

ACE *in* Geriatrics

(Ambulatory Care Education in Geriatrics)

Pocket reference guide and log book.

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Medicine*** (2011)

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Contents:

| | |
|---|---|
| Table of content..... p 2 | Rotation overview..... p 2 |
| Lecture and skills log / sign off page p 3/4 | Functional status p 5 |
| Mini-cog/ MOCA / MMSE p 5 | Depression screening p 6 |
| Mania Screen p 7 | Stages of Dementia p 7 |
| Delirium p 8 | Fall risk assessment p 9 |
| Get up and go test p 10 | Osteoporosis screening P 10 |
| Hearing and Vision Screen p 11 | Evaluating the older driver p 12 |
| Cardiac risk assessment p 13 | Elder abuse screening p 14 |
| Incontinence p 14 | Failure to thrive P 15 |
| Geriatric Math p 16 | Appropriate prescribing – Beers Criteria p 16 |
| Advance Care planning p 17 | Breaking Bad News p 18 |
| Determining Capacity / competency p 18 | Hospice criteria p 19 |
| Home visit criteria P 19 | <i>Preventative Services by covered Medicare</i> p 21 |
| <i>Web references & Telephone #</i> p 21 | <i>Inpatient lecture topic log</i> p 22 |

The rotation & experience: (6 weeks during the second year).

- Longitudinal care of the nursing home patient.
- In patient experience.
- Continuing care of the older patient in the Family medicine clinic.
- Encounters with the elderly while on other rotation – i.e. Medicine subspecialties, surgery etc.

List of activities that **need to be signed** off on – over the course of the 6 weeks rotation in order to be given credit for successful completion of the rotation: (pages 3 & 4)

Lectures or Discussion: *All of these need to be signed off.*

| Topics: | Sign off <i>(Dr's Geri Attending & Others)</i> |
|---|--|
| Normal aging | |
| Delirium | |
| Dementia | |
| Appropriate prescribing | |
| Osteoporosis. (Men & women) | |
| Depression in the Elderly | |
| Functional assessment of the Elderly | |
| Incontinence | |
| Failure to thrive / weight loss | |
| Behavior management in advanced dementia | |
| Pressure ulcers | |
| Ethical Issues in the Elderly | |
| Medicare rules & Nursing home regulations | |

Observed Skills to get signed off on: (Over the course of Year`s 2 and 3 of residency)

- 2 home visits. _____
- 5 Nursing home visit sessions _____

| Skills – To be observed at least on one occasion. | Sign off (any faculty member – including IPS) | |
|---|---|------------|
| | Observed | Proficient |
| - Mini – Cog | - | |
| - MOCA/ MMSE | - | |
| - Get up and go test | - | |
| - Depression Screening | - | |
| - Falls assessment | - | |
| - Discussion of advance directive | - | |
| - Breaking bad news | - | |

FUNCTIONAL STATUS

| Activities of Daily Living (ADLs)* | Instrumental Activities of Daily Living (IADLs)** |
|---|--|
| <i>Bathing</i> | Administering own medication |
| <i>Dressing</i> | Grocery shopping |
| <i>Toileting</i> | Preparing meals |
| <i>Transfers</i> | Using the telephone |
| <i>Grooming</i> | Driving and transportation |
| <i>Feeding</i> | Handling own finances |
| <i>(Loss occurs in this order, with feeding to go last)</i> | Housekeeping |
| <i>Laundry</i> | |

**ADLs are the essential elements of self-care. Inability to independently perform even one activity may indicate a need for supportive services.*

***IADLs are associated with independent living in the community and provide a basis for considering the type of services necessary in maintaining independence.*

MINI-COG

Consisting of two parts: Un-cued 3-item recall plus clock draw test (CDT).

1. Instruct the patient to listen carefully as you name 3 unrelated objects and then to repeat the object names.
2. Instruct the patient to draw the face of a clock, either on a blank sheet of paper or on a sheet with the clock circle already drawn on the page. After the patient puts the numbers on the clock face, ask him or her to draw the hands of the clock to read a specific time, such as 11:20. These instructions can be repeated, but no additional instructions should be given. Give the patient as much time as needed to complete the task.
3. Ask the patient to repeat the 3 previously presented object names.

[If abnormal, proceed with a Cognitive Assessment Screen (MMSE or MOCA) - See below]

MOCA or MMSE

(Mini/Mental State Exam or Montreal Cognitive Assessment) – These are available in the Geri tool boxes, in the clinic or online)

http://www.mocatest.org/pdf_files/MoCA-Test-English.pdf (in multiple languages with instructions)

TWO-ITEM DEPRESSION SCREEN

Ask the patient to respond yes or no to the following two questions.

In the past month: 1. Have you often been bothered by feeling down, depressed or hope less?

2. Have you often been bothered by little interest or pleasure in doing things?

(If yes to either question, please continue to Geriatric Depression Screen. If no both, stop here.)

GERIATRIC DEPRESSION SCREEN

| | |
|---|----------------|
| Are you basically satisfied with your life? | Yes- No |
| Have you dropped many of your activities or interests? | Yes -No |
| Do you feel that your life is empty? | Yes -No |
| Do you often get bored? | Yes -No |
| Are you in good spirits most of the time? | Yes- No |
| Are you afraid that something is going to happen to you? | Yes -No |
| Do you feel happy most of the time? | Yes- No |
| Do you often feel helpless? | Yes -No |
| Do you prefer to stay at home rather than go out & do things? | Yes -No |
| Do you feel you have more problems with memory than most? | Yes -No |
| Do you think it is wonderful to be alive now? | Yes- No |
| Do you feel pretty worthless the way you are now? | Yes -No |
| Do you feel full of energy? | Yes- No |
| Do you feel that your situation is hopeless? | Yes -No |
| Do you think that most people are better off than you? | Yes -No |

Score one point for each bolded answer. Zero to 5 is normal, above 5 suggests depression.

MANIA SCREEN.

DIGFAST: Mnemonic for the Cardinal Symptoms of a Manic Episode

Distractibility

Indiscretion (excessive involvement in pleasurable activities, etc)

Grandiosity

Flight of ideas

Activity increase

Sleep deficit (decreased need for sleep)

Talkativeness (pressured speech)

NOTE: A manic episode requires at least one week of elevated or irritable mood plus three of the seven symptoms described above
<http://www.aafp.org/afp/981101ap/carlat.html>

(ALZHEIMERS TYPE) DEMENTIA STAGES

Mild Cognitive Impairment: (10% annual progression to Dementia)

- MMSE score 26-30/ MOCA <26. (Usually short term memory deficits on tests)
- Noticed memory impairment by others, no functional impairment, mild language & executive dysfunction.

Early/Mild Dementia (1-3 yrs)

- MMSE 21-25
- Disoriented to date.
- Naming difficulty.
- Recent recall problems.
- Decreased insight.
- Social withdrawal.
- Irritable / mood changes.
- Problems with IADL's.

Middle / Moderate Dementia (2-8 years)

- MMSE 11-20
- Disorientation to date, place.
- Comprehension difficulty.
- New learning is impaired.
- Getting lost in familiar areas.
- Impairment in calculations.
- Delusions, agitation, aggression.
- IADLs impaired.
- Often restless, anxious, depressed.
- ADLs start to get impaired.

Severe/late Dementia (6-12 yrs)

- MMSE 0-10
- Severe language impairment.
- Remote memory significantly affected.
- ADL's affected.
- Incontinent.
- Motor, verbal agitation.

DELIRIUM

Disturbed **consciousness** (attention, awareness), **Cognitive change** (memory, language, visual – hallucinations). **Rapid onset** (hrs – days), with **daily fluctuations**. Underlying **identifiable cause**.

CAM (Confusion Assessment Method) – Confusion - Both acute onset and fluctuating course and inattention and either disorganized thinking **or** altered level of consciousness.

Risk factors: - Dementia, advance age, medical co morbidities, physical stressors (Lack of sleep, dehydration, pain, sensory impairment, immobility), acute illness, hospitalizations, medications.

Evaluation:

Assume **reversible until proven otherwise**. **Labs & tests** may include (CBC, CMP, ammonia, TSH, b12, glucose, UA, O2sats, ABG1s, CXR, EKG, CT Head) – depending on circumstances or findings. **Review ALL** their meds, OTC products, alcohol and drug usage. (See Beers list)

Exclude: Infections. (resp, bladder, skin etc) Metabolic disorders (Electrolyte problems, end organ – liver, kidneys, glucose and other endocrine issues). Cardiovascular (Arrhythmia, CHF, MI, shock) and other medical reasons. Neurological (Infections, trauma, seizures, strokes, subdural, TIA`s, Tumors) Others (Post operative states, sleep deprivation, *fecal impaction*, urinary retention).

Treatment:

- Ensure safe environment, use familiar people (family) as sitters if possible, and avoid physical restraints if possible.
- Meds if needed for patient safety:
- Haldol (0.5 – 2mg PO) – works in 4-6 hrs. can be given IM or IV. Keep in mind that the IV dose will work much faster (20-30 min). Can repeat PO Q4 or IM every hour until agitation is calmed then slow down.
- Maintain for 2-3 days. Needs frequent re-evaluation (Q1 hrs). Monitor for side effects (EPS, Prolonged QT, drug interactions).
- If the delirium is improving – taper the Haldol off over 4-5 days with monitoring for relapses.
- If alcohol or Benzodiazepine withdrawal suspected – consider using Ativan (0.5- 2mg) Q6 hr with a slow taper off.

FALL RISK ASSESSMENT

Common risk factors:

- Hx of falls, Gait problems, Balance problems.

Other risks:

- Muscle weakness, visual deficits, arthritis (weight bearing joints), impaired ADL's, depression, cognitive impairment, use of assistive devices, > 80 years & relevant co morbid conditions (i.e. Parkinson's, strokes, DM, CAD, volume loss, anemia, CKD, Thyroid dysfunction etc)

Medication classes that can increase the risk of falls.

- Antipsychotics, Sedative's, Hypnotic's, Anxiolytic's, Antidepressants (TCA, SSRI, MAOI's), Anticonvulsants, Antihypertensive/Diuretics, Antiarrhythmics – Class 1A.

Work up:

History should include information on circumstances, associated symptoms, and information gathering keeping risk factors and medications in mind.

DDx – Exclude acute illness, metabolic process (infections, electrolyte imbalance etc), syncopal vs. nonsyncopal event

Physical Exam:

Vitals- Note bradycardia or tachycardia, check orthostatic P/BPs

HEENT- Note Cataracts, Visual fields, acuity, bruits, motion imbalance

Cardiovascular– Note Arrhythmias, murmurs, pulses, edema

MSK exam – Note joint exam esp. weight bearing, strength, Test Get up and Go.

Neurological exam – Note reflexes, sensation loss, gait or balance problems, tremor, rigidity.

Specific tests for gait, mobility and balance:

- " Get up and Go test" (See section for this).
- Balance (Berg Balance scale), ability to pick up something from the floor, use of assistive device.
- ADL's (See section)
- Romberg

Labs /tests: Per suspected etiology of falls (Consider labs, cardiac monitoring, ECHO, EKG etc).

Prevention:

- Assess routinely i.e. part of annual physical.
- Utilize other members of the healthcare team PRN (i.e. PT, OT etc.)
- Strength and balance training.
- Home safety and environmental assessment.
- Dx and Tx underlying medical causes.
- Review and reduce medications.
- Patient/caregiver education.

TIMED “GET UP AND GO” TEST

To test the subject, give the following instructions:

1. Rise from the chair (Without using ones hands – if possible)
2. Walk approx (10 feet) – ok to use walking aids if needed – cane, walker.
3. Turn around
4. Return to the chair
5. Sit down again

The normal time required to finish the test is between 7-10 seconds. Individuals who cannot complete the task in that time probably have some mobility problems, especially if they take more than 20 seconds.

This information should be documented as a baseline and repeated if any change in mobility occurs or at least yearly.

Reproduced from: Get-up and Go Test in: Mathias S, Nayak USL, Isaacs B. Balance in eld-erly patient” The “Get Up and Go” Test.

OSTEOPOROSIS RISK SCREENING

- (USPSTF) Screening in Women – Begin at 65 if no risk factors. Begin at 60 if risk factors. (Grade B). Risk assessment can start at age 40.
- Screening in Men - Risk assessment should start by age 55- 65. (ACP). Those at increased risk should be considered for screening if they would be candidates for therapy.
- Online assessment tool at :

<http://www.sheffield.ac.uk/FRAX/>

Shortcomings of this screening tool to keep in mind for the Geriatric patient or factors not included:

1. Steroid dose.
2. Previous fracture characteristics.
3. Markers of bone turnover.
4. Fall risk.
5. Impact of other diseases – Parkinson’s, CAD, Strokes, thyroid states, immobility etc
6. Vitamin D status.
7. Chronic medication use (AED, PPI’s, H2 blockers etc).

HEARING & VISION SCREENING QUESTIONS

Hearing/Vision: (Consider when working up depression, dementia, functional status, driving etc)

Ask the patient the following questions – when they are using their hearing aids or glasses.

1- Are you able to follow a conversation one on one?

2- Are you able to follow a conversation in a group of 3 or more?

A – Can you recognize a face from 4 meters (14 ft) away?

B – Are you able to read normal newspaper print letters?

Given the potentially poor reliability in self reporting. Consider doing the following quick tests, as well. Followed by more formal testing if indicated.

- **Whisper test.** (Stand 2 ft behind the patient, cover the ear not being tested and whisper a question easy to answer)
- **Snellen’s chart** (test at 20 ft for far vision) & **Rosenbaum card** (test at 14 inc for near vision) – definition of legal blindness $>20/200$, loss of acuity $>20/40$.

Ref: *Scand J Prim Health Care* 2000; 18 (203-207)

SCREENING TOOL FOR THE EVALUATION OF THE OLDER DRIVER

The **4 C's** in the history – should prompt further discussion on a patient's ability to drive safely and possible need for further assessments.

- **Crash/citation.**
- **Concern** by family members.
- **Clinical status** (Vision, arthritis, neuropathy, diabetes, MS, Parkinson's, Dementia etc)
- **Cognition**

Ref: *JAGS 58:1104-1108, 2010*

Clock drawing (modified scoring) – One can use the test to screen for patients who should get a driving test.

Modified scoring used

3 point for time (exact hands on number – 1-long arm, 1- Short arm, 1- at the number).

2 points for number (1 – numbers inside the clock, 1 all the numbers are present)

2 points for space (1- equal space between numbers, 1-equal space from the edge to the number)

<5/7 – consider further testing.

Freund et al., Cognition Screening for Driving Competency J GEN INTERN MED 2005; 20:240–244

MODIFIED CARDIAC RISK INDEX

Risk Factors: Patient

- | | |
|--|-----------|
| 1. Age older than 70 years: | 5 points |
| 2. Prior Myocardial Infarction | |
| 1. Last infarction within 6 months: | 10 points |
| 2. Last infarction more than 6 months ago: | 5 points |
| 3. Unstable Angina within last 6 months: | 10 points |
| 4. Angina Pectoris | |
| 1. Canadian Angina Class 3: | 10 points |
| 2. Canadian Angina Class 4: | 20 points |
| 5. Alveolar pulmonary edema | |
| 1. Pulmonary edema within one week: | 10 points |
| 2. Pulmonary edema at any time: | 5 points |
| 6. Suspected critical Aortic Stenosis : | 20 points |
| 7. Arrhythmia | |
| 1. Rhythm other than sinus or sinus with PACs: | 5 points |
| 2. More than five premature ventricular beats: | 5 points |
| 8. Emergency surgery: | 10 points |
| 9. Poor general medical status: | 5 points |

Total
_____/120

Interpretation

Class 1: Points 0-15 (Low risk)

Class 2: Points 20-30 (Moderate risk)

Class 3: Points >30 (High risk)

Angina class:

1. Class 0: Asymptomatic
2. Class 1: Angina with strenuous Exercise
3. Class 2: Angina with moderate exertion
4. Class 3: Angina with mild exertion
 1. Walking 1-2 level blocks at normal pace
 2. Climbing 1 flight of stairs at normal pace
5. Class 4: Angina at any level of physical exertion

References: Detsky (1986) *J Gen Intern Med* 1:213

Also read: Assessing and Reducing the Cardiac Risk of Non cardiac Surgery: *Circulation* 2006; 113; 1361-1376

<http://circ.ahajournals.org/cgi/content/full/113/10/1361>

ELDER ABUSE SCREENING

Elder abuse is doing something or failing to do something that results in harm to an elderly person or puts a helpless older person at risk of harm. This includes:

- Physical, sexual and emotional abuse
- Neglecting or deserting an older person you are responsible for
- Taking or misusing an elderly person's money or property

Unfortunately, abusers are not always easy to spot. Adding to the problem, victims may not be physically or mentally able to report their abuse, or they may be isolated and too afraid or ashamed to tell someone.

Red flags:

- Slap marks, most pressure marks, and certain types of burns or blisters (e.g., cigarette burns) should cause suspicion whatever the explanation. Explanations that don't seem to fit with the pattern of **physical injury** are also suspect.
- Withdrawal from normal activities, unexplained change in alertness, or other unusual behavior may signal **emotional abuse or neglect**.
- Bruises around the breasts or genital area and unexplained sexually transmitted diseases can occur from **sexual abuse**.
- Sudden change in finances and accounts, altered wills and trusts, unusual bank withdrawals, checks written as "loans" or "gifts," and loss of property may suggest elder **exploitation**.
- Untreated bedsores, need for medical or dental care, unclean clothing, poor hygiene, overgrown hair and nails, and unusual weight loss are signs of possible **neglect**.

There is no Federal Law protecting the Elderly against abuse. However each state will have laws to this effect. Texas – Adult protective services. (See below)

- www.elderabusecenter.org – to get your local numbers to call.
- 1800 252 54 00, 1800 458 9858. (State of Texas)
- <http://jama.ama-assn.org/cgi/reprint/302/5/588.pdf> (Journal Article)
- <http://www.nlm.nih.gov/medlineplus/elderabuse.html> (Useful information and links)

INCONTINENCE

Urinary incontinence:

DRIPP:

D - Delirium.

R – Restriction (Immobility)

I – Infection, impaction, Inflammation (e.g. vaginitis)

P – Polyuria (Diabetes, caffeine, volume over load)

P- Pharmaceuticals (e.g. Alcohol, Alpha blocker [men], anticholinergics, CCBs, GABA-ergics, opiates)

Types of Persistent urinary incontinence: (Urge, Stress, mixed, overflow, Functional)

Fecal incontinence:

Risk factors:

- Constipation, age (>80), female, urge incontinence, impaired mobility, dementia, neurological disease.

Causes (Usually multi-factorial)

- Overflow (colonic distension from fecal matter)
- Loose feces (Meds, infections, meds)
- Functional or Poor mobility.
- Dementia
- Anorectal incontinence.
- Co morbidities (DM, CVA, cord injuries etc)

FAILURE TO THRIVE

The Institute of Medicine defined failure to thrive late in life as a syndrome manifested by weight loss greater than 5 percent of baseline, decreased appetite, poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol. Its prevalence increases with age.

Adverse outcome is increased in patients with the following states:

- Immobility.
- Depression.
- Cognitive impairment.
- Malnutrition.

Work up should include a complete H&P along with appropriate lab and diagnostic testing.

Medical causes associated with failure to thrive include:

Infections (acute & recurrent,), Cancers, Endocrine problems (DM, Thyroid etc), Depression, Dementia, other poorly controlled psychiatric conditions, CHF/ MI, Renal failure, respiratory failure, liver failure, Immobility secondary to large fractures, strokes, Rheumatologic states
GI states – surgery, malabsorption, loss of vision, iatrogenic (medications) etc.

Treatment:

Directed towards the underlying cause. If the patient is not responsive it is important to get the family prepared for a poor outcome. It's ok to re-evaluate and change treatment strategies if appropriate. Be sure to get services like Hospice & Palliative involved & end of life discussion to happen with family if the patient continues to deteriorate.

Ref: American Family Physician *Volume 70, Number 2* ♦ July 15, 2

GERIATRIC - MATH

Always calculate a patients GFR. (Crockcroft-Gault)

$$Cl(M) = 1.23 \times \text{weight(kg)} \times (140 - \text{age}) / \text{Serum Cr (umol/L)}$$

$$Cl(F) = 1.03 \times \text{Weight} \times (140 - \text{age}) / \text{Serum Cr.}$$

Corrected Ca⁺⁺ (Albumin)

$$\text{Corrected Ca} = \text{Ca (mg/dl)} + 0.8 \times (4 - \text{alb (g/dL)})$$

Corrected Na⁺ (Glucose)

$$\text{Corrected Na} = \text{Na} + \text{glucose(mmol/L)} - 5/3.5$$

Corrected QTc

$$\text{Corrected QTc} = \text{QT} / \text{Sq root of (RR)}$$

$$1 \text{ box} = 0.04 \text{ (sec) at } 25 \text{ mm/sec}$$

$$\text{QTc} > 0.44 = \text{Long QT syndrome.}$$

BEERS MEDICATION CRITERIA LIST

Elderly patients are at risk for significant adverse events from medication prescription.

The Beers list, sometimes referred to as the Beers criteria was first released in 1991, since then, it has been updated twice with the latest revision released in 2003. The list has been broadened to encompass potentially inappropriate medications for the senior population regardless of where they reside or receive care.

The list has been divided into two primary groups:

- 1. Medications considered potentially inappropriate independent of diseases/conditions.
- 2. Medications considered potentially inappropriate when used in seniors with certain diseases or conditions.

The Beers list has proved to have far-reaching applications and has been used by health care professionals, regulators, and researchers internationally. For example, much of the 1997 version of the Beers list was incorporated into the Centers for Medicare & Medicaid Services' Interpretive Guidelines for Long-Term Care Facilities to evaluate a nursing home's compliance with medication-related regulations.

Adverse drug effects may go unrecognized in the elderly because they are nonspecific (e.g., confusion, lethargy, falls). Many of the drugs on the Beers list are included because of sedative and anticholinergic adverse effects. CNS depressants can cause sedation and cognitive impairment in the elderly, resulting in difficulty with self-care and falls. Anticholinergics (e.g., diphenhydramine, amitriptyline) cause cognitive problems by adding to the age-related decrease in cholinergic transmission. Anticholinergics can also cause constipation and urinary retention.

The list is not a substitute for clinical judgment.

Some on line sites to see the list:

- <http://archinte.ama-assn.org/cgi/reprint/163/22/2716.pdf>
- <http://www.medscape.com/viewarticle/496383>
- <http://www.tahsa.org/files/DDF/medbeer1.pdf>
- <http://archinte.ama-assn.org/cgi/content/full/163/22/2716> (2008 update)

ADVANCE CARE PLANNING/ADVANCE DIRECTIVES

- It's a good idea to review these at least once a year with your patient and DOCUMENT the discussion.
- These should be reviewed at every hospitalization.
- Review directives in the event of any significant medical development.
- Encourage patients to discuss their views and decisions with their family and significant others.
- Topics you should discuss
 1. DNR (Code status) – you can also use a term like Allow Natural Death.
 2. Durable power of attorney for healthcare.
 3. Artificial nutrition issues near End-of-life(EOL) (NGT, PEG, IV, or not)
 4. Dialysis.
 5. Organ donation (if eligible).
 6. Antibiotics near EOL.
 7. Routine bloodwork.
 8. Cont'd use of chronic disease medications (statins, bisphosphonates, tight diabetic control, warfarin etc)
 9. Any cultural nuances/interfamily politics near EOL.
 10. Assess pt/family awareness of Hospice and Palliative care.
 10. Senior living settings (home, apt, assisted living, nursing home)
 11. Estate planning/wills/financial issues.

BREAKING BAD NEWS

S.P.I.K.E.S. protocol

Setting, listening **S**kills

Private setting with person of support present, use active listening skills.

Patient's **P**erception

What does the patient know or understand about his condition?

Invide patient to share **I**nformation

Who needs to be present to share in the news to be given?

Knowledge transmission

Give the news avoiding overly medical or vague terms or euphemisms.

Avoid "there's nothing else we can do" or "failed medical therapy".

Explore **E**motions and **E**mpathize

"I know this must be difficult for you, can you tell me how you are feeling right now?"

Summarize & **S**trategize

Ask patient to repeat back what you have told him. Summarize key points and forecast what steps/options may be ahead for the patient.

Adapted from: Buckman, R., M.D., *Breaking Bad News: A Six-Step Protocol. How to Break Bad News: A guide for Health Care Professionals*. Johns Hopkins, 1992.

Determining competency / capacity for treatment:

Competent patients have the right to refuse treatment. Treating them against their wishes can be considered as assault.

If a patient's competency or capacity for adequate understanding is in doubt – it is ok to get a Psychiatric opinion.

Competency or incompetency is more of a legal term. Clinically this is often cited as capacity.

Mnemonic for Evaluating Competency/Capacity: **COMP**

- **C – Consistence** - *Consistent on serial mental tests i.e. MMSE, consistent decision on serial questioning and consistent with life values.*
- **O- Other alternatives to therapy.** – Understands other care alternatives, which also requires an ability to understand factual material and manipulate information rationally.
- **M- Malleable** – Physicians must remain malleable: Patients and their families change their minds about end-of-life decisions in different settings and decisions should be reviewed with a change in situation/setting.
- **P- Particulars** – Patients must be able to appreciate the nature of the particular situation. The physician must be particular about what the patient is competent to do, e.g. – can decide health care but not run a house hold.

Additional information/ recommended reading:

- Nursing home Medicine 1996;4(8):49A – Competency profile.
- N Engl J Med 2007;357:1834-40: Assessment of Patients’ Competence to Consent to Treatment

Eligibility for Hospice

Services can be requested by patients, their families or health care providers. However most will require a physician certification indicative of a prognosis of less than 6 month life expectancy (esp. for Medicare and Medicaid). Conditions that would typically be suited for Hospice in their advanced states:

| | |
|---|--|
| Cancer: Typically advanced stage | End Stage Lung: Disabling Dyspnea at rest, poor med response. |
| Dementia: Advanced stage | End stage Renal: Not seeking dialysis |
| Failure to thrive: BMI less than 22 | End stage liver – Ascities, coag issues, encephalopathy |
| End stage Heart: NYHA 3 or 4, not candidate for stents or by-pass. | End Stage Neuro: ALS, MS, CVA, poor functional status, advanced dementia, complicated CNS infections. |

Criteria for Home Visits/House call

Per Medicare regulations, a person must be homebound and meet medical necessity to qualify for a home visit.

Homebound: if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated or that leaving home requires a considerable and taxing effort by the individual.

Medical Necessity: <http://www.aahcp.affiniscape.com/displaycommon.cfm?an=1&subarticlenbr=50>

Preventative services covered by Medicare

www.medicare.gov

(please visit the web site for details on each of the services)

Abdominal Aortic Aneurysm One time screen- FHx or Male over 65-70 smoked 100 cigarettes in a life time)

Bone Mass Measurement – Q 2 years – (FHx or at risk, steroid use, vertebral #, hyperparathyroid, osteoporosis Tx)

Cardiovascular Screenings – Q 5 years (Lipid panel)

Colon Cancer Screening (Colorectal) – FOBT – Q12months. Flex Sig – Q 24 months, Colonoscopy Q 120 months, BE – Q 24 – 48 months.

Diabetes Screenings :- Q6 months if risks. (HTN, Lipids, high glucose, obesity)

Diabetes Self-Management Training: Referral.

EKG Screening: One-time at initial visit.

Flu Shots: Annual

Glaucoma Tests – Annual.

Hepatitis B Shots – Covered based on risk.

HIV Screening:- Any time any age.

Mammogram: Annual - 40 and older. One time 35-39 yrs.

Medical Nutrition Therapy Services: By referral with risks

Pap Test and Pelvic Exam: Q 2 years or Q 1 year – high risk.

Physical Exam : Annual

Pneumococcal Shot; once or twice lifetime.

Prostate Cancer Screenings: DRE + PSA annual over 50 yrs.

Smoking Cessation (counseling to stop smoking)

References and online sites.

- www.aafp.org
- www.americangeriatrics.org
- www.cdc.gov
- <http://www.sheffield.ac.uk/FRAX/>
- http://www.fallssa.com.au/documents/hp/Berg_Balance_Scale.pdf
- www.elderabusecenter.org
- <http://www.alz.org> (Alzheimer's association)
- www.caps4caregivers.org (Children of aging parents)
- www.nia.nih.gov (National Institute on aging)
- www.nadsa.org (National Adult day services association)
- www.ncoa.org (National Council on the aging)
- www.ncea.aoa.gov (National Center on Elder Abuse)
- www.nhpco.org (National Hospice and Palliative Care Organization)
- www.mowaa.org (Meals on Wheels)
- <http://www4.utsouthwestern.edu/library/links/linkUsage.cfm?linkID=6640> (UTSW Geriatric resource page)

Important Telephone numbers: (subject to change)

1. Nursing Homes: Legacy – 214 363-5100, Traymore – 877-572-1852, Bentley – 469-619-0687.
2. On call pager: Geri – 214 759 1355 or IPS on call – 214 745 0553
3. Adult protective services. 1-800-252-5400 or <https://www.txabusehotline.org>
4. Toxicology line / poison control: 1-800-222-1222
5. City of Dallas Social Services: 311
6. Parkland Social work (Clinic):- 214 266-0339
7. Residency Clinic: **Charge Nurse** – 214 266 0315 or 6 0336 **main line** (patients) – 214 266 0312.
8. Residency Clinic : Preceptor – 214 648 1411 , Front Desk – 214 266 0336.