About Minerva

Minerva is an 86-year old female seen for the first time in a post-discharge visit. She was hospitalized at Memorial Hospital with a congestive heart failure exacerbation complicated by bilateral leg edema and cellulitis. She was discharged home two days ago. History of multiple other admissions this past year for leg edema and cellulitis attributed to CHF; also one admission for UTI/ mental status changes. She has a history of moderate Alzheimer's disease with behavioral disturbances. Her dementia was diagnosed 6 years ago, but her behavior has worsened over the last 6-9 months.

Patient's son is her HPOA, history obtained from him via telephone. Patient's daughter lives with the patient and is main caregiver. Both son and daughter have noted increased forgetfulness, repeatedly asking the same questions, asking to eat soon after a meal, becoming agitated when personal care is performed, and increased frequency of verbal aggression (loud voice, foul language) and some physical aggression as well (swinging fist, pushing daughter away, or firmly grabbing her arm).

Demographic Intake Form

Patient information included here is fictional.

PATIENT INFORMATION

Name: Minerva Barbas
Address: 14851 St. Louis Avenue
Facility/Complex: ______ Room # ______
City: Joliet
State: IL Zip Code: ______
Primary Phone: (847) 555-3232
Secondary Phone: ______
Birth Date: 2/12/1934 O Male ✓ Female
Social Security Number: ___ – ___ – ___ *(helpful for billing)*

Marital Status:
O Married O Divorced ✓ Widow (er) O Single

Race:
✓ White
O Black or African American
O Asian
O American Indian or Alaska Native
O Native Hawaiian or Other Pacific Islander

Ethnicity:
✓ Hispanic
O Non-Hispanic

Lives alone: O Yes ✓ No
If no, who does patient live with: Daughter, Alicia Juarez

EMERGENCY CONTACT INFORMATION

Contact #1 Name: Alicia Juarez
Relationship to Patient: Daughter
Primary Phone: (847) 555-3232
Secondary Phone: (847) 555-5454
Contact you regarding visits/times/etc? ✓ Yes O No
Contact you with medical results/advice? ✓ Yes O No

Contact #2 Name: Ramón Barbas
Relationship to Patient: Son
Primary Phone: (847) 555-2121
Secondary Phone: ______
Contact you regarding visits/times/etc? O Yes ✓ No
Contact you with medical results/advice? O Yes ✓ No

RESPONSIBLE FINANCIAL PARTY INFORMATION

Name: Alicia Juarez
Address: 14851 St. Louis Avenue
City: Joliet
State: IL Zip Code: ______
Primary Phone: (847) 555-3232
Secondary Phone: (847) 555-5454
Relationship to Patient: Daughter

PRIMARY INSURANCE INFORMATION

(attach a copy of the front and back of insurance card)
Insurance Company: Medicare Part B

SECONDARY INSURANCE INFORMATION

(attach a copy of the front and back of insurance card)
Insurance Company: None

CURRENT/PREVIOUS PRIMARY CARE PROVIDER

Name: ______
Phone: ______
Fax: ______

OTHER INFORMATION

How did you hear about us? ______

Do you have home health? ✓ Yes O No
Agency name: Angels Home Health
Agency phone: ______

Durable medical equipment in the home? ✓ Yes O No
(List any medical equipment utilized such as bedside commode, walker, wheelchair, hospital bed, tube feeding pump, etc.)

Equipment	Supplier Name and Phone
Lift Chair	
Bedside Commode	
Standard Wheelchair	
Transport Wheelchair	
Walker	
NO Hospital Bed	

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HBPC Assessment Form

CHIEF COMPLAINT (CC)

Follow up from hospital discharge two days ago; admitted for congestive heart failure and cellulitis of her legs.

HISTORY OF PRESENT ILLNESS (HPI)

86- year-old female with history of recurrent leg swelling and cellulitis due to exacerbation of her CHF. History of moderate Alzheimer's disease with behavioral disturbances. Her dementia was diagnosed 6 years ago but her behavior has worsened over the past 6-9 months. Patient has become more forgetful, asking the same question repeatedly, asking to eat soon after a meal, becoming agitated when personal care is performed, and increased frequency of verbal aggression and some physical aggression as well. This morning at breakfast, the patient got upset and threw her glass of orange juice on the floor. History of admission for UTI and altered mental status.

PAST, FAMILY, AND SOCIAL HISTORY (PFSH)

HFrEF, EF 35%
Alzheimer's dementia with behavioral disturbance
CVA 5 years ago with mild residual dysphagia
CAD
HTN
CDK 3
Macular degeneration
Generalized osteoarthritis
Hypothyroidism
GERD
Breast cancer, s/p mastectomy, right
Recurrent UTIs

Immunizations: Influenza 9/18, Pneumovax 1/14, Prevnar 8/17, Tdap 1/14, Zostavax 6/17

Past Surgical History: s/p mastectomy, right

Family History: Mother died of MI in her 80's. Father with history of CAD, died of CHF in his 80's.

Social History: Retired housewife. Non-smoker, non-drinker, no illicit drug use. Patient lives with her daughter who is the primary caregiver. The patient's son is HPOA.

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REVIEW OF SYSTEMS (ROS)

Constitutional (e.g., general findings): Well developed, well nourished

Eyes: No redness, no discharge

ENT (ear, nose, mouth and throat): Possible hearing loss, per family's report

Cardiovascular: No chest pain or heaviness

Respiratory: Mild cough, no shortness of breath

Gastrointestinal (GI): No nausea, no vomiting, no abdominal pain, no constipation or diarrhea

Genitourinary (GU): History of frequent UTIs, but currently without hematuria or dysuria

Endocrine: History of hypothyroidism and taking medication for this condition

Musculoskeletal: Generalized aches and pains in her joints especially when weather is cold and/or rainy

Integumentary (Skin): Wound sacral area with some drainage

Neurological: Swelling of legs and history of recurrent cellulitis of legs

Psychiatric: History of dementia with agitation at times. Verbally and physically aggressive at times, especially when personal care if performed. Family noted patient's mood has been down recently.

Hematologic/Lymphatic: Recurrent leg swelling

Allergic/Immunological: No allergy symptoms reported recently

☐ All other systems reviewed and are negative

MEDICATION MANAGEMENT

Current Medications	Dosage	Current Medications	Dosage
Donepezil	10mg PO QHS	Hydrocodone/APAP	5/325mg PO Q6h PRN taking once or twice a day
Memantine	5mg PO BID	APAP	325mg PO Q6h PRN taking twice a day
Isosorbide	60mg PO QD	Levothyroxine	112mcg PO QD
Furosemide	40mg PO BID	Omeprazole	20mg PO QD
KCL	20mEq PO BID	Ocuvite	1mg PO QD
MgCl	64mg 2 PO BID	Multivitamin	1 PO QD
Metoprolol	25mg PO QD	Lisinopril	10mg QD

Allergies & Sensitivities: NKDA

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SCREENINGS	
Condition	**Screening/Questions/Resource**
Alcohol Abuse	AUDIT-C score of 0
Opioid Risk	Opioid Risk Tool Score of 1
Mobility, Balance, Walking, Fall Risk	Patient spends most of her time in bed; minimally ambulatory, can stand and pivot with hands on assist with gait belt.
Risk of Death and Functional Decline in Vulnerable Elders	
Additional ADL questions	Needs assist with all ADLs. Using adult incontinence product. Sponge bath given in bed.
Mood (Depression) Assessment	PHQ9 score of 14
Cognitive Assessment	Mini-Cog Score of 0
Condition	**Screening/Questions/Resource**
Environmental	Patient lives with daughter who is the primary caregiver. The home is clean and well maintained.
Nutrition	Daughter and son assist with grocery shopping and daughter prepares meals for patient. Patient's appetite fluctuates, some days better than other days.
Safety/Abuse	Yes No *Do you feel safe at home?* Yes No *Has anyone ever been physically or emotionally threatening to you?* Yes No *Signs of physical abuse present?*
Spiritual	Raised Catholic but has not attended church in years.
Caregiver	Short Form Zarit Burden Interview Score of 21 indicating high burden for daughter.

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SCREENINGS (cont'd)	
Social Determinants of Health (SDOH)	
Access to medical care, medicines, supplies	Patient depends on family members to pick up and administer medications.
Health literacy	
Family or social support	Patient lives with daughter and son visits patient every 1-2 weeks.
Communication capabilities *(phone, computer, video)*	Daughter and son both have smart phones and home has high speed internet service.
Preferred language *(potential barriers)*	English
Adequate housing and functioning utilities *(in COVID, separate bedroom for patient)*	There is separate bedroom for daughter.
Financial status	Lives on Social Security payments.
Transportation	Patient rarely leaves home due to severe mobility limitations.

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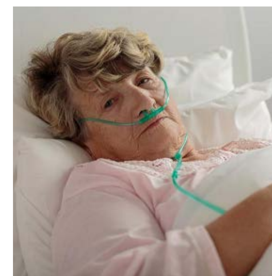

PHYSICAL EXAMINATION

Vitals: Blood Pressure, Pulse, Height, Weight, RR: BP: 136/62 P 65, irregular RR 12, T 97.9, 02 97% on room air

Constitutional (e.g., general findings): Alert, uncooperative at times with exam requiring redirection

Eyes: Anicteric sclera, no redness no discharge

ENT (ear, nose, mouth and throat): Impacted cerumen bilateral, removed with curette and forceps, patient reported improved hearing post procedure

Cardiovascular: Regular, normal S1, S2 without murmur

Respiratory: Clear to auscultation, decreased breath sounds bilaterally

Abdominal: Soft non-tender, bowel sounds normal active, no guarding, no rebound

Genitourinary (GU): No urinary catheter noted, no rashes

Endocrine: No thyromegaly noted

Musculoskeletal: Mild Flexor contracture knees, arthritic changes greatest knees and fingers DIP's

Integumentary (Skin): Sacral-coccygeal stage 4 pressure ulcer L 4cm x W 4cm x D 2.5cm with serous drainage, no undermining or tunneling, 75% of dressing saturation, 25% adherent yellow slough, 75% granulation tissue, non-malodorous, margins defined without maceration, or induration.

Neurological: Alert, speech clear, not consistently cooperative with commands. Can move all 4s. Limited exam regarding patient's muscle strength due to inconsistent cooperation.

Psychiatric: Flat affect, irritable at times but easily redirected

Hematologic/Lymphatic: 1+ edema bilaterally, with chronic venous changes noted bilateral legs

Allergic/Immunological: No rashes on skin

PATIENT PREFERENCES / GOALS OF CARE

Family desires advice on how to manage her heart failure and leg swelling in order to avoid trips to the ER/hospital. Family wants patient to get stronger, more mobile to reduce caregiving burden and help bedsore get better. Family want intervention to help with patient's mood and behavior. Family desire intervention to reduce frequency of UTIs.

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PROBLEM-BASED ASSESSMENT AND PLAN

List each condition, diagnosis, and/or symptom meaningfully assessed during this specific encounter:

Symptom and Diagnosis Related Assessment	Treatment Plan/Provider Recommendations

DISCUSSION QUESTIONS

1. **What Matters:** What are the patient/family preferences for care? What are the short-term and long-term goals? What else do you need to know?
2. **Mentation:** What interventions can be instituted in order to improve the patient's mood/mentation?
3. **Mobility:** Does Minerva need help with ADLs? Is she a fall risk? How can you help facilitate mobility and safety?
4. **Medication:** How complex is Minerva's plan of treatment, and how feasible will it be for her caregivers to follow? Would you consider making changes in Minerva's medications? If yes, what?
5. **Multicomplexity:** What makes Minerva a complex patient? What concerns do you have? What resources might be helpful?

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