CATCH-ON

CATCH-ON Evolving Cases: Student Guide August 2017

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About This Student Guide

Purpose

This student 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 for free online 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.

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 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.

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 more on some questions 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.

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.

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 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.

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 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. His sister, Charlotte, who had moved in with him 6 months ago to help out, sleeps very soundly and did not hear him fall. The next morning, Charlotte awoke to find Mr. Kozlowski on the floor. He was awake and in a lot of pain. Charlotte immediately called 911, then called his daughter, Anne. The emergency medical service was on the way. Anne drove to the hospital, where she met her father and Charlotte 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 and sister 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. Charlotte was working full time and wasn’t sure she could provide the level of supervision he needed. Mr. Kozlowski’s children wanted him to move to an assisted living facility (ALF). For Mr. Kozlowski, it was not an option.

Case Study: Mrs. 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.

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.

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.

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.

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.

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:

- 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.

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.

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 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.

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 Kemps, 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.

- ✓ 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?

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?"

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.

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.

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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