Interprofessional Health Professions Course Resources

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TeamSTEPPS™ Team Performance Observation Tool Survey

Original survey used the coding system below:

1 = Very Poor
2 = Poor
3 = Acceptable
4 = Good
5 = Excellent

Team Structure

a. Assembles a team – was not used, as students did not pick their teams.
b. Establishes a leader – changed to "Our team worked cohesively."
c. Identifies team goal and vision
d. Assigns roles and responsibilities
e. Holds team members accountable
f. Actively shares information among team members

Comments on response to team structure questions.

Leadership

a. Utilizes resources efficiently to maximize team performance
b. Balances workload within the team – was not used.
c. Delegates tasks or assignments, as appropriate
d. Conducts briefs, huddles, and debriefs – was not used, as students had assigned meeting times.
e. Empowers team members to speak freely and ask questions

Comments on response to leadership questions.

Situation Monitoring

a. Includes patient/family in communication
b. Cross monitors fellow team members
c. Applies the STEP process when monitoring the situation – was not used.
d. Fosters communication to ensure team members have a shared mental model

Comments on response to situation monitoring questions.

Mutual Support

a. Provides task-related support
b. Provides timely and constructive feedback to team members
c. Effectively advocates for patient – was not used.
d. Uses the Two-Challenge rule, CUS, and DESC script to resolve conflict – was not used.
e. Collaborates with team members

Comments on response to mutual support questions.

Communication

a. Coaching feedback routinely provided to team members, when appropriate – was not used.
b. Provides brief, clear, specific and timely information to team members
c. Seeks information from all available sources
d. Verifies information that is communicated
e. Uses SBAR, call-outs, check-backs and handoff techniques to communicate effectively with team members – was not used

Comments on response to communication questions.

Items used from TeamSTEPPS™ Team Performance Observation Tool (TPOT) with original subscales.

Subscale	α	Item
Team structure	.81	We decided on roles and responsibilities.
		Our team worked cohesively.
		We identified team goals and vision.
		We held each other accountable.
		We actively shared information with each other.
Leadership	.67	The team delegated tasks or assignments appropriately.
		Team utilized resources to efficiently maximize team performance.
		Our team empowered members to speak freely and ask questions.
Situation monitoring	.71	The team monitored each other in order to reduce or avoid errors.
		Team included patient/family in communication.
		Team fostered communication to ensure team members had a shared understanding of assessment outcomes and client needs or goals.
Mutual support	.70	The team provided timely and constructive feedback to each other.
		Team kept the patient's well-being as focus of their work.
		Team collaborated with each other.
Communication	.58	The team provided brief, clear, specific and timely information to each other.
		Team sought information from all available sources.
		Team verified information that was communicated by the patient, caregiver, and other team members.

Rated on Likert scale from 1 (strongly disagree) to 5 (strongly agree), with 0 being, “I do not understand the prompt.”

Items used from TeamSTEPPS™ Team Performance Observation Tool (TPOT) with adjusted subscales.

Subscale	α	Item
Knowledge sharing	.86	We actively shared information with each other. Our team empowered members to speak freely and ask questions. Team verified information that was communicated by the patient, caregiver, and other team members. Team kept the patient's well-being as focus of their work.
Communication	.81	The team provided brief, clear, specific and timely information to each other. Team included patient/family in communication. The team monitored each other in order to reduce or avoid errors. The team provided timely and constructive feedback to each other. Team sought information from all available sources. Team fostered communication to ensure team members had a shared understanding of assessment outcomes and client needs or goals.
Team roles	.76	The team delegated tasks or assignments appropriately. We decided on roles and responsibilities. Our team worked cohesively. Team collaborated with each other.
Goal setting	.79	We identified team goals and vision. We held each other accountable. Team utilized resources to efficiently maximize team performance.

Rated on Likert scale from 1 (strongly disagree) to 5 (strongly agree), with 0 being, "I do not understand the prompt."

Student Case Study, Part 1

Case Part I: Introduction

Mrs. Rosa Rivera is a 66 year old widowed female who was born in Okarche, OK. After her marriage to Diego Rivera at age 17, she moved to a small, Midwestern town. She has lived ever since on a small soybean farm. Her husband worked at the local grain mill until his unexpected death from a heart attack in 2011 at the age of 61. Mrs. Rivera was a homemaker who raised three daughters. She knew almost everyone in town, attended church services daily, and was widely regarded as the best cook at the local church suppers. She is less active in the community than previously because many of her friends have died or moved away to live closer to family members. As the town's population shrinks, there are fewer social activities or other resources available. The local priest visits Mrs. Rivera each month and she had always expressed enjoyment of his visits. Last month, Mrs. Rivera was alone when he arrived for his usual visit and she would not open the door. She became anxious and told him to go away because she did not talk with strangers. Later, Fr. Joe contacted Luz to explain that her mother did not seem to recognize him so he did not persist in case it alarmed her further. During family or other social events, she still dresses appropriately for the occasion, displays appropriate animation, and participates coherently in conversations although friends notice that she has difficulty remembering names and mild problems with word retrieval or with accurate chronology of her stories. Those who know her well admit that her attention to her appearance has declined, although still meeting social standards. She no longer applies make-up or spends time doing her hair as she did in the past when she went into town or when company comes to her home. On at least 3 occasions, she forgot to turn off the stove for over 8 hours and twice set off the smoke detectors. When the volunteer fire department arrived, she acted so distraught and overwhelmed by the smoke and noise that they debated bringing her into the ED for examination. Instead, a daughter came to spend the night because Luz was not available. Mrs. Rivera cannot remember her daughters' phone numbers and constantly misplaces her IPhone in the house. She is increasingly inconsistent with taking her medications and becomes evasive when questioned. These memory lapses cause concern among her daughters. She consistently remembers to feed "Rover", her beloved dog

Mrs. Rivera's youngest daughter, Luz, still lives with Mrs. Rivera. Luz is 43, unmarried with no children, and assumes most of the caretaking and household management responsibilities. Luz works from 7:45AM-4:00PM on a nine month contract as a kindergarten teacher at a local private school. Prior to 2014, Luz worked a second job in the summers for financial reasons but finds it difficult to do so now that Mrs. Rivera requires more supervision. She supplements her income with some private tutoring at students' homes but it is time consuming and only brings in a third of her usual summer earnings. Financially, Luz can live comfortably on her salary but only because she has no housing expenses. Luz's smoking has recently increased to ½ pack per day (ppd) due to stress over her increased caregiver burden. As

a result, several parents have cancelled their tutoring arrangements due to concerns about second hand smoke exposure to their students from the smoke trapped in Luz's hair and clothing. Although Luz knows it is dangerous, smoking helps to curb her appetite and she is reluctant to quit. If asked, she only admits to smoking 4-5 cigarettes per week.

Mrs. Rivera's remaining two daughters are married. Both live in the city with 4 pre-teen/teenaged children between them. Their spouses have made it clear that they do not want their mother in law to live with them full time but do not object to her daughters spending time/money to care for her. The daughters visit their mother monthly and during these visits, their children and husbands take care of light yard work and minor repairs. They have offered to cook meals to freeze for later use but Luz takes offense at their efforts to, in her words, "…sweep in like self-important queens and imply that I cannot take care of Mom. I am here all the time and I know what she needs. They have made it pretty clear that they don't want to have Mom in their own homes and underfoot every day." Luz has her own health issues with a BMI of 32, shortness of breath during exertion, and chronic low level (3 on 10 scale) non-specific non-neurological back pain and calf cramping during ambulation that is partially relieved by sitting or leaning forward. Her physician warned her 4 years ago that she is considered pre-diabetic so Luz has unsuccessfully tried many diets since then. Mrs. Rivera always drove competently but in the past five years, she has begun to get lost even in her familiar town environment. She stopped driving after dark when her husband died due to early cataract formation in the R eye. Despite successful cataract surgery in late 2011, in the past two years she has also gradually decreased her daytime driving too. She relies on her children and others to assist with transportation to the grocery store, the doctor's office and to church. Mrs. Rivera lost 15 pounds after her husband's death, declining from 125 to 110 pounds on her 5'5" medium frame (BMI 18.3). Her daughters initially dismissed the weight loss as a short term grief response since their mom consistently claimed that she felt fine and just was not hungry. Lately, they have commented to each other that she never gained the weight back and never returned to her previous pattern of eating three meals each day. Mrs. Rivera often ignores mealtimes and even if Luz cooks, she sometimes forgets to eat the food placed in front of her unless reminded. She retains a strong preference for sweets but Luz is trying to lose weight and refuses to purchase anything she views as fattening. Mrs. Rivera seems to have little interest in the veggies and low fat products that Luz buys for their consumption. Although her family speaks Spanish in the home, Mrs. Rivera's English is perfect although slightly accented. The grandchildren, who barely speak Spanish, have told their parents that when upset or tired, grandma will switch into Spanish to find words without seeming to realize that they can't really understand her.

In 2014, Mrs. Rivera's long-time family practitioner decided to retire. He called Luz and recommended a referral to a neurologist for her mom. The doctor does not think there is a problem but feels that there have been enough small changes to warrant an examination by a specialist to set everyone's mind at ease. relationship with another doctor. Initially, the sisters did not see a need for this examination and Luz felt uncertain since on some days, her mother seemed like her old self again. The triggering event for Luz came after a morning where she watched her mom first become increasingly confused about where her clothes were kept in the house and then progressed to angry outbursts where she repeatedly yelled at Luz to get dressed because they were late for a party that had occurred 10 years earlier. An hour later, it was as if the event had not happened because her mother seemed calm and did not refer to it again. Luz

thought that perhaps an underlying illness was exacerbating the normal age-related forgetfulness and wanted her mom to get medication to stop it. The neurologist examined Mrs. Rivera and diagnosed her to have Alzheimer's disease on the basis of her memory loss and functional changes. She received prescriptions for Aricept 10 mg daily and Namenda 10 mg BID. The neurologist plans to follow up with her quarterly to assess changes. The neurologist mentioned that Mrs. Rivera needs to gain at least 10 pounds and recommends that she should be allowed to eat favorite foods whenever she is hungry. Luz was advised to supplement with slightly sweetened Ensure drinks on those days when her mother refused food. The neurologist recommended that Mrs. Rivera take a multivitamin with calcium too.

The diagnosis was a shock to the family, especially Luz. She had expected the doctor to recommend some medication that would improve energy and return her mother to her previous level of independence. Luz did not express it verbally but mentally she refused to accept what he told her about the progressive nature of the disease and the inevitable caregiver burden that would accompany it. Mrs. Rivera listened with apparent interest but said little. After returning home, Luz texted her sisters but provided scanty information in a dismissive manner, claiming he "overreacted to a few problems." After calling the neurologist themselves, the other daughters sadly accepted the findings and the likely prognosis. Since they saw their mom less frequently, they noticed had obvious changes over the past year but Luz did not want to hear their input so they stopped mentioning it. There have been 2 follow up visits since the initial diagnosis and Luz feels increasingly unsatisfied with his services. She constantly complains that his visits are rushed and that he exaggerates about Mrs. Rivera's level of decline. Luz repeatedly states that Mrs. Rivera received treatment from the same family practitioner for 22 years and he never felt any concern about mental status changes until the last few months before he retired. To Luz, that is proof that her mother is showing signs of mental symptoms probably related to an acute illness rather than cognitive changes of Alzheimer's disease that have been progressing over time. Luz plans to switch to another neurologist in their HMO as soon as she finds one who is accepting new patients. She has not told her mother of this plan. Mrs. Rivera rarely argues with Luz and typically follows her suggestions so Luz is certain that she knows what is best in this situation..

Other than her newly established relationship with the neurologist, Mrs. Rivera does not receive much medical oversight. The now retired family practitioner had handled all of her health issues for several decades. After his retirement, the HMO offered her a choice between having a male gynecologist and a male family medicine physician as her new PCP or she could choose to use just the male family medicine physician as her new PCP. No female physicians associated with her insurance were currently accepting new patients. She requested both the male gynecologist (who speaks fluent Spanish) and the family practice physician due to Luz's insistence. Although the family practitioner can offer all gyn/women's health care services, in Luz's mind, the family practice physician is not a specialist and care is always better with a specialist. Mrs. Rivera does not argue. For the past 10 years, Mrs. Rivera was offered the pneumovax and the influenza shots during her visits,, she consistently refused. Luz influenced her decision based on internet sources that report dangerous side effects from these immunizations. Three months ago, at the first visit with the new family medicine physician, she refused again. Last month's first visit to the new gynecologist did not go well. He seemed very competent but brusque and rushed in his interactions. He clearly wanted Mrs. Rivera to present a focused and clear recitation of her symptoms and needs to maximize use of the office visit.

Since Mrs. Rivera found it difficult to perform at level of organization, and due her embarrassment about discussing personal issues with a man, she shut down even more and did not ask any questions. Luz liked the family practice physician but did not care for the gynecologist. Luz is reluctant to have the family practice physician provide all services because of her bias against his credentials and because the bilingual gynecologist could understand her mother when she unintentionally lapsed into Spanish. Luz did suggest that her mother switch to the nurse practitioner who is assigned to the same gynecological practice, but her mother refuses to seek care from anyone but a real doctor.

Mrs. Rivera's medication list grows longer each year, but she feels confident that she can still independently manage it. Luz, fearing that her mother will make a mistake, has recently taken charge of maintaining and distributing her mother's meds. These medications include (*for sake of case continuity, important but previously taken meds as well as present and future meds prescribed later in the case, are listed*):

Prescribed by neurologist: *(Continued during hospitalization)*

- Aricept (pre-existing medication; discussed in part I)
- Namenda (pre-existing medication; discussed in part I)
- Generic multivitamin with calcium and vitamin D (pre-existing medication; 1x daily)

Prescribed by gynecologist: *(not taken during hospitalization for reasons outlined below*)

- HRT-estrogen only (long standing medication that was DC'd in 2010; discussed in Case part II)
- Estrace vaginal cream (not prescribed until later; discussed in Case part II)

Self-prescribed: *(not taken during hospitalization but also not discussed with nurse during hospitalization intake interview)*

- St. John's Wort to manage fatigue and insomnia x 6 years

http://www.nlm.nih.gov/medlineplus/druginfo/natural/329.html

**She also drinks 4-5 cups of pennyroyal tea every day for her digestion but does not view that as a medicine. She has never mentioned it to anyone because it seems like a benign habit similar to chewing gum or sucking on peppermints. By now, her family is so used to her 'drinking her tea' that they never consider whether it could have any impact on her health.

http://www.drugs.com/npc/pennyroyal.html

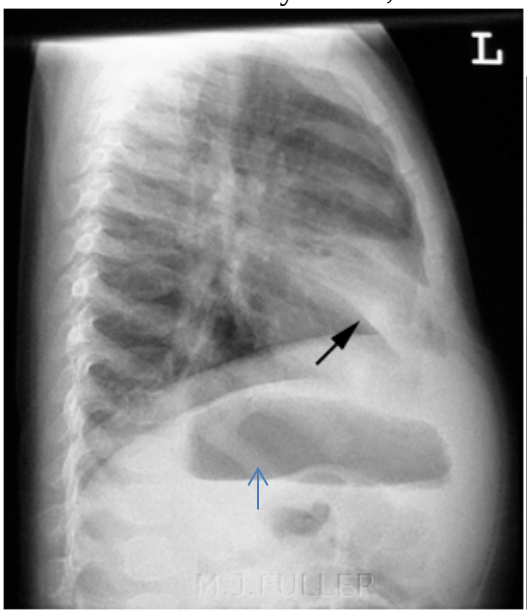
Luz believes that if her mother would just concentrate and take some energy supplements, then she could function fairly independently again. She encourages her mom to take St. John's wort because the patient's comments found on WebMD highly recommended it. She chafes at her ongoing role as caregiver and wonders aloud to her sisters if these 'symptoms are due to laziness and desire to be babied (as her husband did) rather than due to Alzheimer's disease. Privately, the other daughters feel that Luz does not realize how much she controls their mother's life and activities so that it appears she is still functioning well. They think that it will upset their mother to switch to a new neurologist when she has just become accustomed to the present one and wholeheartedly believe that the present neurologist's observations are sad but accurate. They would like to stop Luz's focus on 'fixing' their mother and move onto realistic planning for the future. Their husbands have advised them to avoid arguing since Luz is stubborn and seems to resent their interference. They point out that things with Mrs. Rivera will inevitably worsen over time and Luz will eventually realize the truth.

Two weeks ago:

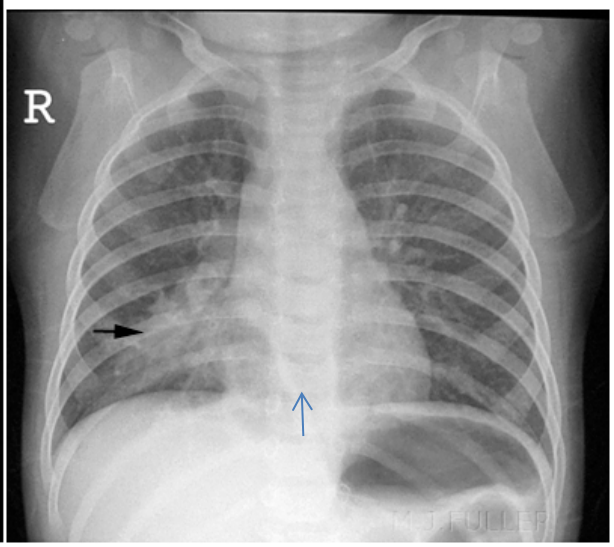
Luz woke at midnight to hear her mother coughing so hard that she struggled for each breath. Although for weeks Luz had felt concerned that her mother's harsh, productive cough had steadily worsened, Mrs. Rivera refused any treatment other than herbal pennyroyal tea. http://www.webmd.com/vitamins-supplements/ingredientmono-480-PENNYROYAL.aspx?activeIngredientId=480&activeIngredientName=PENNYROYAL

She believed that the tea is a good solution for any ailment and regularly drinks 4-5 cups daily. Along with her mother's difficulty with respiration, Luz discovers that her mother has a fever of 102 degree F (38.88 degree C). Luz was alarmed enough to call an ambulance to drive her mother the 50 miles to the nearest outpatient medical center.

Mrs. Rivera was admitted to OU Medical Center with a diagnosis of bacterial pneumonia that developed as a result of an untreated flu virus complicated by comorbidities of anorexia and mental changes (dementia). As mentioned earlier, Mrs. Rivera did not receive a flu shot this year and has never had a pneumovax. At time of admission, chest x-ray (PA and lateral views) showed right middle lobe (RML) consolidation from acute pneumonia complicated by malnutrition with dehydration, confusion and fever.



Lateral view of RML consolidation



AP view of RML consolidation

Her LOS as IP at OU Medical Center lasted for 8 days. Luz slept in the room each night and the other daughters visited daily. Sometimes, there were as many as 6 visitors in her room at once and nursing notes documented that the patient seemed exhausted and overwhelmed at times. The night shift nurses reported that Mrs. Rivera seemed to have difficulty sleeping on most nights.

The hospital stay:

Due to her dusky skin color, difficulty breathing, and lung consolidation, the ER physician admitted her to the Internal Medicine service where she was cared for by a hospitalist. FACULTY SHOULD RAISE DISCUSSION POINT HERE: The pneumonia was treated with IV Zithromycin for 8 days in the hospital as well as nebulized Albuterol q 4 hours, Mucinex 600

mg BID. During meal rounds, the bedside nurse noticed that Mrs. Rivera choked easily on her food.

Mrs. Rivera slept most of the day but routinely became upset at the end of each afternoon, sometimes loudly claiming that 'strangers' were coming into her room to smother her. She refused to eat some meals, claiming that the food was poisoned. Once she reached a certain level of agitation, her daughters could not calm her and she became a disruption to the staff and patients. In addition, they feared her flailing limbs might result in self-injury so the physician ordered Valium (diazepam x 5mg prn). Restraints were discussed as a possibility but the family disliked that suggestion. Nursing reported that the Valium seemed to calm Mrs. Rivera enough to make her manageable although she ate very little while receiving it due to lethargy. FACULTY SHOULD RAISE DISCUSSION POINT HERE: During the 5th IP day, when Mrs. Rivera seemed more coherent than usual, she casually mentioned to Luz that her "…bleeding down there seems much less than usual now that I am in the hospital." Luz, even with further questioning, could not figure out if the alleged bleeding came from the rectum or vagina. Details about quantity, severity of problem, any associated pain, etc, were met with head shakes and silence. Mrs. Rivera finally refused to discuss the topic saying that, "When it happens, I wipe it away because I don't want anyone to know. It is too embarrassing and these things just happen with old women." Mrs. Rivera forbade Luz from mentioning this problem to the nurses. Luz agrees, reassuring herself mentally that the bleeding must be her mom's imagination because surely someone would have noticed bleeding during the hospital intake process and already addressed it. FACULTY SHOULD RAISE DISCUSSION POINT HERE:

During the stay, her symptoms responded well to rest, medication, and hydration. She was discharged on IP day 8. She was advised to follow up with her primary care family medicine physician in 5-7 days. She will be discharged with orders to take Zithromycin 250 mg tab PO daily for 2 more days to complete a 10 day course of antibiotics. She will also take Mucinex 600 mg BID for 2 more days. Mrs. Rivera was discharged on home oxygen 2L continuous per nasal cannula for one week. Mrs. Rivera was given a referral for 4 weeks of home health OT and PT services. There is one home health agency in her town and they promised to send out a nurse case manager and possibly both types of therapists within the week. Mrs. Rivera does not believe that she needs therapy and is very anxious about the thought of strangers coming into her home. She frets to Luz but feels too much respect for her male physician to argue with the discharge plan. Luz fully expects her mom to refuse therapy beyond the first session but plans to enlist her sisters to persuade their mother to participate. Luz plans to be present for the first visit but that is all. Despite what the social worker said about the value of Luz learning strategies to improve her mother's functional level, Luz is already planning how she can use this windfall of unexpected 'free time' during the 2x weekly therapy sessions to perform errands without her mother. Perhaps, there will even be time to slip away to the local casino for an hour without anyone knowing where she is. It will be a relief to get a break and online gaming gets dull after a while.

Student Case Study, Part 2

Mrs. Rivera Case: Part II

ATTENTION: All Rehab Sciences Students must read the Kortebein article. PT students must read the Singh article, which reviews concepts from Exercise Science I and II courses, and also read the geriatric exercise protocol. OT students must read the Thinnes article. Complete readings PRIOR to meeting.

Home Interview by therapists from HHA after hospitalization ends:
The initial home health referral: *PT and OT: 12 visits authorized; Evaluate and treat patient for deconditioning related to recent hospitalization, functional limitations, and cognitive decline.*

Information sources: Hospital discharge summary from nursing (not seen by PT or OT while hospitalized).

Most information was provided over the phone prior to the 1st home visit by the adult (caretaker) daughter Luz Rivera. During the first three minutes of the interview, Luz answered immediately regardless of where the question was directed. The mother seemed comfortable with this arrangement although she would answer a question herself if addressed directly by name or if Luz gave an incomplete answer. Mrs. Rivera's answers tended to be brief with some conflicting information provided, compared to her daughter's answers. She tends to look toward Luz before offering any information as if to see if she objected to her mother speaking up. The therapist quickly asked Luz to just observe and allow her mother to answer. Both women remained in the room and interacted with the interviewing provider until Luz unexpectedly left near the end.

Summary of course of hospitalization: Mrs. Rivera is an aging woman who has recently been diagnosed with Alzheimer's disease due to progressive changes in her cognitive status. Other than quarterly follow up with her neurologist and a yearly follow up with her gynecologist, Mrs. Rivera had little contact with medical providers. Due to concerns (unfounded, according to Luz) that she has barely enough money to survive, Mrs. Rivera refuses to obtain a flu shot or pneumovax." Luz commented that she herself rarely obtains much preventative care and she was pretty healthy overall. She did not think it was a big deal and sourly noted that health providers tried to sell all sorts of unnecessary services to old people so they could make money. In late fall 2015, Mrs. Rivera was exposed to the flu virus which, combined with her age/malnourished status, progressed into a serious condition that required hospitalization. She was discharged after 8 days for home services and case management. Patient has completed the 10 day course of Zithromycin as well as Mucinex.

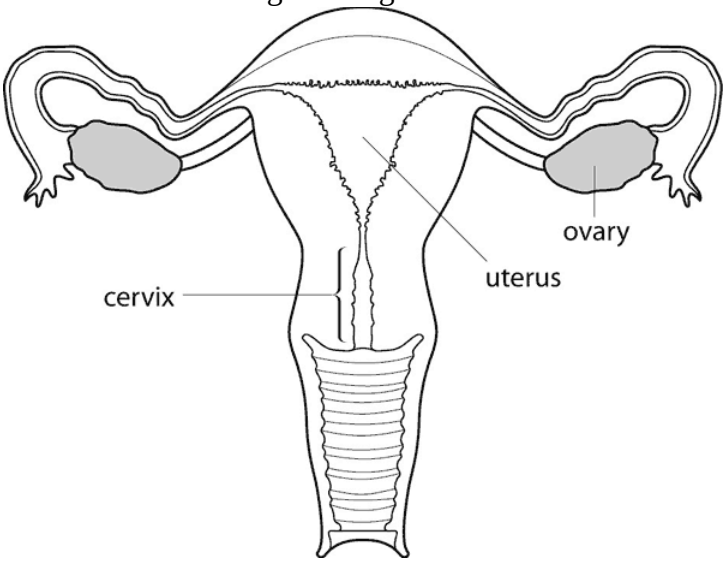
Communication: Patient speaks softly with slight accent. Her English is understandable but she often chooses to speak Spanish when communicating with her daughter during the interview. Two or three times, the mother accidentally answered the provider in Spanish too. She did not seem to notice this error until Luz corrected her and provided the mother's response in English for the provider. Whisper test for hearing was normal when tested at time of hospitalization. Interviewer noted mild problems with retrieving common words which appears frustrating and embarrassing for Mrs. Rivera. Luz's response to these errors was to sigh impatiently. When

stressed, Mrs. Rivera asks for Rover which Luz explained is her dog. The dog is outside because Luz does not like shedding in the house.

Appearance: The patient is an elderly woman who appears slightly disheveled (shirt is buttoned incorrectly, lipstick is freshly applied but smeared, and hair tangles are not completely combed out), tired, older than stated age, and noticeably underweight. Her complexion is sallow underneath her tanned skin.

Cardiorespiratory: vital signs include blood pressure 133/84, pulse rate 80/minute and regular, respiratory rate averages 12/minute and quiet,, digital ear thermometer temperature 98.2.F. She coughs occasionally but the cough is dry. She has been afebrile since discharge from OU Medical Center and she denies any shortness of breath, wheezing, or orthopnea. Luz confirms these statements.
Both lungs are clear to auscultation bilaterally without wheezes or rales. The lungs are resonant by percussion. The heart is RRR (regular rate and rhythm) without murmur. At discharge, Mrs. Rivera received a repeat chest X-ray which showed no infiltrate and the pneumonia has cleared.

Genitourinary: Mrs. Rivera is post-menopausal (late 50's when menopause started) and had a total abdominal hysterectomy (TAH) to remove uterus and ovaries in 2006 because of uncontrolled bleeding and large fibroids.



She received estrogen-only HRT for 4 years to treat symptoms of hot flashes, insomnia, emotionally labile affect, chronic irritability, and forgetfulness **(STUDENTS: In discussion, ask faculty for more info here.) Her (retired) family practice physician discontinued the HRT in 2010 due to her family's concerns about side effects. For the last 6 years, Mrs. Rivera no longer experiences the symptoms of hot flashes but the emotional changes and fatigue seem worse than ever. She also has (according to Luz) experienced an increasing frequency of urinary tract infections (UTI) since being diagnosed with post-menopausal painful vaginal atrophy. During Mrs. Rivera's most recent office visit, the gynecologist offered to prescribe topical estrogen creams to relieve the intense discomfort from tissue friability/sporadic bleeding but Mrs. Rivera refuses. (After the visit ended, Luz left her mother in the waiting room and returned to the

physician to obtain the prescription for Estrace topical vaginal cream. The prescription is filled and she hopes her mother might decide to use it later.) Her daughter reported that her mother felt embarrassed to be asked about the situation at the yearly visit and responded to questioning in monosyllabic answers; much to the physician's obvious frustration. Neither mother nor daughter has called the gynecologist to discuss changes in the (patient described) "bleeding down there" which have worsened during the 6 months since the last women's health visit. . Luz has never noticed any bloodstains on her mother's laundry but knows that her mother often wears a sanitary pad and sometimes handles the laundry herself. Luz is not too concerned and states, "At her age, it is probably just one more sign that her body is slowing down. After all, she has a scheduled follow up in 6 months and if there is a real problem, he will deal with it then. This is how it is when women get old."

Luz tells the provider that her mother often waddles when she walks as if she feels intense discomfort during any adduction, and that she avoids sitting on a chair unless it is cushioned. Although reluctant to say much, Mrs. Rivera has told Luz that sometimes urination is so painful that she often tries to hold her urine rather than experience the discomfort. When asked by the therapist, Mrs. Rivera will only say that she has not had any episodes of incontinence and does not feel she must rush to the toilet. Luz then interjects that she limits her mother's fluids to 30 oz daily. Mrs. Rivera notices the startled look on the therapist's face and quickly stated, "I always drink as soon as I feel thirsty." **(STUDENTS: In discussion, ask faculty for more info here.) Luz tells providers that she reminds her mother to use the toilet every 90 minutes and also sets her alarm to get her mother up at 2AM for a mandatory bathroom visit. Although her mother indicates that it often hurts to urinate, she cooperates. When asked if this rigid routine was necessary to avoid incontinence, Luz replied, "It works for me. I'd rather make sure there won't be a problem than wait and end up dealing with a mess of wet clothes ad sheets. When Mama complains about the peeing pain too much, I figure that she must have a UTI and so I call the doctor (gynecologist) and he phones in a prescription for an antibiotic if she needs one. She usually takes Cipro 250 BID but since he always prescribes way more than she needs to take, I usually have some antibiotics left over for next time. That way, I don't have to bother the doctor every time she gets a UTI." Mrs. Rivera said nothing during the entire discussion about genitourinary matters and only looked down at her lap with a slightly reddened face. Meds include a daily multivitamin and Fosamax (bisphosphonates)70 mg once monthly for mild osteopenia x 3 years. She tolerates all medications well. Neither woman says anything about the frequency with which Mrs. Rivera actually takes these medications but Luz, accompanied by exasperated sighs, states that she sometimes sees her mother spit out and hide doses but, "What can you do?"

Circulatory: Mild pitting edema in both lower extremities in ankle/feet. Feet are cool to touch with mild trophic changes in toenails. Patient usually wears nylon socks and slide on backless slippers because she finds it difficult to tie shoes sometimes and it is easier for Luz to get these shoes onto her feet.

Laboratory values: (as reported in the electronic medical record (EMR) at time of DC from OU Medical Center http://www.globalrph.com/labs.htm

- WBC: 12,000 cells/mcL; (normal 4,500-10,000)
- lipid panel: total cholesterol 220 mg/dL, (normal <200)

HDL 30 mg/dL (normal> 35)
LDL 195 mg/dL (normal 65-180)
TRIGLYCERIDES175 mg/dL (normal 45-155)

- O2 Sat % 89% (normal 90-95%)
- WBC: Repeated prior to discharge with 8,500 cells/mcL (normal 4,300 to 10,800 cells/mcL)
- Creatinine: 1.1mg/dL (normal 0.5 to 1.1 milligrams per deciliter in adult females)
- BUN (blood urea nitrogen): 16 mg/dL (normal 7 to 20 mg/dL)
- Potassium; 3.7 mEq/L (normal 3.5-5.0 mEq/L)
- Sodium: 135 mEq/L (normal 135-145 mEq/L)

**(STUDENTS: In discussion, ask faculty for more info here.)

Musculoskeletal: (see attached MMT/ROM initial examination results.** (STUDENTS: In discussion, ask faculty for more info here.)

Integumentary: Skin appears thin and translucent; no areas of breakdown or redness noted when extremities, trunk, sacrum and ischeal tuberosity areas were visually inspected. Distal calves are hairless without need to shave. No perineal skin breakdown was reported although examination was not performed.

Functional Mobility

Mobility: Patient has a cane that she uses when alone but prefers to hold her daughter's arm on uneven or outdoor surfaces, especially in dim lighting. Sometimes, she stops in the middle of walking and seems upset that she cannot remember where she is going. She uses her arms to rise from a chair or toilet. Her static upright and seated balance is good but she sometimes sways and needs support when transitioning between positions. Other than a widened BOS, limited amount of bilateral arm swing, and occasional (<30% of the time) failure to completely clear L toe on swing, causing toe to catch followed by brief loss of balance control, her gait is slow but unremarkable. According to Mrs. Rivera and Luz, she has never fallen but often has 'near falls' that are stopped by grabbing onto a person, wall, or furniture. Findings of the remainder of physical examination are unremarkable. The patient has been less active in the past 6 months. She used to take daily walks but stopped because she lost her way once and the sheriff's department had to bring her home. This episode frightened Luz so she now discourages unsupervised walks. Due to Luz's obesity and chronic back pain, she does not enjoy walking. As a result, she is unwilling to exercise with her mother so Mrs. Rivera rarely leaves the house for exercise.

Timed up and go test (TUG): results showed 22 seconds to complete but the therapist was uncertain as to whether Mrs. Rivera moved slowly due to mobility issues or if she became confused with the task midway through and slowed her movements. **(STUDENTS: In discussion, ask faculty for more info here.)

Functional Reach Test: She scored 7.2 inches. **(STUDENTS: In discussion, ask faculty for more info here.)

Occupational Performance Assessment

During the OT interview, the Canadian Occupational Performance Measure was used to prioritize and rate performance and satisfaction with occupational performance. Because the Mrs. Rivera and Luz's goals/ratings were slightly different, the occupational therapist documented both.

Goals	Performance	Satisfaction with Performance
Mrs Rivera		
1.Use phone to call daughters	7	7
2.Prepare food using stove when alone	8	8
3.Take medications regularly	7	8
4.Perform morning routine independently	8	8
Luz		
1.Use phone to call daughters and 911 appropriately	2	1
2.Prepare food without stove when alone	2	2
3. Take medications when alone regularly	2	1
4. Perform morning routine independently	5	3

** (STUDENTS: In discussion, ask faculty for more info here.)

Activities of Daily Living

Functional Independence Measure Scale:

Eating: 7
Grooming: 5 (cues to initiate and for thoroughness)
Dressing: 5 (cues to initiate and to check for mistakes)
Toileting: 6 (extra time)
Bathing: 5 (cues to initiate and for thoroughness).
Toilet transfers: 6 (uses grab bar and raised toilet seat)
Bathtub transfers: 5 (supervision using grab bar to sit on plastic garden chair)
**. (STUDENTS: In discussion, ask faculty for more info here.)

Instrumental Activities of Daily Living

Performance Assessment of Self-Care Skills (PASS) administered for goal areas prioritized in COPM.

	Independence	Safety	Adequacy
Phone use	2	3	2
Medication management	2	2	1
Food preparation	2	2	2

Cues were needed to remember directions, sequence steps of task, and safely perform task (use knife correctly, turn off stove after completion) and complete all directions thoroughly.
**.(STUDENTS: In discussion, ask faculty for more info here.)

Cognitive Performance: Mrs. Rivera scored a 21/30 on the Mini-Mental Status Exam. Points missed included orientation to date (day, year, month), attention (cannot spell "world" backwards), and recall of information. Results of the Cognitive Performance Test (CPT) indicate that she scored a 4.6 with cues needed to attend to and persevere with complex tasks such as finding her way in a new location and medication management. She also needed cues to remember task directions.** (STUDENTS: In discussion, ask faculty for more info here.)

Behavioral health: Mrs. Rivera appears withdrawn and uneasy during the evaluation. At times, Mrs. Rivera becomes "short" with the interviewer. Luz apologizes and suggests that when Mrs. Rivera becomes stressed, she becomes more "crabby." When she becomes angry, she retreats to her room for hours and sleeps. The Geriatric Depression Scale (short form) was administered. She scored a 7/15.
** (STUDENTS: In discussion, ask faculty for more info here.)

Social and Environmental Assessment
Caregiver burden: Luz completed the Caregiver Burden Scale (Zarit et al. 1990). She scored a 22/40. Areas of burden that were identified included feeling a sense of strain, anger, and feeling overtaxed with responsibility.
** (STUDENTS: In discussion, ask faculty for more info here.)

Environmental issues:
Mrs. Rivera lives in a 3 bedroom/2 bathroom, one- story ranch home with 3 steps leading up to the front door. The hand rail was lost in the last wind storm so she holds Luz as she walks up and down the steps. Unsecured throw rugs are present at the doorway, 2 in the kitchen and one in each bathroom. She has a small, beloved, 10 year old dog, named "Rover" that follows her around everywhere she goes. Doorways are 28" wide throughout the home. The floor is free from clutter. The bathroom sink where Mrs. Rivera gets ready contains so many products that it is difficult for Mrs. Rivera to locate what she needs and she no longer uses many of them (see picture below). She has a bathtub/shower combo in her room with a plastic yard chair sitting in the tub (see example of chair below). She has a horizontal grab bar inside the tub wall but nothing near the front. She does not have a hand held shower spray. Her toilet is very low (15") but she has a raised toilet seat with handles. They have wall phone which is located in the kitchen.




Rover, 10 yrs old

Mrs. Rivera Case (Part 2) Appendices:

Timed Up and Go Test:
http://www.rehabmeasures.org/Lists/RehabMeasures/DispForm.aspx?ID=903

- Rise from an armless chair without using hands
- Stand still momentarily
- Walk to a wall 10 feet away
- Turn around without touching the wall
- Walk back to the chair
- Turn around
- Sit down

Individuals with difficulty or who demonstrate unsteadiness performing this test require further assessment.

The Functional Reach Test:
http://www.rehabmeasures.org/PDF%20Library/Functional%20Reach%20Test.pdf

- The patient is instructed to stands close to, but not touching, a wall and position the arm that is closer to the wall at 90 degrees of shoulder flexion with a closed fist
- The assessor records the starting position at the 3rd metacarpal head on the yardstick
- Instruct the patient to "Reach as far as you can forward without taking a step"
- The location of the 3rd metacarpal is recorded
- Scores are determined by assessing the difference between the start and end position is the reach distance, usually measured in inches
- Three trials are done with 15 sec rest break between trials and the average of the last two is noted

Whisper Test:
http://webmedia.unmc.edu/intmed/geriatrics/reynolds/pearlcards/functionaldisability/whisper_test.htm

- The examiner stands at arm's length (~0.6 m) behind the patient (to prevent lip reading)
- The opposite auditory canal is occluded by the patient or examiner to block hearing from that ear.
- The examiner exhales and whispers a combination of numbers and letters (example 4-K-2-B). *Whispering at the end of exhalation is done to ensure as quiet and as standardized voice as possible.*
- If the patient responds correctly, hearing is considered normal and no further screening is necessary on that ear.
- If the patient responds incorrectly, then repeat using a different number-letter combination.
- If on repeated testing, the patient can answer three out of a possible six numbers-letters combination correctly, the patient passes. If they cannot answer three out of six or more, the patient fails in that ear.

Repeat the sequence in the opposite ear using different combinations of numbers and letters. (Note: patients with memory problems may need a simplified letter/number combination to

compensate for their inability to remember). Whisper test takes 1 minute with Sensitivity 80-100%, and specificity 82-89%

Student Case Study, Part 3

Mrs. Rivera, Part 3

ATTENTION: All Rehab Sciences Students must read:

1. A Patient's guide to the HIPAA Privacy Rule: When health care providers may communicate about you with your family, friends, or others involved in your care
2. Also click on the following link to read this DHHS handout. (2.5 pages) http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/consumer_ffg.pdf
3. Diamond article
4. Interviewing and the Health History pp 42-43, 44 (bottom)-45, 47-48; and 51-52.

PT Only Reading:

5. APTA curricular guidelines from the Women's Health Section

5 weeks after discharge from the hospital:

Turnover is common in home health agencies, and after a month of receiving OT and PT services (4 visits from each service), both of Mrs. Rivera's original providers have left to pursue alternative employment. Substitute therapists (Carly - PT) and Jaimie -OT) have just been assigned to Mrs. Rivera's care starting with visit 5. Since both therapists have less than two years of professional experience and only 6 months of home health experience, they decided to schedule their initial session (visit 5) with back-to-back timeslots. This plan would allow them to see the patient on the same day and then work together to coordinate their intervention plans. Luz is present for both services in visit 5 and asks that they both schedule their sessions on the same days and immediately following each other. Both therapists agree that Mrs. Rivera fatigues too quickly for that schedule to be successful. Instead, the OT plans to visit on MWF from 9-10AM and the PT on TTHF from 2:30-3:30pm. Although Luz seems displeased, grumbling that this schedule is inconvenient for her, she does not argue.

The day after visit 6, Luz called Carly at the HHA office to confide that she is not really comfortable with Jaimie's (OT) appearance. Jaimie is an older therapist who entered OT practice after a career as a singer in a rock band. She has a great deal of body art, and some designs are visible with the clothing that she typically wears to work. Carly privately thinks of Jaimie as "biker chick wanna-be" and believes that Jaimie should cover her tattoos in the workplace. She finds it embarrassing to work with her. However, the HHA company's dress code as outlined in the handbook only requires staff to "Maintain a clean and professional appearance…" without further defining the term, "professional". Carly feels uncomfortable with the topic of the phone call and passes it to the office manager. The administrator quickly reviews Mrs. Rivera's chart and then reads aloud to Luz the following note documented by Jaime after visit 5. "…Mrs. Rivera seemed visibly distracted and agitated when I arrived but the colors and pictures of the body art on my (the OT) upper arms seem to mesmerize her. Her breathing and demeanor gradually calmed as she strokes the colors and floral designs with a finger and we eventually had a productive interview and task completion session."

Even after the administrator conveys the observations from Jaimie's documentation, Luz remains adamant that people with tattoos are drug addicts or devil worshipers or both. She claims to fear for her mother's safety. When the administrator questions whether Luz is typically present at most of her mother's sessions, Luz hedges and does not answer directly. When

questioned further, Luz admits that her mom has never said anything negative about Jaimie's body art or piercings, but then explains that her mother rarely complains. Luz requests a different, more professional looking therapist, but the manager explains that the HHA does not have another OT available. As an alternative, Luz wants Carly to arrange all of her PT sessions to follow immediately after the OT sessions. Luz believes that this overlap will provide a chance for another professional to observe Jaimie's interaction with Mrs. Rivera. She has spoken with her sisters and they are in agreement with this proposed plan. The manager explains that as a term of the employment contract, the therapists are allowed to plan their own weekly schedules. Any changes must be negotiated directly with the therapists. The HHA manager contacts the NP assigned to the case to ask whether she has concerns about Jaime's professionalism or competence. The NP comments that while she personally believes Jaime could use better judgment in selecting work attire with more coverage, there are no problems that she has observed.

STUDENTS: In discussion, ask faculty for more information here.

Carly has no therapy-related reason to provide services on the same day/time as Jaimie and would find it doable but very restricting to her schedule if she tried to comply with the family's request. Carly wonders if Luz really fears for her mother's safety with Jaimie or if Luz has seized upon a pretext to design a therapy schedule that provides a 2 hour block of free time where Mrs. Rivera is supervised by someone other than Luz.

Picture of Jaimie in typical work clothes

Since starting home health services two months ago, Mrs. Rivera has participated in 8 physical therapy sessions and 9 occupational therapy sessions. Each therapist had scheduled additional visits, but cancellations occurred for various reasons. According to their documentation, three or four more visits are planned for each profession and then, if all goes well, Mrs. Rivera's services will end. (*See D2L attachment for changes to MMT/ROM measurements after 2 months.*) Luz states that she and her sisters are grateful for the care their mother has received but believe that the cost of these Medicare services are too expensive to continue for someone who lives on a fixed income. Luz has only attended two sessions, despite

the therapists' request that she remain to observe her mother's abilities in action. In Luz's mind, the therapy visit offers her an open hour when she can accomplish things without bringing her mother along. After a discussion with the OT and PT, Luz seems unconcerned about her mom's continued ROM limitations in her shoulder. The therapist assumes that the family simply has decided Mrs. Rivera's other health concerns are more important at this time. As a result, the therapist documents the functional limitations but does not specifically discuss them directly with the patient.

In occupational therapy, Mrs. Rivera has made progress using the Photo phone and can now call each of her daughters and contact 911 with 100% accuracy. With the new bathtub transfer bench in place, she can transfer to the tub with modified independence while holding the new vertical grab bar located at the front of the shower. She needs min cues to initiate taking her noon meds, 25% of the time, despite the addition of her pill reminder watch but the OT believes that with more practice, she could achieve 100% accuracy. Because she wanted to continue to cook on the stove, her daughters pooled their money to purchase an automatic stove turn-off which goes off after one hour of use. Mrs. Rivera has independently prepared cold meals (cereal for breakfast and sandwiches for lunch) with the OT as long as extra time is allotted. While Mrs. Rivera is doing well, the OT feels frustrated, because she believes Luz continues to do everything for her mother rather than allowing the time for Mrs. Rivera to attempt a familiar task herself. She is also concerned that Luz and her mother are not practicing the task the same way every time which reinforces learning for people with mild dementia.

In physical therapy, her shoulder ROM and strength are improving very slowly. *Carly reviews the MMT/ROM chart and must decide whether adhesive capsulitis is still a problem.* Although the patient's UE muscle strength and physical stamina have improved and her breathing is less labored during activity, the LE endurance shows fewer changes. Mrs. Rivera's distance and gait pattern during ambulation are still slower than the typical speeds for women in her age group. (*May want to re-discuss Peel article from session 1*). Mrs. Rivera alludes to frequent stomach aches, but there are no specific symptoms to follow up on. The PT believes that the remaining gait problems, especially the wide base of support and shortened swing phase on both legs are probably related to chronic UTI irritation and chaffed tissue pain from underlying vaginal atrophy condition and are not related to strength or ROM deficits. Jaime has twice documented that during dressing/bathing activity practice, she has noted dried blood on Mrs. Rivera's underwear. Carly believes that eliminating vaginal pain (related to changes due to vaginal atrophy and post-menopausal estrogen decline) and tissue irritation could make a bigger improvement in her gait (and lessen falls risk) more effectively than if she only continues to

work on gait distance and lower extremity strengthening. On two separate occasions, Carly (PT) has awkwardly tried to address details (such as when/how severe/what triggers it) of pain with Mrs. Rivera but the patient says little and Luz seems offended at this type of questioning. Jaimie reports to Carly that she has seen a prescription labeled tube of Estrace sitting unopened on the bathroom counter when she worked on ADL's with Mrs. Rivera. http://www.rxlist.com/estrace-vaginal-cream-drug/patient-images-side-effects.htm (*read to the very bottom of the side effects for important info*). Carly (PT) is uncertain how to proceed since the initial therapists' documentation shows that Mrs. Rivera has never been thoroughly questioned about this part of her history. In addition to the incomplete initial interview information, Carly also wonders whether OT is the more appropriate discipline to handle this issue. After all, the same pelvic tissue irritation and pain that impacts her gait must have a negative effect on her concentration during performance of functional activities that require prolonged sitting or ambulation. Jaimie does not feel comfortable with pelvic issues and suggests involving the NP. Carly asked Luz to obtain a copy of the gynecologist's patient summary report so Carly can better understand both the severity of the issue and his future plans for medical management. Luz claims that she called the office and was told that it is their policy not to share any information from the record with anyone.

STUDENTS: In discussion, ask faculty for more information here.

During her home health sessions, Mrs. Rivera seems to unconsciously switch into Spanish more frequently in the past three weeks. Both therapists felt uncomfortable with Luz's habit of interrupting to correct her mother and then answer for her, so they adopted strategies to handle the issue. Jaime no longer waits for Luz to jump in, but actively invites her to serve as an interpreter. She waits for Luz to translate her statements to Mrs. Rivera and then for Luz to translate Mrs. Rivera's comments back to Jaimie. Luz seems to enjoy her central role and relations between Jaimie and Luz are (at least on the surface) more cordial. Jaimie has noticed that Mrs. Rivera's spontaneous communications with her have decreased lately and she addresses her statements to Luz. Since Carly was a Spanish minor in college, she relies on Spanish/English flashcards with short sentences or often used words on them, as well as pantomime gestures, her Spanish phrases, and online translations of handouts. She has developed a more direct verbal interaction with Mrs. Rivera but there have been a few language related miscommunications. The NP has been accompanied by a paid translator on both of her visits which worked well, but the frequency of therapy makes that option a scheduling nightmare.

Visiting a patient's home over several months allows insight into a patient's life. At first, the NP viewed Luz as a wonderful person who sacrificed her personal life to make it possible for Mrs. Rivera to remain in her own home. She sympathized with the constant demands placed upon her, and worried that Luz's own health, already complicated by obesity, low back pain, and pre-diabetes, was negatively impacted by her caregiving role. The large size of the TV and the computer screen did seem at odds with the relatively modest home décor and the patient's limited income, but the NP decided that is was just a personal choice and nothing to raise a red flag of concern about financial abuse. A 1x home consult by a social worker occurred last week to gain additional input as to whether the original decision for Mrs. Rivera to live at home is still the best option. The Social Worker pointed out that Luz has few social outlets other than work and has voiced preference for watching TV or play online gambling games on the computer in

her limited free time. Mrs. Rivera stated that she has little interest in using the computer and, aside from one Spanish language television show, rarely watches TV. The Social Worker wonders if Mrs. Rivera felt pressured to allow the purchases of the new computer and big screen TV. Luz admits that she should get out more and be more physically active, but claims that she limits her activities to these sedentary things because it allows her to remain in the home and readily available to her mother. When the HHA case manager (NP) reviewed the record last week as part of an HHA quality review, she noticed that the Social Worker had documented unexplained bruises on Mrs. Rivera's cheek and upper arms. Her finding was corroborated by an earlier observation of a shoulder bruise by the OT that, at the time, had been excused by the patient as 'bumping into a cabinet'. The Social Worker's note indicated that the patient and the daughter claimed no knowledge of how these bruises occurred. After the review, the NP spoke with the therapists to determine if abuse is a likely issue. Neither therapist had ever considered this possibility because "this is such a nice family" but they plan to observe more closely.
STUDENTS: In discussion, ask faculty for more information here.

With an imminent discharge planned, all providers (OT, PT, NP, Social Worker) must consider transitional and/or long-term services for this family, which can include home programs, further modifications, technology or social services.
STUDENTS: In discussion, ask faculty for more information here.

Case Study Part 1, Faculty Version

Case Part I: Introduction

Mrs. Rosa Rivera is a 66 year old widowed female who was born in Okarche, OK. After her marriage to Diego Rivera at age 17, she moved to a small, Midwestern town. She has lived ever since on a small soybean farm. Her husband worked at the local grain mill until his unexpected death from a heart attack in 2010 at the age of 61. Mrs. Rivera was a homemaker who raised three daughters. She knew almost everyone in town, attended church services daily, and was widely regarded as the best cook at the local church suppers. She is less active in the community than previously because many of her friends have died or moved away to live closer to family members. As the town's population shrinks, there are fewer social activities or other resources available. The local priest visits Mrs. Rivera each month and she had always expressed enjoyment of his visits. Last month, Mrs. Rivera was alone when he arrived for his usual visit and she would not open the door. She became anxious and told him to go away because she did not talk with strangers. Later, Fr. Joe contacted Luz to explain that her mother did not seem to recognize him so he did not persist in case it alarmed her further. During family or other social events, she still dresses appropriately for the occasion, displays appropriate animation, and participates coherently in conversations although friends notice that she has difficulty remembering names and mild problems with word retrieval or with accurate chronology of her stories. Those who know her well admit that her attention to her appearance has declined, although still meeting social standards. She no longer applies make-up or spends time doing her hair as she did in the past when she went into town or when company comes to her home. On at least 3 occasions, she forgot to turn off the stove for over 8 hours and twice set off the smoke detectors. When the volunteer fire department arrived, she acted so distraught and overwhelmed by the smoke and noise that they debated bringing her into the ED for examination. Instead, a daughter came to spend the night because Luz was not available. Mrs. Rivera cannot remember her daughters' phone numbers and constantly misplaces her Iphone in the house. She is increasingly inconsistent with taking her medications and becomes evasive when questioned. These memory lapses cause concern among her daughters. She consistently remembers to feed "Rover", her beloved dog

Mrs. Rivera's youngest daughter, Luz, still lives with Mrs. Rivera. Luz is 43, unmarried with no children, and assumes most of the caretaking and household management responsibilities. Luz works from 7:45AM-4:00PM on a nine month contract as a kindergarten teacher at a local private school. Prior to 2014, Luz worked a second job in the summers for financial reasons but finds it difficult to do so now that Mrs. Rivera requires more supervision. She supplements her income with some private tutoring at students' homes but it is time consuming and only brings in a third of her usual summer earnings. Financially, Luz can live comfortably on her salary but only because she has no housing expenses. Luz's smoking has recently increased to ½ pack per day (ppd) due to stress over her increased caregiver burden. As

a result, several parents have cancelled their tutoring arrangements due to concerns about second hand smoke exposure to their students from the smoke trapped in Luz's hair and clothing. Although Luz knows it is dangerous, smoking helps to curb her appetite and she is reluctant to quit. If asked, she only admits to smoking 4-5 cigarettes per week.

Mrs. Rivera's remaining two daughters are married. Both live in the city with 4 pre-teen/teenaged children between them. Their spouses have made it clear that they do not want their mother in law to live with them full time but do not object to her daughters spending time/money to care for her. The daughters visit their mother monthly and during these visits, their children and husbands take care of light yard work and minor repairs. They have offered to cook meals to freeze for later use but Luz takes offense at their efforts to, in her words, "…sweep in like self-important queens and imply that I cannot take care of Mom. I am here all the time and I know what she needs. They have made it pretty clear that they don't want to have Mom in their own homes and underfoot every day." Luz has her own health issues with a BMI of 32, shortness of breath during exertion, and chronic low level (3 on 10 scale) non-specific non-neurological back pain and calf cramping during ambulation that is partially relieved by sitting or leaning forward. Her physician warned her 4 years ago that she is considered pre-diabetic so Luz has unsuccessfully tried many diets since then. Mrs. Rivera always drove competently but in the past five years, she has begun to get lost even in her familiar town environment. She stopped driving after dark when her husband died due to early cataract formation in the R eye. Despite successful cataract surgery in late 2011, in the past two years she has also gradually decreased her daytime driving too. She relies on her children and others to assist with transportation to the grocery store, the doctor's office and to church. Mrs. Rivera lost 15 pounds after her husband's death, declining from 125 to 110 pounds on her 5'5" medium frame (BMI 18.3). Her daughters initially dismissed the weight loss as a short term grief response since their mom consistently claimed that she felt fine and just was not hungry. Lately, they have commented to each other that she never gained the weight back and never returned to her previous pattern of eating three meals each day. Mrs. Rivera often ignores mealtimes and even if Luz cooks, she sometimes forgets to eat the food placed in front of her unless reminded. She retains a strong preference for sweets but Luz is trying to lose weight and refuses to purchase anything she views as fattening. Mrs. Rivera seems to have little interest in the veggies and low fat products that Luz buys for their consumption. Although her family speaks Spanish in the home, Mrs. Rivera's English is perfect although slightly accented. The grandchildren, who barely speak Spanish, have told their parents that when upset or tired, grandma will switch into Spanish to find words without seeming to realize that they can't really understand her.

In 2013, Mrs. Rivera's long-time family practitioner decided to retire. He called Luz and recommended a referral to a neurologist for her mom. The doctor does not think there is a problem but feels that there have been enough small changes to warrant an examination by a specialist to set everyone's mind at ease. relationship with another doctor. Initially, the sisters did not see a need for this examination and Luz felt uncertain since on some days, her mother seemed like her old self again. The triggering event for Luz came after a morning where she watched her mom first become increasingly confused about where her clothes were kept in the house and then progressed to angry outbursts where she repeatedly yelled at Luz to get dressed because they were late for a party that had occurred 10 years earlier. An hour later, it was as if the event had not happened because her mother seemed calm and did not refer to it again. Luz

thought that perhaps an underlying illness was exacerbating the normal age-related forgetfulness and wanted her mom to get medication to stop it. The neurologist examined Mrs. Rivera and diagnosed her to have Alzheimer's disease on the basis of her memory loss and functional changes. She received prescriptions for Aricept 10 mg daily and Namenda 10 mg BID. The neurologist plans to follow up with her quarterly to assess changes. The neurologist mentioned that Mrs. Rivera needs to gain at least 10 pounds and recommends that she should be allowed to eat favorite foods whenever she is hungry. Luz was advised to supplement with slightly sweetened Ensure drinks on those days when her mother refused food. The neurologist recommended that Mrs. Rivera take a multivitamin with calcium too.

The diagnosis was a shock to the family, especially Luz. She had expected the doctor to recommend medication that would return her mother to her previous level of independence. Luz did not express it verbally but mentally she refused to accept what he told her about the progressive nature of the disease and the inevitable caregiver burden that would accompany it. Mrs. Rivera listened with apparent interest but said little. After returning home, Luz texted her sisters but provided scanty information in a dismissive manner, claiming he "overreacted to a few problems." After calling the neurologist themselves, the other daughters sadly accepted the findings and likely prognosis. Since they saw their mom less frequently, they noticed had obvious changes over the past year but Luz did not want to hear their input so they stopped mentioning it. There have been 2 follow up visits since the initial diagnosis and Luz feels increasingly unsatisfied with his services. She constantly complains that his visits are rushed and that he exaggerates about Mrs. Rivera's level of decline. Luz repeatedly states that Mrs. Rivera received treatment from the same family practitioner for 22 years and he never felt any concern about mental status changes until the last few months before he retired. To Luz, that is proof that her mother is showing signs of mental symptoms probably related to an acute illness rather than cognitive changes of Alzheimer's disease that have been progressing over time. Luz plans to switch to another neurologist in their HMO as soon as she finds one who is accepting new patients. She has not told her mother of this plan. Mrs. Rivera rarely argues with Luz and typically follows her suggestions so Luz is certain that she knows what is best for this situation..

Other than her newly established relationship with the neurologist, Mrs. Rivera does not receive much medical oversight. The family practitioner had handled all of her health issues for several decades. After his retirement, the HMO offered a choice between a male gynecologist and a male family medicine physician or just the male family medicine physician as her new PCP. No female physicians associated with her insurance were currently accepting new patients. She agreed to the male gynecologist since he spoke fluent Spanish and reluctantly agreed to also see the family practice physician for one visit in 2013 to get established with his practice. Although the family practitioner also offers gyn/women's health care, Luz wants her mother to use her yearly gynecologist visits for both routine wellness and women's health issues. In Luz's mind, the family practice physician is not a specialist and care is always better with a specialist. Mrs. Rivera does not argue. Although offered the pneumovax and the influenza shots at each visit, she has consistently refused. Luz supports her decision which is based on internet sources that report dangerous side effects from these immunizations. The male gynecologist is very competent but brusque and rushed. He clearly prefers for patients to present a focused and clear recitation of symptoms and needs to maximize use of the office visit. Since Mrs. Rivera finds it difficult to perform at level of organization, in addition to her embarrassment about discussing

personal issues with a man, she rarely asks any questions. Luz does not care for this physician, but is reluctant to switch practices because he can understand her mother when she unintentionally lapses into Spanish. Luz has suggested that her mother switch to the nurse practitioner who is assigned to the same practice, but her mother is reluctant to have care from anyone but a real doctor.

Mrs. Rivera's medication list is growing longer each year, but she feels confident that she can still independently manage it. Luz, fearing that her mother will make a mistake, has recently taken charge of maintaining and distributing her mother's meds. These medications include (*for sake of case continuity, important but previously taken meds as well as present and future meds prescribed later in the case, are listed*):

Prescribed by neurologist: *(Continued during hospitalization)*

- Aricept (pre-existing medication; discussed in part I)
- Namenda (pre-existing medication; discussed in part I)
- Generic multivitamin with calcium and vitamin D (pre-existing medication; 1x daily)

Prescribed by gynecologist: *(not taken during hospitalization for reasons outlined below*)

- HRT-estrogen only (long standing medication that was DC'd in 2010; discussed in Case part II)
- Estrace vaginal cream (not prescribed until later; discussed in Case part II)

Self-prescribed: *(not taken during hospitalization but also not discussed with nurse during hospitalization intake interview)*

- St. John's Wort to manage fatigue and insomnia x 6 years

http://www.nlm.nih.gov/medlineplus/druginfo/natural/329.html

**She also drinks 4-5 cups of pennyroyal tea every day but does not view that as a medicine. It just helps with her digestion so she never mentions it to anyone because it just seems like a benign habit similar to chewing gum or sucking on peppermints. By now, her family is so used to her 'drinking her tea' that they never think about what it actually is and whether it has any impact on her health.

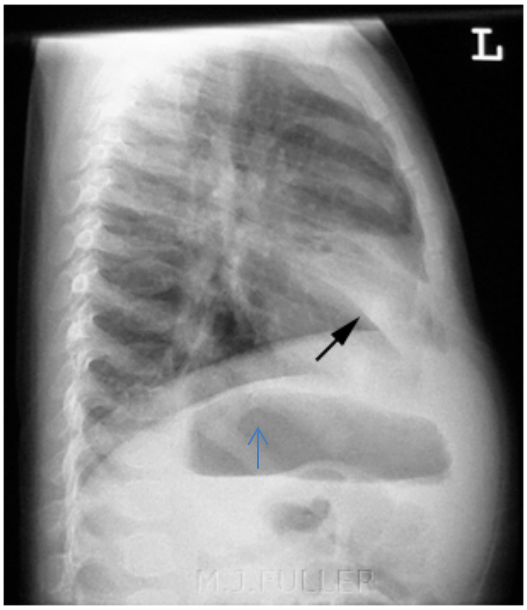
http://www.drugs.com/npc/pennyroyal.html

Luz privately believes that if her mother would just concentrate, then she could function fairly independently. She encourages her mom to take St. John's wort because the patient's comments found on WebMD highly recommended it. She chafes at her ongoing role as caregiver and wonders aloud to her sisters if these 'symptoms are due to laziness and desire to be babied (as her husband did) rather than due to Alzheimer's disease. Privately, the other daughters feel that Luz does not realize how much she controls their mother's life and activities so that it appears she is still functioning well. They think that it will upset their mother to switch to a new neurologist when she has just become accustomed to the present one and wholeheartedly believe that the present neurologist's observations are sad but accurate. They would like to stop Luz's focus on 'fixing' their mother and move onto realistic planning for the future. Their husbands have advised them to avoid arguing since Luz is stubborn and seems to resent their interference. They point out that things with Mrs. Rivera will inevitably worsen over time and Luz will eventually realize the truth.

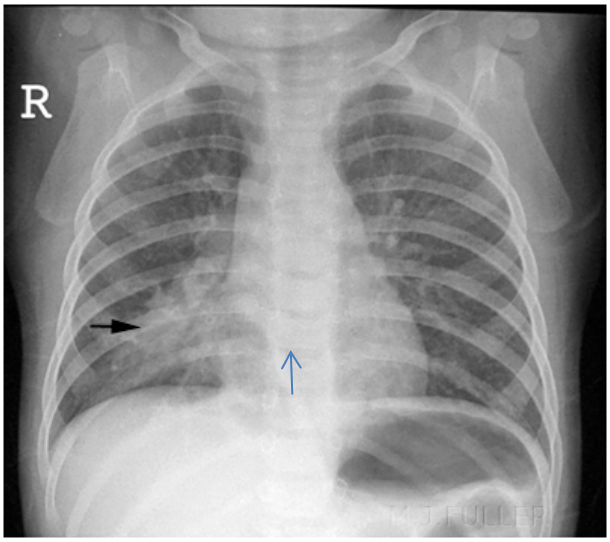
Two weeks ago:

Luz woke at midnight to hear her mother coughing so hard that she was struggling for her breaths. Although for weeks Luz had felt concerned that her mother's harsh, productive cough had steadily worsened, Mrs. Rivera refused any treatment other than herbal pennyroyal tea. http://www.webmd.com/vitamins-supplements/ingredientmono-480-PENNYROYAL.aspx?activeIngredientId=480&activeIngredientName=PENNYROYAL She believed that the tea is a good solution for any ailment and regularly drinks 4-5 cups daily. Along with her mother's difficulty with respiration, Luz discovers that her mother has a fever of 102 degree F (38.88 degree C). Luz is alarmed and calls an ambulance to drive her mother to the nearest outpatient medical center, 50 miles away.

Mrs. Rivera was admitted to OU Medical Center with a diagnosis of bacterial pneumonia that developed as a result of an untreated flu virus complicated by comorbidities of anorexia and mental changes (dementia). As mentioned earlier, Mrs. Rivera did not receive a flu shot this year and has never had a pneumovax. At time of admission, chest x-ray (PA and lateral views) showed right middle lobe (RML) consolidation from acute pneumonia complicated by malnutrition with dehydration, confusion and fever.



Lateral view of RML consolidation



AP view of RML consolidation

Her LOS as IP at OU Medical Center lasted for 8 days. Luz slept in the room each night and the other daughters visited daily. Sometimes, there were as many as 6 visitors in her room at once and nursing notes documented that the patient seemed exhausted and overwhelmed at times. The night shift nurses reported that Mrs. Rivera seemed to have difficulty sleeping on most nights.

The hospital stay:

Due to her dusky skin color, difficulty breathing, and lung consolidation, the ER physician admitted her to the Internal Medicine service where she was cared for by a hospitalist. FACULTY: Please make sure students understand role of hospitalist as it has evolved in recent years. Hospitalists are a model of care in the United States, in which physicians, dubbed

"hospitalists," (often internal medicine specialists) provide inpatient care in place of primary care (private) physicians. Factors leading to this change include cost pressures on hospitals, overwhelmed physician groups, and managed care organizations; the increased acuity of hospitalized patients and the accelerated pace of their hospitalizations; the time pressures on primary care physicians in the office; the decreasing inpatient volumes of most primary physicians; and the evidence that practice makes perfect in other medical fields. The hospitalist movement has grown and ultimately become a well established model for inpatient care in the United States. The pneumonia was treated with IV Zithromycin for 8 days in the hospital as well as nebulized Albuterol q 4 hours, Mucinex 600 mg BID. During meal rounds, the bedside nurse noticed that Mrs. Rivera choked easily on her food.

Mrs. Rivera slept most of the day but routinely became upset at the end of each afternoon, sometimes loudly claiming that 'strangers' were coming into her room to smother her. She refused to eat some meals, claiming that the food was poisoned. Once she reached a certain level of agitation, her daughters could not calm her and she became a disruption to the staff and patients. In addition, they feared her flailing limbs might result in self-injury so the physician ordered Valium (diazepam x 5mg prn). Restraints were discussed as a possibility but the family disliked that suggestion. Nursing reported that the Valium seemed to calm Mrs. Rivera enough to make her manageable although she ate very little while receiving it due to lethargy. FACULTY: Discuss the ethical issues of 'chemical restraints' versus actual 'physical restraints.' Can restraint use co-exist with a patient centered care approach? During the 5th IP day, when Mrs. Rivera seemed more coherent than usual, she casually mentioned to Luz that her "…bleeding down there seems much less than usual now that I am in the hospital." Luz, even with further questioning, could not figure out if the alleged bleeding came from the rectum or vagina. Details about quantity, severity of problem, any associated pain, etc, were met with head shakes and silence. Mrs. Rivera finally refused to discuss the topic saying that, "When it happens, I wipe it away because I don't want anyone to know. It is too embarrassing and these things just happen with old women." Mrs. Rivera forbade Luz from mentioning this problem to the nurses. Luz agrees, reassuring herself mentally that the bleeding must be her mom's imagination because surely someone would have noticed bleeding during the hospital intake process and already addressed it. FACULTY: Discuss the intake process for a hospitalization. Is it possible to miss a (seemingly) unrelated symptom if the patient does not mention it? Ask nurses to provide a quick overview of what happens when a patient is admitted as an inpatien.

During the stay, her symptoms responded well to rest, medication, and hydration. She was discharged on IP day 8. She was advised to follow up with her primary care family medicine physician in 5-7 days. She will be discharged with orders to take Zithromycin 250 mg tab PO daily for 2 more days to complete a 10 day course of antibiotics. She will also take Mucinex 600 mg BID for 2 more days. Mrs. Rivera was discharged on home oxygen 2L continuous per nasal cannula for one week. Mrs. Rivera was given a referral for 4 weeks of home health OT and PT services. There is one home health agency in her town and they promised to send out a nurse case manager and possibly both types of therapists within the week. Mrs. Rivera does not believe that she needs therapy and is very anxious about the thought of strangers coming into her home. She frets to Luz but feels too much respect for her male physician to argue with the discharge plan. Luz fully expects her mom to refuse therapy beyond the first session but plans to enlist her sisters to persuade their mother to participate. Luz plans to be present for the first visit but that is

all. Despite what the social worker said about the value of Luz learning strategies to improve her mother's functional level, s Luz is already planning how she can use this windfall of unexpected 'free time' during the 2x weekly therapy sessions to perform errands without her mother. Perhaps, there will even be time to slip away to the local casino for an hour without anyone knowing where she is. It will be a relief to get a break.

Role Play Exercise Instructions, First Year Students
Simulated Patient Interviews, Year 1 Instructions

Objectives:
Year 1 OT/PT students will gain experience in:

- Establishing rapport with an unfamiliar patient.
- Asking interview questions that will build rapport and provide information that will allow PTD/OPP and prognosis to be developed
- Organizing and conducting a patient interview in a logical and efficient manner
- Managing their time during the interview (Actual interview NTE 30 minutes)

Logistics:
Date: Arranged in year 1 Clinical Process lab times for Oct. 4.
Interview Time: Arranged according to year 1 partner's schedule (see attached);
Outcome: Interview, provide feedback, create a year 1 goal, complete FORM 3 and reorganize work area.
Partner List: See D2L
Location: Labs on both campuses
Dress code: Year 1 students must follow the Department of Rehabilitation Sciences Clinical Education dress code and wear a nametag. Year 2 — no assigned attire.

- **During this assignment, Year 1 student "therapists" will hone their history-taking skills by interviewing a "patient" simulated by a second year rehabilitation sciences student. Here are the steps to follow:**
- **Year 1 brings a copy of the student interviewer feedback form to the interview. Read it in advance so you know what qualities the year 2 partner will assessing during the experience.**
- The interview with the mock patient (Mrs. Rosa Rivera) will occur in the department labs. Yr. 1 — please arrive ten minutes early to prepare for your interview.
- The mock patient will play the role of a home health patient who is 1 week s/p discharge after an 8 day hospital admission for bacterial pneumonia. She is in the early stages of dementia with changes in her affect noted. Treat this simulated patient as a real patient from the very start of the interaction. View yourself as a therapist and behave accordingly.
- Conduct a semi-structured interview that lasts about 20 – 30 minutes. Year 1 may prepare a few questions in advance but do not write rely on them so heavily that it will impact rapport. Allow flexibility in your questions to obtain the pertinent information that Mrs. Rivera has to offer. Remember, one of her diagnoses is dementia so be prepared to respond to whatever she says, even if off topic.
- Use active listening techniques and strive to communicate clearly.
- After the interview is completed, the second-year student will provide verbal and written feedback about the interview on the spot. Both year 1 and year 2 students must discuss, sign and date FORM 3.

Scenario Instructions: *Year 1: You visit a patient's home after the home health agency received an OT and a PT consultation request. You must ask questions that gather information on the patient's pre-hospitalization and post-hospitalization status. Also, ask enough questions to*

evaluate the safety of the home and the adequacy of the caregiver support/patient functional status. Your goal is to assess whether the decision to recommend home services (instead of facility based care) was a sound one. You have received this information (see below) about the patient:

History: *INFORMATION PROVIDED TO THERAPIST FOR THIS PORTION*
Mrs. Rosa Rivera, a widowed 67 year old woman, is a lifelong resident of a small town in the midwest. Although her English is perfect, Spanish was her first language and when stressed or tired, she sometimes reverts to it. Her husband died unexpectedly 4 years ago. She is a homemaker with three grown daughters. One, Luz, is a 42 year old unmarried teacher who still lives with her mother. The other two are married with teenaged children. Though they live an hour away, both visit as often as possible. There is unspoken tension between Luz (who sometimes resents her caregiver role but enjoys being 'in charge' of her mother's health) and her sisters (who want to help but are torn between their own life demands and Luz's resentment of their intrusion).

Many of her friends have moved away so her social circle has decreased in the past three years. The local priest visits her monthly. During social visits, she can participate in conversations though she has difficulty remembering names and sometimes experiences mild problems in retrieving words. Her daughters notice that she does not apply make-up or spend time doing her hair as she did in the past. On at least 3 occasions, she forgot to turn off the stove for over 8 hours and only discovered it when someone dropped by the house. Sometimes, she becomes anxious that she cannot remember her daughters' phone numbers even though they are programmed into her cell phone contacts list. She is increasingly more inconsistent with taking medications. These memory lapses cause concern among her daughters but they do not know if there is real reason to worry or if their mom is still distracted with mourning.

Since the death of her husband, she gradually decreased her driving and relies more on her children and others to assist with transportation to the grocery store, the doctor's office and to church. She claims a lack of interest in driving but secretly fears getting lost. Mrs. Rivera initially lost 15 pounds after her husband's death, declining from 125 to 110 pounds on her pre-hospitalization 5'5" medium frame (BMI 18.3). Her daughters dismissed the weight loss as a short term grief response, since their mom claimed that she felt fine and just wasn't hungry, but she never gained the weight back and now they are concerned.

Observations: *INFORMATION PROVIDED TO THERAPIST FOR THIS PORTION.*
Pretend that you have entered a one-story ranch style home that is in good repair. Furnishings tend to be overstuffed and large. The wall to wall carpeting is covered by many small throw rugs. The TV and computer are enormous and new. You see an undernourished, underweight (BMI 18%; weight 110 lbs) messily dressed female who appears older than her stated age of 67 and is sitting on the couch with a pleasant, but slightly vague look on her face. You notice that Mrs. Rivera's eyes are reddened and puffy as if she has been crying, but she denies it when asked. During the interview, you note that Mrs. Rivera offers no spontaneous comments but only responds when directly asked a question. Sometimes, she looks away as if she hears a voice or sees something that has distracted her. (In reality, nothing in her environment should be a distraction.) She appears friendly, alert and oriented when the interviewer enters her home but

quickly becomes agitated and upset if the questioning becomes too rapid-fire or personal. Luz, her daughter/caregiver remains in the interview and at first tries to interrupts her mother to answer the therapist's questions until the therapist firmly but nicely states that she wants to focus on the mother. Although you spoke mainly to the mother, you would like to interview Luz for more background information. Unfortunately, before the session ended, Luz abruptly announced that she needed to run an errand and left the therapist alone with her mother.
After she is gone, Mrs. Rivera defers a question to Luz, as if she has forgotten that Luz is no longer present. She has a passive attitude when referring to Luz, as if she is accustomed to letting Luz make her decisions.

Chart Review: *INFORMATION PROVIDED TO THERAPIST FOR THIS PORTION.*
You will not assess vital signs and should assume they are WNL for age/gender. Mrs. Rivera's most recent hospitalization for bacterial pneumonia resulted in a loss of the 4 pounds she had recently gained back, a lethargic affect, and mild coughs that still linger. Her post-hospitalization meds include Aricept 10 mg daily and Namenda 10 mg BID for memory loss and functional decline, a generic multivitamin with calcium and vitamin D and a prescription for Valium as needed for agitation. She also ingests St. John's wort for fatigue due to insomnia as a personal medical choice and might be defensive about it. She has not shared this information with her PCP for fear of disapproval. ** HINT: When you ask a patient about "meds", then they will decide what THEY consider to be meds and may (or may not) tell you about only those substances. Ask questions that are worded to gather ALL the info you need about prescribed, OTC, self-designed 'medications'.
***Look up meds in advance to know what type of questions to ask about side effects.*

Health Care Unlimited Home Health Agency

Rehabilitation Services Referral Form

(Check type)

X Occupational Therapy X Physical Therapy __ Speech Language Pathology X Nursing

Patient Number: 50 8767 1049B Date of Birth: 6/5/50 Patient Name: Rosa A. Rivera Physician: Dr. Lane Smith Diagnosis: s/p 8 day LOS for viral pneumonia complicated by Alzheimer's Disease, chronic malnutrition, deconditioning Referral: home health PT today to evaluate and treat to improve ROM, reduce pain related gait deviations and increase strength and overall conditioning Home health OT for cognitive retraining, caregiver education, ADL instruction; please order necessary equipment and recommend any community resources	Additional Information / Office Notes: 12 visits pre-approved Nursing initial assessment determined that further home nursing care is not needed and home based PT/OT therapies are the only skilled services required. Nursing will continue as case manager role for this patient's overall coordination of services.

Role Play Exercise Instructions, Second Year Students
Simulated Patient Interviews

Instructions for Year 2 Students Only — do not share with year 1 partner(s)

Objectives:
Year 2 OT/PT students will gain experience in:

- Developing a peer-teaching relationship by simulating a patient to allow Yr 1 to practice skills.
- Providing peer feedback (written and verbal) designed to encourage behavior change.
- Creating a learning goal to promote peer professional and clinical development.
- Simulating the physical and emotional status of a patient with cognitive changes and general deconditioning who is s/p recent hospitalization for acute respiratory condition.

Logistics:
Date: Arranged for Oct. 4, 2017 during year 1 CP labs*(see schedule with OT change*)
Interview Time: See schedule
Partner List: See D2L
Location: Labs in on both campuses. Arrive 10 minutes early and sit in a chair to mimic sitting in a living room with your home care therapist. Do NOT sit on a plinth.
Dress Code: Be vague and deliberately speak softer than usual. Wear clothes suitable for a deconditioned and mildly confused geriatric patient.

(Examples: Button shirt incorrectly and only partially tuck it in. Skip a belt loop. Allow hair to be partially pinned up and messy. Women should have very little makeup but lipstick could be smeared. Consider wearing unmatched (but similar) shoes or socks to see if the interviewer notices. Leave a shoelace dangling.)

Remain serious while playing the role of Mrs. Rivera. Males are not expected to wear dresses.

Due Dates: Year 1 provides the FORM 3. After the interview, provide examples of what the student did and did not do efficiently, effectively, and what actions did/didn't support a patient centered approach. After that discussion, Year 2 should offer examples from the summer rotations to show what the student could have done better in terms of timing, type of questions, response to patient's actions, body language, rapport building, etc. PLEASE DO NOT INTRODUCE LOCCIDA APPROACH AT THIS TIME. Spend time on the goal-setting. Year 1 must submit a scanned copy of the signed and completed FORM 3 to their Clinical Process Dropbox. Year 2 must submit an assignment verification form to the ICM drop box by Oct. 6th at 5pm. There is time to complete all of the paperwork associated with this assignment in the two hour timeslot provided for the interview.

Responsibilities:

- Year 2 students: You will simulate Mrs. Rosa Rivera, a recently discharged inpatient who is being seen by home health therapists in her home. Students on both campuses should read the content below and "*Case Study—Part 1*" PRIOR to the interview to make sure that you

understand her medical and cognitive conditions. Behave as a real patient from the very start of the interaction. Use your acting skills to create a challenging patient interview but do not veer into the realm of the ridiculous. Year 1 does not know as much information about the patient but they know all of the basics about your hospitalization and about some family concerns. Their job is to ask questions that uncover the rest of the information. Pretend her daughter "Luz" is there for the first 2 minutes of the interview but that the therapist asked her to remain silent and observe only. (So it won't matter that there is no Luz actually present.)

- This semi-structured interview should last about 20-30 minutes. After about 10 minutes, show visible signs that the interview is too taxing to tolerate (become confused/tune out briefly/restlessly shift positions or get up and walk away/express fatigue). See whether the student reads the cues and responds appropriately by offering a break or in some way acknowledging that the patient is struggling to stay focused. Year 1 students may prepare a few questions in advance but watch to see if they strictly read from their forms instead of engaging in a two- sided conversation. Note whether they refuse to deviate from their set list of questions even if your answers should suggest some new questions. Comment in feedback if student seems to ignore your nonverbal signs.

- Year 1 student interviewers are practicing rapport building, speed and clarity of communication, organization and development of a more logical flow with their interviews. Some are very unaware of their nonverbal body language. Still others have nervous responses to the situation that might be distracting for a real patient. They are usually so focused on the activity that they cannot assess their own performance. After the interview, offer very direct (but collegial) feedback so that the student knows what went well and where they should improve. Do not make any of the year 1 students feel overwhelmed or incompetent. Do not discuss LOCCIDA format (it is not appropriate for a patient with these comorbidities) but instead encourage Year 1 to take a person-centered view of the patient. Help them figure out how to blend a warm, personable approach with a focused and efficient interview. Pay attention to their opening and closing remarks because these set the overall 'tone' for the interview.

Scenario Instructions: You are Mrs. Rosa Rivera. Assume that the therapist arrived at your home at 9AM on Monday morning. It was very hard to get organized in the morning and already today has not been a good day. Earlier, you forgot that your husband has been dead for years and accidentally set a place for him at the breakfast table. After your daughter Luz (your live in caregiver) exasperatedly corrected your mistake, you cried because you felt old and stupid. You still feel sad. You call out to the girls who are still upstairs getting ready for school that they should hurry and then you remember that they are grown women with families of their own who do not live with you. Things are confusing sometimes and it makes your head hurt. It's better not to think about it. *Who is this therapist that is sitting here? Did I make an appointment? I don't remember that.*

Your behaviors: You are an undernourished female who appears older than your stated age of 67. You sit on the chair but your feet don't reach the ground. It hurts your back to sit unsupported so after a while, you rub it repeatedly. You offer no spontaneous statements but politely respond when directly asked a question. Sometimes, you look away as if you were suddenly distracted by something or as if you are lost in thought. You present as alert and

oriented when the therapist enters your home but within 5 minutes, you have asked the therapist to repeat his/her name again and accidentally called him/her "Luz". Every once in a while, you lose track of what you are saying and ask, "Sorry, what were we just talking about?" or "Did you just ask me something?" Your daughter Luz tries to interrupt and answer all of the questions and you feel slightly anxious when the therapist asks her to just observe and allow you to respond directly. Near the end of the interview, Luz leaves the room and says that she will complete an errand and return in an hour. You become visibly anxious and ask the therapist to tell you again who (s)he is and why (s)he is there. You try to calm down and concentrate on the therapist's questions but tell the therapist that (s)he asks too many questions..

You drink 4-5 cups of pennyroyal tea every day but do not view that as a medicine. It just helps with your digestion so you have never mentioned it to anyone because it just seems like a benign habit similar to chewing gum or sucking on peppermints. By now, your family is so used to you 'drinking your tea' that they never think about what it actually is and whether it has any impact on you. Your meds include Aricept and Namenda for memory loss and functional decline and a prescription for Valium as needed for agitation. **You have the bottles with you to show** and say, "I am taking these and some other stuff". You are taking another medicine that the doctor does not know about but explain to the therapist that Luz said it is ok to self-prescribe if it is herbal. You cannot remember what that medication is called, but it sounds something like warts…. No, that can't be right, so you decide not to mention it unless the therapist directly asked about 'other stuff' or 'over the counter health aids'. Your bladder feels full already. You constantly worry about wetting yourself and know that Luz makes you go to the bathroom every 90 minutes to prevent wetting but she is not here. Sometimes, it is hard to remember on your and you have an accident. You hate that because it is shameful and it burns, but it just happens. *At some point in your interview, cross legs/swing foot rapidly/squirm in chair. If not asked about your nonverbal cues (don't have to ask about toileting needs but should ask if you are uncomfortable,) then urgently ask the therapist to take you to the bathroom. If they do, clutch their arm tightly when walking there. If they ignore signs or say no or want you to wait until later—comment about it on evaluation form.*

Acting tips: Be pleasant, soft spoken (*quiet enough that the therapist cannot hear some of your answers*), and underplay all symptoms as if you have no problems and don't really need therapy. Sigh frequently and prop your head on your hands sometimes as if you feel exhausted. Ask to have questions repeated as if you could not hear it or were not focused when it was initially asked. At least 1x, respond to a question with an answer that makes absolutely no sense. If possible, respond to a question in Spanish (or some version of it) as if you had forgotten that the interview is being conducted in English and unconsciously reverted to your native tongue. Come across as very dependent on your caregiver and often say, "Luz will do that" or "I haven't been able to do that in years so I doubt that Luz will want me to do it now." Give an unrealistic desired outcome such as "I want to live alone so Luz doesn't have to take care of me" or "I was having problems but they are much better now so I don't think I need to have any home services" to see how the interviewer handles it.

Health Care Unlimited Home Health Agency

Rehabilitation Services Referral Form

(Check type)

X Occupational Therapy X Physical Therapy ___Speech Language Pathology __Nursing

Patient Number: 50 8767 1049B

Date of Birth: 6/5/50

Patient Name: Rosa A. Rivera

Physician: Dr. Lane Smith

Diagnosis: s/p 8 day LOS for viral pneumonia complicated by Alzheimer's Disease, malnutrition, deconditioning

Referral: home health PT today to evaluate and treat to improve ROM, reduce pain related gait deviations, and increase strength and overall conditioning

Home health OT for cognitive retraining, caregiver education, ADL instruction; please order necessary equipment and recommend any community resources

Additional Information / Office Notes:
12 visits pre-approved

Nursing initial assessment determined that further home nursing care is not needed and home based PT/OT therapies are the only skilled services required. Nursing will continue as case manager role for this patient's overall coordination of services.

Role Play Exercise Peer-Review Instructions
2017 Peer Interview Assessment Form

Directions: Interview must be completed and submitted by YEAR 1 to D2L between Sept. 21-Sept. 30 at 5pm as part of their OCTH 7133/PHTH 8153 Clinical Process assignments. Year 2 student—Discuss and sign "Interview completion verification form" and submit to D2L by Oct. 30 at 5pm. Complete Outcome section, OSCE portion and written comment section, including goal setting for each student, before submission by Year 1.

Expected Outcomes for students, graduates, and professionals

- Outcome 1: Engage in lifelong learning and professional development
- Outcome 2: Participate in leadership, service and advocacy
- Outcome 3: Practice ethical and evidenced based services delivery
- Outcome 4: Maintain continued competence in physical therapy practice
- Outcome 5: Engage in ethical behavior in all aspects of my professional life.

Outcome #3 required behavior	Expected performance	Rate actual performance level	Provide support for assessment
• Practice ethical and evidence based service delivery	• Achieve OSCE score average of 3.5 (*attach OSCE form*) _____ • Yr 1 self-identifies one 5-step goal that will improve lowest rated OSCE performance area	• Average OSCE score = _____ _____ • Student's written goal (*at end of this form*) has 5 steps and is learner appropriate____	Attach completed OSCE form which includes scores and the written goal. _____ Provide 1-2 sentences explaining how accomplishment of this goal will enhance student's professional development: (below)
Outcome #5 required behavior	Expected performance	Rate actual performance level	Provide support for assessment
• Engage in ethical behavior in all aspects of my professional life	• Fulfill requirements by scheduling interview in timely fashion _____ • Use patient	• Yes___No___ _____	• Identify how long it took to arrange/complete interview **(below)** _____ • Provide 1

	centered language during patient interactions. • Actively used verbal/nonverbal methods to engage patient in decision-making • Adhered to SOLER* in non-verbal body language 100%	• Yes___No___ • Yes___No___ • S-- Yes___No___ • O-- Yes___No___ • L-- Yes___No___ • E-- Yes___No___ • R-- Yes___No___	comment each about quality of patient centered language; patient involvement efforts; SOLAR nonverbal **(below)**
	• Adhere to '4 Habits Model' approach 75%	• Invest ___ • Elicit ___ • Demonstrate ___ • Invest ___	• Provide 1 comment each to identify which element they performed best (and why) and which one needs the most work (and how their interview will be better if they improve in this area **(below)**

SOLER

S: Sit SQUARELY on to the client, preferably at a 5 o'clock position to avoid the possibility of 'head-on staring'.

O: Maintain an OPEN posture at all times, not crossing your arms or legs which can appear defensive.

L: LEAN slightly in towards the client.

E: Maintain EYE CONTACT with the client without staring.

R: RELAX. This should help the client to relax.

Yr 2 comments (supporting scores above):

1. Provide 1-2 sentences explaining how accomplishment of this goal will enhance professional development:

2. Identify how long it took to arrange/complete interview:

3. Provide 1 comment each about:
   a. quality of patient centered language:

   b. patient involvement efforts:

   c. SOLAR nonverbal language:

4. Provide 1 comment each to identify:
   a. Which 4 Habits Model element they performed best (and why):

   b. Which 4 Habits Model element needs the most improvement (and how their interviews will bebetter if they improve in this area:

WRITTEN COMMENTS: (List specific examples to support your recommendations)

Identify two areas of overall strength in the interview and provide support:
1.

2.

Identify two areas for future growth and explain how growth will help:
1.

2.

Development: (Yr 1 and 2 work together to complete this step.)

- Assume that this interview occurred on the 1st Clinical Daily Experience. Assume that the Yr 2 student is acting as the CI/FWE and just observed this interview with Mrs. Rivera. Based on the ratings on Outcomes portion, the OSCE, the SOLER observations, and the comments section, develop one 5-step functional goal that will improve some aspect of the Yr 1student's interviewing skills. Select a goal that the student can achieve in the remaining rotation time (2 more dailies remaining).

  Goal: (print here)

** *5 step goals:*
WHO will DO WHAT under WHAT CONDITIONS and HOW WELL by WHEN.

_____ _____
Year 1 signature/date Year 2 signature/date

_____ _____
Year 1 printed name Year 2 printed name

Electronic printed names/dates are acceptable as signatures and held to honor code standards.

Supplemental Information

4 Habits Model

1. Invest at beginning: create rapport (various techniques); ask open ended questions to gain info so it feels more like a conversation; don't use 1st name until invited; make statement that shows you have read chart and already know something about the patient; find out why seeking services now; plan visit to prioritize main concerns (and to remain on time)

2. Elicit patient's perspective: Ask for desired outcome; see if can identify problems/offer suggestions for resolving problem; assess whether they see interconnectedness of diseases and functional losses

3. Demonstrate empathy: Say something empathetic (not sympathetic); pause after identifying emotion to let them correct if needed; be aware of cultural issues; ask about impact of condition on daily activities or desired life

4. Invest at the end: Use patient's words when possible to reframe diagnosis so they understand it; outline proposed Intervention to see if they accept it and listen (do not have to always adopt) to their ideas/internet research; use 'repeat back' to see if they understood what you taught them; assess satisfaction in some way before they leave (often just verbally assess); thank them for attending session and remind of next session date/time/importance

2017 Standardized Peer-Patient

OSCE-Communication Skills Evaluation *(Circle score)*

	Low *Poor*	*Fair*	*Good*	*Very Good*	**High** *Excellent*
1 - Opening of Interview/Greeting (Greeting, allows uninterrupted opening statement, elicits all concerns)	**1**	**2**	**3**	**4**	**5**
2 - Primary Emotion/Empathy/Rapport (Expresses empathy through reflection, legitimation, and respect. Identifies and acknowledges the primary emotion if present)	**1**	**2**	**3**	**4**	**5**
3 - Questioning Skills (types of questions, pacing, jargon, etc.) (Use of open-ended questions, elicitation of symptom characteristics. Avoids medical jargon, level of language appropriate)	**1**	**2**	**3**	**4**	**5**
4 - Facilitative Behavior (Eye contact, open posture, verbal continuers)	**1**	**2**	**3**	**4**	**5**
5 - Transitional Statements	**1**	**2**	**3**	**4**	**5**
6 - Summarizing (Checks for accuracy including summarization)	**1**	**2**	**3**	**4**	**5**
7 - Diagnostic Evaluation and Counseling Summary (Explains diagnostic possibilities and recommendations, summarizes counseling issues)	**1**	**2**	**3**	**4**	**5**
8 - Closure of Interview (Asks about patient's understanding and willingness to comply, solicits questions, clarifies misunderstandings)	**1**	**2**	**3**	**4**	**5**
9 – Student Attitude	**1**	**2**	**3**	**4**	**5**
10 – Time Management	**1**	**2**	**3**	**4**	**5**
11 – Patient Comfort Measures (i.e. Draping, appropriate touch)	**1**	**2**	**3**	**4**	**5**
12 - Overall Performance	**1**	**2**	**3**	**4**	**5**

OSCE Rubric

OPENING OF INTERVIEW/GREETING

1	2	3	4	5
Begins awkwardly; interrupts patient before opening statement completed; fails to survey all concerns; does not inquire about patient's priorities for encounter.		Provides verbal greeting and shakes hands; introduces self; begins interview with open-ended opening question (e.g. "what brings you in?"); Interrupts patient before opening statement completed.		Provides verbal greeting and shakes hands; introduces self; begins interview with open-ended question (e.g. "what brings you in?"); allows patient to finish opening statement without interruption.

PRIMARY EMOTION/EMPATHY/RAPPORT

1	2	3	4	5
Student does not acknowledge primary emotion. Emotion, if identified is not restated/acknowledged to patient.		Student addresses primary emotion but has difficulty legitimizing or empathizing with patient's emotion.		Student addresses primary emotion, legitimizes, and successfully empathizes with patient's emotion. Student is ready to negotiate a contract.

QUESTIONING SKILLS

(types of questions, pacing, jargon, etc.)

1 2	3	4 5
The interviewer consistently uses leading questions, why questions, closed-ended questions, and multiple questions. Does not elicit characteristics of major symptoms (e.g. onset, duration. Questions asked and information provided during the interview are confusing because of the use of difficult medical terms and jargon. Questions are repeated multiple times. Pauses occur during information gathering which do not seem intentional. Pacing of questions seem rushed or inappropriate slow.	The interviewer often fails to begin a line of inquiry with open-ended questions and uses closed-ended and forced-choice questions excessively to obtain information. Elicits some but not all characteristics of major symptoms. (e.g. onset, duration. The interviewer occasionally uses medical jargon during the interview, failing to define the medical terms for the patient unless specifically requested to do so by the patient. Interviewer may occasionally pause non-intentionally, but this does not affect the pacing of the interview.	The interviewer starts information-gathering with open-ended questions. Closed-ended and forced-choice questions are used sparingly and only when appropriate to elicit or clarify specific facts. Elicits characteristics of major symptoms. (e.g. onset, duration. If there are pauses, they are used deliberately as an effective interviewing technique. (ie silence to facilitate) unless clarification or summarization of prior information is necessary. Questions asked, as well as information provided to the patient during the interview, are easily understandable; content is free of difficult medical terms and jargon. If jargon is used, the words are immediately defined for the patient. Language is used that is appropriate to the patient's level of understanding.

FACILITATIVE BEHAVIOR

1 2	3	4 5
The interviewer makes no attempt at encouraging and supportive gestures and remarks; body language is negative and closed; makes little or no attempt to maintain eye contact. Interviewer is detached data gatherer; inappropriate or awkward physical contact with patients.	The interviewer makes some use of encouraging and supportive gestures and remarks. Frequency of eye contact could be increased. Posture is closed—which present barrier to communication.	The interviewer uses encouraging and supportive gestures and remarks to facilitate communication (e.g. Uh huh, go on, I see). The interviewer makes good use of eye contact and avoids placing barriers (such as a desk) between self and patient, especially during discussion of sensitive or emotional issues. Open posture used (e.g. arms uncovered, leaning forward, When appropriate, physical contact is made with patient.

TRANSITIONAL STATEMENTS

1 2	3	4 5
The interviewer progresses from one subsection to another in such a manner that the patient is left with the feeling of uncertainty as to the purpose of the questions. (No transitions).	The interviewer sometimes introduces subsections with effective transitional statements, but fails to do so at other times. Some of the transitional statements used are lacking in quality, e.g., "Now I'm going to ask you some questions about your family."	The interviewer utilizes transitional statements appropriately between sub-sections, informing the patient why the information being sought is necessary and important, e.g., "Now I'm going to ask you some questions about your family, because we find it will help me to know what level of support is available to you at home."

SUMMARIZING (clarifying and documentation)

1	2	3	4	5
The interviewer fails to summarize any of the data given by the patient. The interviewer makes no attempt at clarification or verification of the patient's responses, accepting information at face value.		The interviewer sometimes summarizes data, primarily as a crutch to collect a train of thought or summarizes data only at the end of the interview. Interviewer uses summary as closure point even when items not clear. The interviewer at times will seek specificity, clarification and verification of the patient's responses, but not always. Questions are repeated not for the purpose of summarization or clarification of information, but as a result of the interviewer's failure to remember the data.		The interviewer summarizes the data obtained in an effort to verify and/or clarify the information, or as a precaution to assure that no important data is omitted. Summarization is specifically done at the end of the interview/examination. I and also at another point in the history as a clarification technique and to facilitate more historical information. The interviewer always seeks specificity, clarification and verification of the patient's responses, e.g.: P: "My knees hurt too much to exercise." I: "What types of exercise have you tried in the past? How long did you try it?”

Diagnostic Evaluation & Counseling Summary

(explains diagnostic possibilities and recommendations, summarizes counseling issues)

1	2	3	4	5
The student fails to explain their impression of what is causing your symptoms (leaves the room after performing the history and examination without further discussion). The student does not discuss any further evaluation or intervention recommendations.		The student explains that they will share the information they have gathered with another therapist and will return to discuss further intervention options, but does not offer their impression of your symptoms or primary concern.		Student explains what they feel is causing your symptoms or what they feel is most important to address during this interaction. The student explains what steps need to be taken to further evaluate your symptoms or treat your symptoms. The student recommends any further treatment is needed and the reasoning behind this recommendation. The student may express their lack of understanding of the diagnosis, but does explain what they feel may be causing your symptoms and further steps may be needed.

Closure of Interview

(asks about patient's understanding and willingness to comply, solicits questions, clarifies misunderstandings)

1	2	3	4	5
The student does not state what they feel is causing your symptoms and does not engage in conversation about their impressions.		The student states what they feel is the cause of your symptoms, but does not involve you in this discussion (i.e., does not question your willingness to comply with your treatment, nor engage in conversation to insure your understanding of the diagnosis and treatment).		The student ensures that you understand their impression of what is causing your symptoms. The student asks if you understand their impression and recommendations, and asks if you have any questions.

STUDENT ATTITUDE

1	2	3	4	5
Student seemed uninterested or "put off" during interaction. Student used inappropriate language or actions.		Student was nervous at beginning, seeming disconnected, but improved during interaction. Language and actions appropriate throughout interview.		Student was friendly, engaging, and appropriate. Seemed genuinely interested in patient.