Interdisciplinary Team Meeting: A simulated geriatric care team meeting for discharge planning with the Cooper Family (2021)

Team Member Input on Ms. Cooper

Physician

Gives prognosis and comments

Her recent hip fracture has taken a lot out of Mrs. Cooper and she has declined quite a bit. In your opinion, Mrs. Cooper has now progressed from MCI to early stage Alzheimer's disease dementia, which means frequent recent memory loss, particularly of recent conversations and events; repeated questions, some problems expressing and understanding language. Mild coordination problems: writing and using objects becomes difficult. Depression and apathy can occur, accompanied by mood swings. She needs reminders for daily activities.

The next or middle stage leads to pervasive and persistent memory loss, including forgetfulness about personal history and inability to recognize friends and family. Mobility and coordination are affected by slowness, rigidity, and tremors. Mrs. Cooper is likely to progress to this stage in the next two years given her current rate of decline. She will need structure, reminders, and assistance with the activities of daily living.

Given the progressive nature of the disease and the frail condition of husband/primary caregiver Mr. Cooper, you advise more help (either assisted living or paid help in the home). A facility has a couple of "levels of care" (e.g. a CCRC) might be a good option for the couple as she is likely to be more impaired and need more help than he does. Such a facility might allow them not to be separated in the years to come.

Physician Assistant

Gives history and comments about the rehabilitation stay (this provider saw her the most)

Mrs. Cooper did well in rehab, progressing well without any complications except for one urinary tract infection (UTI) that was caught early by you and treated early during her rehab stay. She has not been delirious, but often times does get confused about the date and needs to be reminded where she is.

Nurse Practitioner

Gives history and comments about the rehabilitation stay (this provider saw her the most)

Mrs. Cooper did well in rehab, progressing well without any complications except for one urinary tract infection (UTI) that was caught early by you and treated early during her rehab stay. She has not been delirious, but often times does get confused about the date and needs to be reminded where she is.

Registered Nurse

Gives history about how Mrs. Cooper has been doing at the rehabilitation facility

Mrs. Cooper did well during her rehabilitation stay. She did require two nurse's aides or nurses to help her in the beginning, but then she gradually got stronger. Her main issue is getting up by herself in the middle of the night to go to the bathroom. She would not remember to ask for help and twice we had close calls where she almost fell; luckily the fall alarm she was wearing alerted you that she had gotten out of bed. You are worried that she will fall at home without such care. She also had an early stage pressure area on her sacrum that your staff were able to notice and take care of with good nursing care and turning her every 2 hours when she came from the hospital. Now that she is walking and able to get up more, this area is better.

Pharmacist

Reviews Mrs. Cooper's medication list and comments

- Altace (ramipril: ACE inhibitor) 10 mg once a day for hypertension
- Hydrochlorothiazide (diuretic) 25 mg once a day for hypertension
- Adalat CC (nifedipine: calcium channel blocker) 30 mg once a day for hypertension
- Aricept (donepezil: cholinesterase inhibitor) 10 mg once a day for mental function
- Lunesta (eszopiclone: hypnotic) 1 mg at bedtime for sleep
- Fosamax (alendrantate: bisphosphonate inhibits bone resorption) 70 mg once a week for osteoporosis
- Glucosamine (500mg) Chondrontin (400mg) twice a day for joint discomfort
- Caltrate 600+D (calcium citrate + vitamin D3) once a day dietary supplement
- Hydrocodone/acetaminophen (narcotic analgesic/analgesic) 5mg/325mg, one tablet every 4 hours as needed for pain

You have applied the updated **Beers Criteria** to the list and find no potentially inappropriate medications. Mrs. Cooper will need assistance with her medications due to her declining cognition.

> **New York, NY, March 1, 2012** – A wide range of medications—some relatively new and others long available—can cause serious side effects and other adverse events in people 65 and older if not prescribed with care, according to the new *American Geriatrics Society* ***Updated Beers Criteria*** *for Potentially Inappropriate Medication Use in Older Adults*. More than 40% of people aged 65 and older take five or more medications according to a 2008 study published in the *Journal of the American Medical Association (JAMA)* and each year more than a third of them will suffer a drug side effect or other adverse drug event (ADE).

Social Worker

Gives social history and makes home visit

The social worker reports that the Coopers have been married 68 years. Mr. Cooper served in the Navy during WWII, went to college on the GI Bill and then attended dental school. He sold his dental practice and retired at age 66. Mrs. Cooper was a full-time homemaker and earlier had been active in community service. The Coopers live in an older 2-story home on the edge of an historic neighborhood near downtown.

You made a home visit to carry out a home safety assessment (which sometimes is done by occupational therapists also). The Coopers had already fitted the rear entry with a ramp for wheeling items in and out of the house. However you found the doorways too narrow to accommodate a wheelchair. The only bathroom on the first floor is a half bath that is too small to renovate, but the utility room could potentially be fitted with a shower. There are 16 steps leading from the first to second floor which presents a significant safety risk to Mrs. Cooper.

The Coopers have retirement savings of $140,000, but do not have Long Term Care Insurance. The Coopers receive $2040 per month from Social Security. The Coopers own their home, which is currently valued at $340,000. Ms. Cooper has traditional Medicare (Parts A & B) as well as Part D Medicare. She has no "gap" or other insurances, including long term care insurance.

You met with the Coopers and their son/daughter Mr./Mrs. Allen to discuss placement options for Mrs. Cooper. You learned that Mr. Cooper prefers to take his wife home and their son/daughter wants Mrs. Cooper to go to an assisted living facility. You have read the therapy reports and after completing the home safety assessment, know that returning to home would require the Coopers' make expensive home modifications to accommodate Mrs. Cooper's physical limitations. However, recommendations for the best placement for Mrs. Cooper must also take into account the Coopers' financial resources in addition to what is currently allowed by Medicare.

Physical Therapist

Reports rehab status and prognosis, makes recommendations for physical requirements of residential environment

The PT is aware that Mrs. Cooper fell at home at least twice. The last time she fractured her hip. What isn't known are the causes for the falls. It could be polypharmacy or could be the influence of other intrinsic risk factors such as muscle weakness or a visual deficit. In order to make recommendations for it is important to determine the cause(s) of these falls. Mr. Cooper was unable to lift and assist her and had to call for help.

Mrs. Cooper was seen by you at the in-patient rehabilitation hospital to determine fall risk. You administered the Berg Balance Scale a test validated to identify older adults at risk for falls. In addition you tested Mrs. Cooper's strength, sensation, range of motion, and flexibility, all intrinsic variables known to contribute to fall risk. You also had Mrs. Cooper complete a questionnaire (The Activities Specific Balance Confidence Scale (ABC) to determine her level of confidence completing routine activities. Testing revealed: lower extremity sensory loss, lower extremity weakness a score of 42 on the Berg Balance Scale indicating a moderate level of fall risk and a score of 48 on the ABC. At a follow-up appointment you had Mrs. Cooper complete the Dual Task Timed Up and Go (TUG) to determine whether Mrs. Cooper's falls were due to an inability to divide attention between two tasks such as walking and carrying a cup of water. Mrs. Cooper scored very poorly on the task as it took her almost 30 seconds to complete the test, where normally it should have taken about 10 seconds. This indicates that Mrs. Cooper is unable to walk safely while performing even a simple secondary task. Mr. Cooper, due to his frail condition, is unable to assist with lifting or transferring Mrs. Cooper.

Given the findings of the examination, inability for Mr. Cooper to assist with lift and transfer, and home safety assessment you recommend that Mrs. Cooper should not be discharged to home, but would get the therapy and attention she needs in a safe environment such as in an assisted living facility.

Registered Dietitian/Clinical Nutritionist

Reports current diet and future needs

Mrs. Cooper initially had poor intake when she came to rehabilitation**. From her weight of 130 lbs before her injury, her weight has declined to 124 lbs.** This was felt due to a combination of lingering delirium from the hospitalization leading to poor attention to eating and also possible side effects of the medications (pain medications causing constipation and decreased appetite). **Liberalization of her 2 gm sodium diet to a No Added Salt diet for her hypertension allowed increased intake during rehab. Also** she was offered simple finger foods that were easier for her to eat.

Wherever she goes, caregivers should change her diet to more of these types of foods, especially as the dementia progresses**. They should also monitor her intake and weight. She should continue her daily calcium citrate supplement that provides 600 mg of calcium and 1,000 IU vitamin D to reduce risk of bone fractures in the presence of her osteoporosis.**