Instructions for Case Study Discussion

This case is an abridged version of the one used by students for the 2022 intercampus Geriatrics Case Competition. It represents the complexity often encountered in geriatrics practice. The purpose of this exercise is to apply the principles of interdisciplinary team care to such a case. Breakout groups may have several disciplines represented, but not all that would be required to address the case.

In the time available (about 30 minutes), breakout groups will read and discuss the case. The task is to try to prioritize the problems and then develop at least 2-3 SMART goals that are patient-centered along with a list of health care disciplines that might be involved in achieving that goal. (Do not be restricted by health care insurance coverage or access to services issues, which in many cases limit success of such care plans).

The National Committee for Quality Assurance (NCQA) describes writing a SMART goal as follows:

> **Writing a SMART Goal:**
> **Specific:** State the goal clearly. If the goal is"I just want to stay healthy," ask what that means. For one person, it might mean staying out of the hospital; for another, it might mean being able to walk a certain distance three days a week.
>
> **Measurable:** Identify and quantify the observable markers of progress, such as pain levels or number of days walked each week.
>
> **Attainable:** Break the goal into smaller, actionable steps. Identify expected barriers and make a plan to address them.
>
> **Relevant:** Make sure the goal reflects what's important to the individual. Motivational interviewing can be used to tie clinical goals, such as blood pressure control, to the goal of staying healthy.
>
> **Time-Bound:** Define the period in which the goal is to be attained. Agree when to check progress.

An example of converting a general goal to SMART goals is:

General Goal: *The main one is to keep trying to move, walk and do some of the things I like to do."*

Smart Goal Statements:
1. The patient will have a pain level of 4 or less, which will enable her to be more independent with her ADLs and IADLs.
2. The patient will lose 15 pounds over the next 6 months.

MAGIC 2022 Pre-conference Case Study

The Case of Charlotte Kenny

BACKGROUND OF THE PATIENT

Ms. Charlotte Kenny (she/her/hers) is a 71-year-old, female, life-long resident in a rural area of Minnesota, except for her service as a nurse in the Army in Viet Nam. She currently lives alone in a two-bedroom, two-story home. She is retired from managing a floral shop. She was active in her church but does not attend as often now. She has had comprehensive multi-disciplinary work-ups during a recent hospitalization for cellulitis. She is coming in for an appointment at a rural health center with her younger sister, Mary, due to complaints of increased lower back pain.

Biomedical Assessment:

Ms. Kenny thinks her back pain is related to injuries during military service. It takes her a lot of time in the morning to get around the house and start her day. She also struggles getting consistent sleep, averaging just over five hours per night. At least two nights per week, she sleeps on the couch due to pain climbing stairs. She uses hot packs and Vicodin from her sister, who lives nearby. Also has some increasing numbness and tingling in her feet in recent months. Ms. Kenny reports feeling fatigued throughout the day.

Psychosocial Assessment:

Ms. Kenny does not have a robust network of friends or close family. Due to a lack of transportation, she is unable to see her doctor. She also struggles socializing with others, given her numerous health issues and fear of certain situations in public. An Adult Protection report filed by a repairperson noted severe clutter and hundreds of cigarette butts. She is now resistant to people coming to her home.

She drinks about 2 oz off alcohol per week. Smoke half a pack cigarettes per day.

Ms. Kenny has denies being depressed, but sister reports poor eating and hygiene and tearfulness on the phone.

Personal and Deployment History

Due to stress of military nursing, she quit the profession after returning from Viet Nam. She never pursued disability from VA or enroll for VA health services and rarely spoke of her experiences. She has occasionally expressed interest in local VFW activities. She is divorced with a son in Chicago but rarely speaks to him. The patient does not have a healthcare POA and chooses to make all medical decisions on her own. She relies on her sister for primary assistance for medical and personal concerns.

Mobility and ADLs:

Ms. Kenny has noticed that her balance has been declining over the past couple of years. She has fallen twice in the past year, both times due to tripping over loose cords and objects on the floor in her living room.

Ms. Kenny reports she can dress herself in the mornings, but she prefers to stay in her pajamas all day since it is more comfortable. She wears slip-on slippers because she is unable to wear socks or tie shoes as she can't bend over due to her back pain. She has not taken a shower in a long time because she doesn't feel safe standing in the bathtub while showering, as she is fearful of falling. Instead, she washes up at the bathroom sink with a washcloth.

Patient is independent in dressing, using the toilet, and eating. Her washing machine and dryer are not working, so she has been buying clothes from the thrift store to replace her dirty clothing. She has a narrow-cluttered path to her bathroom. She relies on her friend or sister for transportation and to take her shopping. She does not prepare food in her kitchen, preferring to eat cheap ready to eat processed food. She has several bottles of pills and a partially filled pillbox on her cluttered kitchen table. Her sister sets up her medications in a pill box each week. Her household bills are often unpaid or are paid late because she loses them. She relies on a cell phone to contact her sister or friend.

The last time the patient saw a dentist was over six years ago, who was concerned about infected gums. Over the last year, the patient has had on-and-off pain in a bottom tooth. The pain medication from her sister helps both her back pain and tooth pain.

Ms. Kenny has recently experienced swallowing and articulation issues. She has also experienced pain when swallowing solid foods. The patient eats a high-sugar diet and drinks very little fluids throughout the day. In recent months, she has become dizzy throughout the afternoon, responding to this by siting down for a few hours in front of the television to recover. Her sister also brings in fast food 3-4 times per week. She reports some discomfort when swallowing and has lost some taste of certain foods. No known COVID infection, but never tested.

Her sister recently suggested the patient consider options of assisted living or nursing home placement, due to the ongoing health issues and her hoarding. Ms. Kenny is very resistant to this idea and says, "They'll have to drag me away from my place before I go into a strange facility." The patient's mother went into a nursing home after a serious stroke and passed away one year later. The patient is very apprehensive that the same could happen to her.

- Ht. 5'3, Wt. 215 (BMI=38.1), Temp 98.7, HR 90, RR 24, SaO2 96%, Sitting BP=145/88 •
- Physical Exam: (positive findings):
  - CONSTITUTIONAL: Slightly disheveled with foul odor coming from clothing
  - HEENT (Head/Eyes/Ears/Nose/Throat): poor dentition, areas of gum bleeding
  - CARDIAC: rate 108, regular rhythm, no murmur, no jugular venous distention ○ PULMONARY: lungs clear
  - EXTREMITIES: 2+ edema to mid-calf in stocking distribution

- SKIN: ruddy brownish skin discoloration with flaking over area of edema in legs; multiple sores on her lower back may be due to infection
- NEUROLOGIC: + difficulty rising from seated to standing position, slow gait, no focal areas of weakness, reflexes normal

• MENTAL STATUS: alert, oriented x 4. Mood is reserved and guarded. Affect blunted. SLUMS Questionnaire score = 25/30 Depression: Patient Health Questionnaire (PHQ-9) score = 16

Medical conditions: hypertension, high cholesterol, herniated lumbar disk, osteoarthritis

Surgical history: Diskectomy and lumbar laminotomy for herniated lumbar disk 6 years ago. Herniated disc led to some nerve damage. Hip replacement 5 years ago.

Labs: Lipid Profile: Total cholesterol 237, LDL 144, HDL 36
HbA1c: 6.3%
Basic Metabolic Profile: sodium 134, potassium 4.9, chloride 102, creatinine 0.8, BUN 23 CBC: normal

Mobility

- Timed Get Up and Go Test = 14-16 seconds (slow)
- Gait Speed=0.8 m/s (slow)
- Grip Strength Score=14.8 kg (nl)

Current Medications:

- Norvasc: 5 mg daily
- Spironolactone: 12.5 mg daily
- Vicodin: (from sister) 5 mg/500 mg
- Alprazolam 0.25 mg: PRN
- Chantix: 0.5 mg 1x/day

Past Medications:

- Percocet (5/325 mg every 6 hrs)
- A Codeine containing medication

COVID vaccinations in June/July of 2021 and flu shot in November of 2021

What Matters

• Ms. Kenny would like to volunteer for her church and take arts/crafts classes at the town senior center. She hopes that getting back to the church more often will help her socialize and become less isolated. She also wants to re-connect with the Veterans of Foreign Wars, (VFW) group but does not have internet setup to connect with members and committees. This was a group that she used to be more connected to and made lots of friends.