison, 2007 – The Geriatric Emergency Department) – Option for additional reading/general information

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



Test Bank

Question 1

Which of the following is/are important considerations for a hospitalized person living with dementia? (select all that apply)

- a. Location of hospital
- b. Change in environment
- c. Approach and tone
- d. Safety

The correct answer is A. The answer is B, C, and D

Reference: <https://www.nia.nih.gov/alzheimers/publication/acute-hospitalization-and-alzheimers-disease>

Question 2

Which of the following increases the risk of hospitalization for a person living with dementia?

- a. Age
- b. Multiple chronic conditions
- c. Diet high in fruits and vegetables
- d. Environmental allergens

The correct answer is B.

Reference: https://www.alz.org/national/documents/topicsheet_hospitalization.pdf

Part 5: Follow up

The Social Worker from the hospital care team has recommended a referral to the Department on Aging Community Care Program for Choices for Care screening. Because of this, the care coordinator from the local Illinois Department on Aging designated Care Coordination Unit came to meet the Kems, with a particular interest in helping Mr. Kemp as a caregiver. In order to reduce the caregiver stress, a number of intervention strategies were put into place, which included respite care, a referral to Savvy Caregiver Training and homemaker services to prepare light meals and carry out light housekeeping tasks. Although Mr. Kemp is capable of carrying out these tasks, the additional light housekeeping support will enable Mr. Kemp to get out of the house and have coffee with his friends at the local café. This indirect form of respite care offers Mr. Kemp a break in addition to the respite care that he receives from the Care Coordination Unit.

The care coordinator also offered Mr. Kemp:

- ✓ Some books related to caregiving, including, *The 36-Hour Day: A Family Guide to Caring for People Who Have Alzheimer Disease, Related Dementias, and Memory Loss*, by Mace & Rabins and *The Comfort of Home for Alzheimer's Disease: A Guide for Caregivers*, by Meyer, Mittleman, & Epstein.

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



- ✓ Referral to work with a financial advisor and elder lawyer to help Mr. Kemp prepare for the possibility that his wife may be admitted to a nursing home, or to prepare if something happens to him.
- ✓ The Prevention of Spousal Impoverishment Program (<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/spousal-impoverishment-page.html>) will enable Mr. Kemp to live in the family home without losing all his income to pay for long-term care.

Due to the progressive nature of dementia, involving the team early in the course of the illness to pursue advance care planning is recommended, particularly because in early/moderate stages the person living with dementia can still participate in decision-making.

Reflection Points/Questions

- ✓ Receiving a diagnosis of dementia may be one of many adjustments in life. The journey for the care recipient and the caregiver/family because of a diagnosis may be challenging at times, but rewarding in others. Caregivers often report that, in addition to being stressful, caregiving provides meaning, strengthens relationships, and enabled them to learn new skills. At the same time, caregivers experiencing strain have a 63% higher risk of mortality than non-caregivers do, and one third of family caregivers of people with dementia are depressed. As part of the health care team, it is critical that family caregivers' health is assessed and managed.
- ✓ After this “snap-shot” into the lives of the Kemp family, as you begin to reflect, consider what you would do similarly and differently. How would you incorporate these strategies into your training and practice?

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Case Study: Mrs. Martinez

Part 1: Nurse Visit

Mrs. Martinez is a 68 year old Spanish-speaking, Catholic woman with 3 years of formal education in Mexico, who has a history of arthritis, hypertension, diabetes, depression, and a recent stroke. She is a small, modestly dressed woman. Her hair is neatly pulled back from her face. A small gold cross hangs from the chain around her neck. She presents to the clinic describing terrible pain and requesting pain medication refills. Although Mrs. Martinez speaks and understands Spanish, she cannot read Spanish. Her ability to speak and understand English is limited. She is interviewed in Spanish by Nurse Cynthia. When Nurse Cynthia asks Mrs. Martinez to describe her pain, Mrs. Martinez said, “It hurts everywhere.”

Asked about her home life, Mrs. Martinez said that she has been divorced for 12 years. Her husband was an alcoholic and abusive throughout the marriage. Although they divorced, she still has feelings for him. Mrs. Martinez raised her three children, “to be strong and independent.” She lives with her daughter, Araceli, her son-in-law Martin, and their 2 children, ages 12 and 15. However, Martin works construction and has to leave home early, and Araceli works 2 jobs and so was only able to drop her mother off at today’s appointment, and Mrs. Martinez will have to catch the bus home afterward. One of her sons also lives with her, but works 2 jobs as part of contributing to the rent and also the educational expenses of raising a special-needs 6 year-old. Her other son lives in another state and works long hours to support his family. “I’m basically alone all day, since my family is only around in the evenings,” she said. “We get along well, but it’s so late and they’re all so tired and rushed over dinner. No one has time for me, I feel like God is punishing me and that’s why I’m having all this pain. If my family could understand how sick I am, they would spend more time with me,” she said.

After validating how difficult this must be for Mrs. Martinez, Nurse Cynthia asked Mrs. Martinez to describe other people in her life aside from her family. Mrs. Martinez said that she had not gone to church in years because, “all of my friends there are still married, and my marriage failed. I stay home most of the time.” Mrs. Martinez said that she was seeing a psychiatrist soon after her divorce, but stopped when her ex-husband’s insurance cancelled her coverage. She tearfully added, “My husband was rough on me and the kids, but we had money and nice things. Now I’m at the public hospital because I don’t have any insurance. I’ve really come down in life.” Asked if she ever took medicines for depression, Mrs. Martinez said, “I take about 10 different medications. I don’t know the names of them or what they’re for. The only ones I need all the time are the ones for pain – can I see the doctor now for refills?”

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



Discussion Questions

What concerns do you have about Mrs. Martinez?

Teaching Points

- ✓ Depression/Anxiety: pain all over body, lonely, guilt, tearful
- ✓ Pain: diffuse presentation, entangled with mood, drug-seeking
- ✓ History of trauma: abusive husband and ongoing attachment to him
- ✓ Insufficient family support: family present but busy with other challenges such as chaotic work schedule, young kids 1 of whom is developmentally disabled; change in relationship with friends, church
- ✓ Religious issues related to divorce: church perceptions and self-perceptions
- ✓ Lack of financial and supportive resources
- ✓ Spanish language: communication with providers; access to linguistically appropriate services
- ✓ Literacy: 3 years of formal education
- ✓ Health literacy: inability to describe health issues or medications
- ✓ Medication adherence: questionable, possible pain medication seeking behavior
- ✓ Ongoing stroke risk
- ✓ Self-management of chronic conditions
- ✓ Importance of working with an interpreter in discussing/navigating all of the above issues with Mrs. Martinez

Resources

- ✓ Multiple Chronic Conditions Chartbook 2010 Medical Expenditure Panel Survey Data
 - <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf>
- ✓ Depression and Pain
 - http://www.health.harvard.edu/newsweek/Depression_and_pain.htm
- ✓ Overcoming the Challenges of Providing Care to Limited English Proficiency (LEP) patients
 - http://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_13_May_2015_EMBARGOED_5_27_15.pdf
- ✓ Health Coverage and Care for Immigrants
 - <http://kff.org/report-section/health-coverage-and-care-for-immigrants-issue-brief>
- ✓ Medical and psychological comorbidity predicts poor pain outcomes after total knee arthroplasty
 - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3630396/>

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



How would you assess her for these concerns?

Resources

Depression/Anxiety Screening

- ✓ Patient Health Questionnaire – 2 item (PHQ-2) – http://www.cqaimh.org/pdf/tool_phq2.pdf
- ✓ Patient Health Questionnaire – 9 item (PHQ 9) – http://www.cqaimh.org/pdf/tool_phq9.pdf
- ✓ Geriatric Depression Scale (GDS) – <https://www.healthcare.uiowa.edu/igec/tools/depression/GDS.pdf>
- ✓ Generalized Anxiety Disorder 2-Item (GAD-2) – http://integrationacademy.ahrq.gov/sites/default/files/GAD-2_0.pdf
- ✓ Generalized Anxiety Disorder 7-Item (GAD-7) – <http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf>

Pain

- ✓ GeroCentral: <http://gerocentral.org/clinical-toolbox/clinical-issues/pain-management/>
- ✓ Geriatric Pain information: <http://www.geriatricpain.org/Content/Assessment/Intact/Pages/default.aspx>

Trauma

- ✓ Primary Care Post Traumatic Stress Disorder (PTSD) Screen: <http://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp>
- ✓ PTSD Checklist for DSM-5 (PCL-5): <http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>

Health Literacy

- ✓ Health literacy measure: REALM (Rapid Assessment of Adult Literacy in Medicine)
- ✓ CDC Simply Put: A guide for creating easy to understand materials

Medication Adherence

- ✓ CDC Medication Adherence slide deck: <https://www.cdc.gov/primarycare/materials/medication/docs/medication-adherence-01ccd.pdf>
- ✓ Medication Adherence Measures Overview: <http://www.hindawi.com/journals/bmri/2015/217047>

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



Before she leaves the clinic today, what questions do you want to ask about Mrs. Martinez's mental health?

Teaching points

- ✓ Rule out suicidal ideation: Mrs. Martinez has multiple risk factors for suicidality, including known diagnosis of depression, physical illness, pain, and feelings of social isolation.

Resources

- ✓ P4 Suicidality Screener: <http://gerocentral.org/wp-content/uploads/2013/04/P4-Suicide-Risk-Screener.pdf>
- ✓ Ask Suicide-Screening Questions (ASQ): <http://www.nimh.nih.gov/news/science-news/ask-suicide-screening-questions-asq.shtml>
- ✓ GeroCentral on Suicide: <http://gerocentral.org/clinical-toolbox/clinical-issues/suicide-2/>
- ✓ Garand L, Mitchell AM, Dietrick A, Hijawi SP, Pan D. Suicide in older adults: Nursing assessment of suicide risk. *Issues in Mental Health Nursing*. 2006;27(4):355-370. doi:10.1080/01612840600569633. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2864075/>

What do you want to be sure to follow up on next time?

Resources

Cognitive screening

- ✓ Mini-Cog™ – http://www.alz.org/documents_custom/minicog.pdf
 - Most time efficient, and easiest to use cognitive screening tool when a patient and a provider do not speak the same language and an interpreter is required.
- ✓ MOCA (Montreal Cognitive Assessment) – http://dementia.ie/images/uploads/site-images/MoCA-Test-English_7_1.pdf
- ✓ SLUMS (St. Louis University Mental Status exam) – http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf

Functional assessment

- ✓ Timed Up and Go (TUG) Test: <http://www.cdc.gov/steady/materials.html>
- ✓ Katz Index of Independence in Activities of Daily Living (ADL) - <https://consultgeri.org/try-this/general-assessment/issue-2.pdf>

Who should be part of her care/support team?

Teaching Points

- ✓ Chaplain – to address religious issues with the church and her own faith
- ✓ Occupational Therapy – home function/evaluation
- ✓ Physical Therapy – mobility
- ✓ Nurse – review medication indication & strategies for adherence at home
- ✓ Physician and Physician Assistant – medical management, cognitive screening, education on health issues

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- ✓ Social worker – transportation, home services, finances, connection to language appropriate social resources, etc.
- ✓ Family – daughter, sons, son-in-law, grandkids
 - Assess Mrs. Martinez’s goals in terms of how she would like family involved, then develop a flexible, feasible way for them to be involved in her care plan

Test Bank

Question 1

Each of the following is a risk factor for depression EXCEPT:

- A. Speaking English as a 2nd language
- B. Diabetes
- C. Stroke
- D. Social isolation

The correct answer is A.

Reference: <http://www.nimh.nih.gov/health/topics/depression/index.shtml>

Question 2

Which of the following is true about caring for older adults with multiple chronic conditions?

- A. It’s best to treat each condition (disease) according to the target for that specific disease
- B. They become less common as adults get older
- C. They have no impact on function or life expectancy
- D. It is best to care for them with a multidisciplinary team of providers

The correct answer is D.

Reference: <http://www.hhs.gov/ash/about-ash/multiple-chronic-conditions/addressing-multiple-chronic-conditions/index.html#framework>

Part 2: Provider Visit

As you process the complex information reported to you by the nurse, you review Mrs. Martinez’s chart, which shows various prior pain medications she has tried that “didn’t work.” She now takes three pain medications, including two opioids, and routinely sees various providers in your practice’s walk-in clinic for refills.

What questions do you have about Mrs. Martinez’s pain?

Teaching points

- ✓ Is there more than one type/cause of her pain?
- ✓ How long has she had this pain?
- ✓ Have non-medication interventions been tried?
- ✓ Is she running out of medications early?
- ✓ How does her depression affect her pain?

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



- ✓ Given her increased risk of self-medicating depression and existential pain with opioids, there is concern about an increased risk of opioid dependence. Her older age, female gender, and ethnic minority status all make it more likely that any dependence or addiction will be missed/overlooked.

Resources

- ✓ OPQRST Assessment Tool – <http://www.ems1.com/survivability/tips/475522-How-to-use-OPQRST-as-an-effective-patient-assessment-tool>
- ✓ Core Principles of Pain Assessment for Providers – <http://www.geriatricpain.org/Content/Assessment/Principles/Pages/default.aspx>
- ✓ Center for Substance Abuse Treatment. Substance Abuse Among Older Adults. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1998. (Treatment Improvement Protocol (TIP) Series, No. 26.) Chapter 1 - Substance Abuse Among Older Adults: An Invisible Epidemic. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK64422/>

Part 2a:

After the physician and the interpreter introduced themselves and greeted Mrs. Martinez, they asked her about her pain. “I have so many different pains,” Mrs. Martinez said. “I have this aching in my knees and back and when I walk, it gets worse and worse. And when I’m sitting sometimes, I feel like my left knee is so stiff, I won’t be able to get up from the chair.” The physician asked her what she takes for the pain. “I take naproxen but it gives me heartburn,” she said. Asked about other pain, Mrs. Martinez said, “Day and night, my toes are on fire. It’s very bad. Sometimes I can’t sleep. For five years now, nothing helps.” The physician asked if this is why she is taking Vicodin and Tramadol. “Doctor, those don’t help very much but at least I can go to sleep and forget my suffering for a little while,” she said. “Any other pain?” the physician asked. “Once in a while my stomach is filled with gas and I feel like my stomach is getting very big and it hurts,” she said. The physician realized that she was describing bloating. “What makes it better?” the physician asked. “My neighbor told me about prune juice and so I drink it and then I go to the bathroom,” she said.

What might be causing or contributing to Mrs. Martinez’s pain?

Teaching Points

- ✓ Musculoskeletal – left knee arthritis
- ✓ Neuropathic – diabetic peripheral neuropathy in feet
- ✓ Constipation causing abdominal pain. The constipation itself is likely from opiates prescribed without any stool softener, but other medications (e.g. calcium channel blockers for hypertension, Benadryl for sleep), disease factors such as visceral diabetic neuropathy, bowel ischemia, and stroke (all more obscure), and factors such as a sedentary lifestyle and a diet low in fresh fruits and vegetables can all contribute.

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



- ✓ Depression – mental health concerns often present physically in older adults; and in all adults, depression can exacerbate the experience of physically caused pain.

What concerns do you have about Mrs. Martinez?

Teaching Points

- ✓ Chronic pain is defined as pain lasting longer than three months or past the time of normal tissue healing. It is estimated that 11% of the US adult population suffers from chronic pain. Although there is no conclusive evidence that the benefits of opioid medications in treating chronic pain outweigh the risks, approximately 4% of the US adult population is prescribed long-term opioid therapy.
 - See the CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016 for detailed advice on patient/provider shared decision-making on this topic: <http://jama.jamanetwork.com/article.aspx?articleid=2503508>
- ✓ Depression may be contributing to or exacerbating her pain. See screening resources above.
- ✓ Social outlets may help with the depression. Social work consultation may be helpful for linkage to community-based resources.

How do you feel about the use of opioids as part of Mrs. Martinez’s medication management?

Resources

- ✓ Opioid Risk Tool – <https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf>
- ✓ Illinois Prescription Monitoring Program – <https://www.ilpmp.org/>

Learning Activity: Mrs. Martinez has no medications with her today, but you review her electronic chart and find her medications listed as follows:

Medication	Dosage
70/30 insulin	30 units injected ½ hour before breakfast, 15 units injected ½ hour before dinner
Enalapril 40mg	Daily
Nifedipine XL 60mg	Daily
Hydrochlorothiazide 25mg	Daily
Aspirin 81mg	Daily
Simvastatin 40mg	Daily at bedtime
Vicodin 5/300	2 tabs every 6hrs as needed
Tramadol 50mg	3 times daily as needed

If you have difficulty accessing any of these resources, please email catch-on@rush.edu.



Naproxen 500mg	Twice daily with food as needed
Benadryl (Diphenhydramine) 25mg	At bedtime as needed
Fluoxetine 20mg	Daily

Learning activity: Name at least 1 of Mrs. Martinez's diseases/conditions that can be treated by each of the medications above.

Possible answers (can be more):

Medication	Indication/Diagnosis Treated
70/30 insulin	Diabetes
Enalapril 40mg	High blood pressure
Nifedipine XL 60mg	High blood pressure
Hydrochlorothiazide 25mg	High blood pressure
Aspirin 81mg	Cardiovascular disease risk reduction; Secondary prevention of another stroke
Simvastatin 40mg	High cholesterol
Vicodin 5/300	Pain
Tramadol 50mg	Pain
Naproxen 500mg	Pain
Benadryl 25mg	Insomnia
Fluoxetine 20mg	Depression/anxiety

What are your concerns about her medication list?

Teaching Points

- ✓ Benadryl (diphenhydramine) is an antihistamine with anticholinergic effects including sedation, constipation, dry mouth, and memory impairment. It is on the Beers List of medications to avoid in older adults. This is especially concerning because this medication is available over-the-counter and commonly used to treat symptoms such as insomnia, itching, and runny nose caused by seasonal allergies or by the common cold.
- ✓ Mrs. Martinez is on two narcotic medications (tramadol & vicodin) without clear rationale for the combination, or appropriate monitoring.
- ✓ Non-steroidal anti-inflammatory drugs (NSAIDs) such as Naproxen can cause gastrointestinal bleeding, elevated blood pressure, and renal (kidney) dysfunction. Their renal effects are worsened by being prescribed with ACE (angiotension converting enzyme) inhibitors such as the enalapril the Mrs. Martinez has been prescribed. NSAIDs as a category of drugs are on Beers List of potentially inappropriate medications for older adults

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- ✓ In general, Mrs. Martinez is on several medications that are only as safe as the monitoring and self-management education that her healthcare team should ideally be providing as part of her care.
 - For instance, insulin requires teaching on how patients can monitor themselves for symptoms of blood sugar that is too high or too low, test their blood sugar, and adjust their insulin accordingly. Similarly, both enalapril and hydrochlorothiazide can alter kidney function and minerals such as potassium, so patients should be monitored with periodic lab testing and, if indicated by lab results, provider adjusting medication dose.

Resources

- ✓ Anticholinergic Cognitive Burden Scale –
http://www.agingbraincare.org/uploads/products/ACB_scale_-_legal_size.pdf
- ✓ STARTing and STOPPING Medications in the Elderly –
http://www.ngna.org/resources/documentation/chapter/carolina_mountain/STAR_TandSTOPP.pdf
- ✓ Providers: American Geriatrics Society 2015 updated Beers Criteria for potentially inappropriate medication use in older adults.
<https://www.guideline.gov/summaries/summary/37706>
- ✓ Consumers: Medications in Older Adult Tip Sheets for Consumers -
<http://www.healthinaging.org/medications-older-adults/>

Mrs. Martinez's physical exam:

- ✓ Vital signs:
 - Blood pressure: 170/90
 - Heart Rate: 95
 - Current Weight: 190lbs (Body Mass Index 37; class III obesity)
 - Weight in Emergency Department for stroke 3 months prior: 198lbs
- ✓ Random (non-fasting) fingerstick glucose in clinic today: 254
- ✓ Affect: sad
- ✓ Cardiovascular: Regular heart rate and rhythm with 2/6 systolic ejection murmur at base → carotids; 1+ bilateral pitting edema
- ✓ Extremities: Feet with decreased pulses. Decreased monofilament sensation both feet.
- ✓ Neurological assessment: Right lower facial droop

Timed-Up-and-Go (TUG) test: 20 seconds; pushes up with hands on arms of chair to rise from seated to standing. Slow gait without aids, limping to spare left knee, touching the wall to keep her balance when she turns/reverses direction

PHQ (Patient Health Questionnaire) 2-item: positive screen (score = 5/6)

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MiniCog (via Spanish interpreter): 1/5 – recalls only 1 of 3 words, draws numbers correctly on clock face, but places hands at 11 and 10 when asked to write time as 11:10 (normal 3/5 or higher)

What are your concerns about the management of Mrs. Martinez’s medical problems?

Teaching Points

- ✓ Hypertension – poorly-controlled, especially after recent stroke
- ✓ Diabetes – poorly-controlled
- ✓ Mini-cog – concerning for cognitive impairment
- ✓ Depression – screened positive for depression
- ✓ Balance/gait – took more than 12 seconds to complete TUG (indicating fall risk)
- ✓ Arthritis in left knee with poorly-controlled pain, unsteady gait → fall risk

How would you address Mrs. Martinez’s concerns at today’s visit?

Teaching Points

- ✓ Simplify the plan and address pain and depression before expecting Mrs. Martinez to engage much with the less “symptomatic” diseases such as hypertension and diabetes.
- ✓ Remove Benadryl as it may contribute to cognitive impairment.

Learning Activity: Match the diagnosis with the risk factor for a geriatric syndrome. Each diagnosis may be associated in various ways with more than one syndrome.

- Disease/Diagnosis**
- ✓ Diabetes
 - ✓ Hypertension
 - ✓ Depression
 - ✓ Chronic Pain

- Geriatric Syndrome**
- ✓ Depression
 - ✓ Falls
 - ✓ Incontinence
 - ✓ Memory Loss
 - ✓ Polypharmacy
 - ✓ Sleep Disturbance
 - ✓ Weight Loss

Answer Key

Disease/diagnosis	Geriatric syndrome with answer(s)/explanations
Diabetes	<ul style="list-style-type: none"> ✓ Incontinence and weight loss due to hyperglycemia ✓ Falls due to hypoglycemia ✓ Memory loss – various, including labile glucose, cardiovascular disease ✓ Depression – various mechanisms
Hypertension	<ul style="list-style-type: none"> ✓ Memory loss due to cardiovascular disease ✓ Falls due to orthostasis (a sudden drop in blood pressure when someone goes from lying or sitting down to standing up) with medications

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	<ul style="list-style-type: none"> ✓ Incontinence, falls and sleep disruption if on diuretic
Depression	<ul style="list-style-type: none"> ✓ Memory loss – epidemiologically associated with increased dementia risk ✓ Sleep disturbance is 1 of symptoms ✓ Chronic pain – Synergistic diagnosis. In addition, older adults may believe pain is a more socially acceptable complaint than depression. ✓ Polypharmacy via self-medication with drugs such as narcotics and alcohol for pain, antihistamines for insomnia.
Chronic pain	<ul style="list-style-type: none"> ✓ Polypharmacy <ul style="list-style-type: none"> ○ Overlap between over the counter & prescribed medications (e.g. Tylenol + prescribed Vicodin = high acetaminophen exposure). ○ More than 1 medicine may be required to effectively manage hypertension, but the definition of polypharmacy includes the patient's challenges in managing the risks of medicines even if they are indicated ✓ Depression – synergistic with pain ✓ Sleep disturbance ✓ Falls – potentially due to primary complaint such as arthritis, but also drug effects such as sedation with narcotics, gastrointestinal bleed with non-steroidal anti-inflammatory drugs (NSAIDs), etc.

What did you notice as you were going through this exercise?

Teaching Points

- ✓ More than one disease contributes to each syndrome or symptom cluster, so in older adults, we need to think about function rather than simply the management of individual diseases.

Resources

- ✓ American Geriatrics Society Expert Panel on the care of Older Adults with Multimorbidity. Guiding principles for the care of older adults with multimorbidity: An approach for clinicians. *J Am Geriatr Soc* 2012;60(10):E1-25.
 - <http://www.americangeriatrics.org/files/documents/MCC.principles.pdf>
- ✓ James PA, Oparil S, Carter BL, et al. 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8). *JAMA*; 311(5):507-520. doi:10.1001/jama.2013.284427.
 - <http://jama.jamanetwork.com/article.aspx?articleid=1791497>

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Which care providers and community resources should be involved in addressing Mrs. Martinez's overall care plan moving forward?

Teaching Points

- ✓ Referral to Area Agency on Aging, designated Care Coordination Unit (CCU) for a comprehensive in-home needs assessment, including food security and transportation access.
 - Specifically request that the care coordinator advise her of resources including nutrition programs, Program Encouraging Active and Rewarding Lives for Seniors (PEARLS), designed to reduce depressive symptoms and improve quality of life in older adults, and social supports (e.g. area senior centers for exercise classes, meals with other older adults, etc). Request a report from the CCU on follow up.
- ✓ In addition to PEARLS, refer Mrs. Martinez to the team psychologist for comprehensive assessment of depression and any other mental health issues that were not apparent in this visit.
- ✓ Send Mrs. Martinez to get lab tests to rule out adverse acute medical effects, e.g. anemia from Ibuprofen-related GI bleed, renal impairment from the combination of ibuprofen/ hydrochlorothiazide/enalapril.
- ✓ Plan for Mrs. Martinez to return to clinic in 1 week and bring all medications with her to review labs and plan future medication regimen.
- ✓ Encourage Mrs. Martinez to bring a family member with her to next visit, offer to write a work excuse for family's absence from work.
 - If her family is unable to come, ask for Mrs. Martinez' permission to include them in at least part of the visit via speakerphone, to share concerns and review management plan.
- ✓ Mrs. Martinez could be seen by her faith-based community/Church's Parish Nursing program for medication monitoring, social support resource, and spiritual assessment. Parish Nursing can also connect Mrs. Martinez to a chaplain, who can discuss her spiritual concerns with her.

Resources

National

- ✓ Area Agencies on Aging: <http://www.n4a.org/>
- ✓ Eldercare Locator : <http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx>
- ✓ PEARLS Program: http://www.acl.gov/Programs/CPE/OPE/docs/PEARLS_InterventionSummary.pdf

Resources for Purchase

- ✓ Purple Binder (<http://www.purplebinder.com/>): a fee-based service connecting providers with community resources and referrals.
- ✓ Now Pow (<http://www.nowpow.com/>) – initially developed as a Centers for Medicare and Medicaid Innovation project, NowPow “connects people to high

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quality community resources. From stress management to smoking cessation, fitness classes to family planning, we collect and share detailed information on the services everyone needs to do good, stay well and live long.”

- See You Tube video by project director, Dr. Stacy Lindau:
https://www.youtube.com/watch?v=NhyU0uj_qg0

Test Bank

Question 1

Which of the following medications is potentially dangerous for older adults because of its anticholinergic effects, including memory loss?

- A. Aspirin
- B. Insulin
- C. Benadryl
- D. Enalapril

The correct answer is C.

Reference: file:

www.scanhealthplan.com/media/1743/printablebeerspocketcard.pdf

Resources:

- ✓ Providers – American Geriatrics Society 2015 updated Beers Criteria for potentially inappropriate medication use in older adults.
<https://www.guideline.gov/summaries/summary/37706>
- ✓ Consumers – Medications in Older Adult Tip Sheets for Consumers -
<http://www.healthinaging.org/medications-older-adults/>
- ✓ Definition and discussion of risks of anticholinergics:
<http://www.healthline.com/health/anticholinergics#Precautions4>
- ✓ Provider Resource: Anticholinergic Pocket card: <http://www.public-health.uiowa.edu/cert/education/AnticholinergicCard.pdf>

Question 2

Which of the following medications is most likely to increase the risk of constipation?

- A. Vicodin
- B. Insulin
- C. Enalapril
- D. Fluoxetine

The correct answer is A.

Reference: Gartlehner G, Jonas DE, Morgan LC, et al. Drug Class Review: Constipation Drugs: Final Report [Internet]. Portland (OR): Oregon Health & Science University; 2007 Sep. Introduction. Available from:

<http://www.ncbi.nlm.nih.gov/books/NBK10506/>

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Question 3

All of the following increase the risk of stroke EXCEPT

- A. Hypertension
- B. Weight loss
- C. Diabetes
- D. Older age

The correct answer is B.

Reference:

http://www.strokeassociation.org/STROKEORG/AboutStroke/UnderstandingRisk/Understanding-Stroke-Risk_UCM_308539_SubHomePage.jsp

Question 4

Which of the following home/community-based services is covered by Medicare?

- A. Meals on Wheels to deliver meals to a person's home
- B. Homemaker service to provide cleaning and laundry
- C. Home health nurse to help organize and educate patient about medications
- D. Adult Protective Service investigation of suspected elder abuse

The correct answer is C.

Reference: www.medicare.gov/what-medicare-covers/

Questions for Self-Reflection

- ✓ In healthcare, providing culturally competent care is necessary to overcome barriers for the providers, patients and their families. When managing multiple chronic conditions among older adults, mental health and possible substance misuse issues, how would you address the need for and provide a more culturally responsive and team-based approach to care management?
- ✓ What are your own perspectives, questions, and concerns about managing chronic persistent pain, including the psychological, social and cultural aspects? Why is it important for professionals to be aware of their own concerns?
- ✓ If you become aware that a patient's goals and preferences, as described in the evaluation and other documentation, are being overlooked or ignored, what do you do?

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CATCH-ON Education Team Members

- Magdalena Bednarczyk, MD, Physician, Rush University Senior Care, Rush University Medical Center
- Fawn Cothran, PhD, RN, GCNS-BC, Assistant Professor, College of Nursing, Rush University Medical Center
- Kimberly Dixon, MD, Section Chief of Geriatric Medicine, John H. Stroger Hospital, Cook County Health & Hospitals System
- Erin Emery-Tiburcio, PhD, Associate Professor, Behavioral Sciences, Rush University Medical Center
- Carol Farran, DNSc, RN, FAAN, Professor Emeritus, College of Nursing, Rush University Medical Center
- Sheila Greuel, MA, Consultant, Area Agencies on Aging
- Elaine Jurkowski, PhD, Professor, School of Social Work, Southern Illinois University
- Michael Koronkowski, PharmD, Clinical Assistant Professor, Pharmacy Practice, University of Illinois at Chicago
- Stan Lapidus, MA, Associate Professor, Preventive Medicine, Rush University Medical Center
- Joanne Miller, PhD, RN, Associate Professor, College of Nursing, Rush University Medical Center
- Michelle Newman, MPH, Coordinator of Interprofessional Program Development, Health and Aging, Rush University Medical Center
- Sandra Swantek, MD, Medical Director, Geriatric Psychiatry, Rush University Medical Center
- Lynette Washington, MA, Instructional Designer, Rush University Medical Center

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