Rural Geriatric Education and Mental Health Curriculum

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Module #1: Introduction to Teamwork

Overview: An interdisciplinary health care team brings together a group of individuals with diverse training and education to work on an identified task. These health care teams can include doctors, dentists, nurse practitioners and registered nurses, occupational therapists, pharmacists, physician assistants, physical therapists, social workers, nutritionists, and clergy. Team members collaborate to address patient problems that are too complex for one discipline, or even many sequential disciplines, to solve. At the most basic level, effective teamwork depends on the ability of members to determine the overall mission, establish shared and explicit goals, and work collaboratively to define and treat patient problems. Ideally, teams can also learn to accept and make use of disciplinary differences, differential amounts and types of power, and overlapping roles to clarify and evaluate the team's development and effectiveness. [1]

Learning Objectives:

1. Define an interdisciplinary team.
2. Describe the need for interdisciplinary teamwork.
3. Delineate three goals of an interdisciplinary team.
4. Describe two benefits and two problems unique to a team environment.
5. Identify three types of interdisciplinary teams.
6. Identify the various roles of interdisciplinary team members.

Content Outline:

I. Defining a "Team": The word "team" derives from Old English, and is defined as "a group of animals harnessed together to draw some vehicle". Today, there are many definitions and descriptions of teams, and the team 'concept' is broadly utilized in the corporate world, government agencies, and military organizations. For the purposes of this curriculum, however, we will focus on teams in the health care system.

A. Multidisciplinary vs. Interdisciplinary Teams. The terms **multidisciplinary** and **interdisciplinary** are often confused when referring to team structure and process in the health care setting. Members of a multidisciplinary team typically work together in caring for the patient, but only one team member, such as physician or nurse manager, makes the treatment decisions. On the interdisciplinary team, the decisions are made by the group.

The Multidisciplinary Team:

- Members represent different disciplines
- Members provide information towards decision-making
- One person (MD, Nurse Case Manager) makes the treatment decisions
- "Parallel Play"

The Interdisciplinary Team:

- Members represent different disciplines
- Members provide information and combine input into a common decision making process
- Decisions are made by a group
- "Group Play"

B. What is an Interdisciplinary Team? Here are three definitions of the interdisciplinary team that can help frame a discussion on teamwork:

1. "A team is a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable." [2]
2. "The interdisciplinary team is a group of persons who are trained in the use of different tools and concepts among whom there is an organized division of labor around a common problem with each member using his own tools, with continuous intercommunication and re-examination of postulates in terms of the limitations

provided by the work of the other members and often with group responsibility for the final product." [3]

3. "Teamwork can be broadly defined as a mechanism that formalizes joint action towards mutually defined goals." [4]

C. Trans-disciplinary Teams: Lately there has been a growing emphasis on "trans-disciplinary" (or "cross-disciplinary") teamwork. In these teams, which are rooted in the research and business worlds, members of different disciplines are not only proficient in their own specialties but also, through cross-training and working on the team, become knowledgeable in other specialties as well, making team members' skills overlap. Trans-disciplinary training and teamwork not only allow the provider to see a more complete picture of each patient, but also allow a single provider to assess and, in some cases, treat patients in an area other than his or her own.[5]

II. The Rationale for Teamwork

A. **The Advantages of Teamwork:** There are many strong reasons for teamwork. Chief among these is the fact that teams are client centered and helpful in addressing complex health and psychosocial issues such as in geriatric patients and those with life limiting illnesses. However, teamwork does require work and commitment from both the team members and the organization. For example, teams may be personnel and resource intensive, thus requiring commitment from institutional leaders. Furthermore, teamwork calls for tolerance and respect among members. Some health professionals shy away from teams because they have been members of teams which were dysfunctional for a number of reasons, including a lack of leadership, interest, structure, and process.

B. Better Care for Patients: Patients who are older or facing life limiting illnesses are best served by interdisciplinary teamwork as described below.

1. Within Geriatric Care: Older people are more likely to suffer from complex illnesses, and are thus best served by a team approach. The complexity of formulating a treatment plan entails addressing multiple illnesses, disabilities, medications, and procedures. Because geriatric patient care has often been uncoordinated, treatments may overlap or conflict causing great confusion. Therefore an interdisciplinary team can offer a comprehensive and integrated means of providing effective care.

2. Within End-of-life and Palliative Care: Traditionally, care at the end of life was administered solely by a physician. However patients requiring palliative care generally suffer from an advanced disease in which problems and symptoms are complex and urgent. There are many aspects to palliative care, such as pain

management, advanced directives, and the alleviation of psychosocial and spiritual distress. Therefore, interdisciplinary care planning and coordination is essential.

III. Goals of the Team

A. Guidelines: Team goals will oftentimes vary. However, the following general guidelines will facilitate effective teamwork and maximize patient outcomes.

1. Interdisciplinary team members agree on the mission.

2. The mission of the geriatrics team is viewed as realistic and achievable. If not, team members agree to narrow the mission to a workable size.

3. There is a clear team vision, and the group can progress steadily towards the established goals.

4. The purpose of the meetings, discussions, individual efforts and other activities is understood to relate to the larger project.[6]

IV. Benefits Unique to a Team Environment

A. Recent studies suggest that both patient and health care professionals involved in interdisciplinary teams experience many benefits.

1. The interdisciplinary team will have broadened access to resources – funds, research design development, data collection, computerized data management, statistical consultation and data analysis, grant writing, support staff, sustained communication, and costs of presentations and publication.

2. The accountability that each team member has to the others will increase timely completion of designated tasks and maintain quality standards.

3. Shared responsibility for completion of tasks and preparation of materials for dissemination will enhance the geriatrics team's level of productivity.[7]

4. Team meetings offer opportunities for informal contacts and feedback among the disciplines concerning patient care that is unrelated to the specific cases scheduled for discussion.

5. The meetings also allow ease of access to each other and reduce time needed for health care professionals to connect with each other about patient care.

6. It is highly probable that interdisciplinary geriatrics team care for the elderly will prove to be more cost-effective than traditional medical approaches.[8]

V. Problems Unique to a Team Environment

A. **Culture and philosophy of each discipline**: Every discipline has its own culture and philosophy toward geriatric patient care which can create misunderstandings and lack of sympathy by members of one discipline towards the members of another discipline. The culture also results in a specific language or jargon, which may lead to miscommunication. Until the members of the disciplines become familiar with these different nuances of meaning, difficulties may arise in both clinical and educational settings.

B. **Varying Qualifications**: Required qualifications for health care disciplines vary and can range from doctoral or fellow status to bachelor's degree or para-professional training. The differential status that is assigned by society because of educational attainment can influence how power and leadership are distributed on a team rather than actual knowledge, expertise or familiarity with the specific patient case.

C. **Scheduling and Time Constraints**: Health care professionals may divide their time between various locations. The logistics of bringing the disciplines together for team meetings or even of engaging in telephone contacts can be daunting, especially when the various disciplines tend to follow different scheduling patterns.[9]

VI. Types of Teams [10]

A. By composition: The University of Pennsylvania GITT planning year group identified five types of geriatric interdisciplinary teams based on their professional composition.

1. The Nurse-Dominated Team: This team consists of nurse practitioners, geropsychiatric clinical nurse specialist, registered nurses, physical and occupational therapists, speech and language pathologist, social worker, geriatrician, and psychiatrist. It is strongly patient-centered and focused on time-limited intensive rehabilitation of elders.

2 The Nurse-Physician Team: This team is composed of geriatricians, two nurse practitioners, and one social worker. It delivers community-based care in the patient's home and relies heavily on shared roles and informal mechanisms of communication and clinical management.

. 3. The Physician-Dominated Team: This team, which provides interdisciplinary assessment and primary care for older adults, consists of nine physicians, one registered nurse, two nurse practitioners, and one social worker. Patients are assigned to a physician and interact with other team members as appropriate.

4. The Social Work-Dominated Team: This team practices in an assisted living facility offering other levels of acute and skilled nursing home care. The team consists of an administrator, assistant administrator, social worker, physicians, nurse manager, and an activity coordinator. The team involves physicians as medical problems arise, but for the most part, social workers manage day-to-day care for these elders experiencing functional losses.

5. The Consensus Model Team: This type of team divides the facility into separate units, each of which is led by a nurse practitioner, in consultation with the medical director. It provides roles for a wide range of team members, including registered nurses, social workers, dietary staff, and recreational aides.

B. By Setting: There are also types of teams based on the location of care, given the fact that elders are often transferred from setting to setting.[11]

1. Hospital based inpatient team: Due to specific changes in medical status, patients are frequently admitted directly from the home, doctor's office, or the Emergency Department to a unit within the hospital. This hospital based inpatient team then provides acute care for the elderly within the hospital setting. Physicians and nurses perform an initial assessment, monitor the patient's health status by making rounds, and collaborate to formulate an effective treatment plan.

2. Ambulatory care team: The outpatient geriatrics interdisciplinary team is increasingly used for initial assessment and ongoing care coordination. Typically, the interdisciplinary team consists of a physician, nurse and social worker with the "extended team" comprised of representatives from rehabilitation therapy, psychiatry/psychology, nutrition and pharmacy. A comprehensive initial assessment includes evaluation by each of the three core team members -- physician, nurse practitioner and social worker -- with inclusion of other specialties on an as-needed basis. Some teams may assess patients on a quarterly basis with the team meeting more frequently for clients in acute care. Outpatient teams meet in a variety of ways, including face-to-face meetings, hallway conversations, and telephone consultations and increasingly through virtual means such as e-mail.

3. Emergency department team: This team, most likely not geriatrics-specific,

can consist of registered nurses, physicians and/or surgeons that provide acute care during a medical emergency. Because of the nature of the department, the patient's time with this team is limited. Therefore, it is imperative that the emergency department team ensures that care is properly transferred to a member of the patient's usual interdisciplinary team.

4. Home care team: This type of geriatrics team may include a social worker, a nurse practitioner, and/or a physician who make regular visits to the patient's residence to assist the patient's with his or her medical problems and to monitor the patient's ability to live at home. Because home care or hospice services enable the patient to remain in a familiar, comfortable environment with some degree of autonomy, this model of care is becoming increasing popular.

5. Nursing home team: Because the medical problems of elders are often chronic, complex and sometimes accompanied by limited cognitive capacity, older adults are not always able to continue living at home. When this occurs, the nursing home provides a setting for an interdisciplinary geriatrics team to monitor and treat the chronic illnesses of frail patients on an ongoing basis.

6. Palliative Care Team: The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care is both a philosophy of care and an organized system for delivering care. Comprehensive palliative care services often require the expertise of various health care professionals in order to adequately assess and treat the complex needs of seriously ill patients and their families. Members of a palliative care team may include professionals from nursing, medicine, social work, chaplaincy, nutrition, rehabilitation, pharmacy as well as other disciplines. Trained volunteers are sometimes part of palliative care teams as well.. Team leadership, collaboration, coordination and communication are key elements for effective integration of these disciplines and services. [12,13,14,15]

7. Community-based assessment teams: Elderly persons in rural areas are less willing to seek mental health care, despite the fact that they have a greater need for the services which may be available to them. The reasons for this behavior include factors associated with rural life, including poorer health status, greater poverty, and lack of specialized providers. One strategy which has been shown to increase the utilization of services in rural areas is a mobile multidisciplinary team of a psychiatrist or psychologist, nurse, and social worker that conduct in-home mental health assessments.[16]

VII. Geriatric Care Teams

A. **Geriatric teams** can be confined to one setting, such as a hospital unit, or span various settings, such as a geriatric consultation team. One of the major challenges in effective teamwork is ensuring successful transitions as the patient moves from setting to setting along the care continuum.

B. Typical Settings for Geriatrics Teams: Geriatric teams can be found in a multitude of settings, including just about any facility or agency that provides services for the elderly can utilize this approach. Long-term care facilities; in-patient and outpatient mental health care agencies, home care agencies and facilities or agencies providing palliative care are all typical settings for Geriatric teams.

C. Team Members: Professional Roles, Education and Skills: See attached chart, "Houston Geriatric Interdisciplinary Team Training Manual: Team Members Overview" (Appendix A)

VIII. Development of a Team

A. **It's a Process**: Becoming a team is a process in which missions and tasks are defined and the members define their roles and relationships.

B. **Phases of team development:**

- Forming- creation stage of the group
- Norming- norms and patterns are worked out
- Storming- Tasks and roles are worked out through conflict
- Performing- Team working together for improved patient care

For expanded explanation of the above, refer to the handout from the University of Colorado Health Sciences Center's Geriatrics Interdisciplinary Team Training Workbook: "Forming, Storming, Norming, and Performing"[17] (See Appendix B)

C. **Repeating the Process**: Each time the team composition changes, the process of team development is repeated. Particular attention must be given to the orientation of new team members.

IX. Different Roles Within a Team

A. Team Functions: Aside from the professional role as described in Section IX above, various team member also fulfill certain informal, but critically important, team functions and responsibilities. The assumption of these responsibilities for the group 'process' ensures that team decision-making, as well as care plan implementation, proceeds smoothly and efficiently. (See Table 1: "Functions of Different Roles Within a Team")

Table 1: Functions of Different Roles within a Team:

ROLE	RESPONSIBILITIES
Facilitator	Leads the team through the agenda and the consensus making process.
Recorder	Writes down the team's decisions. Checks to make sure that what everyone hears is what the team member means.
Timekeeper	Watches the clock. Informs the team when half of the allotted time has expired, when only five minutes remain, and when time is up.
Encourager of Individuals	Encourages other members to express their ideas. Asks individuals what they think.
Initiator	Expresses his or her ideas. Gets the discussion going. Allows others to speak and then initiates again.
Summarizer	After two or three people have spoken, tries to summarize what has been said thus far. Should be done more than once.
Elaborator	Elaborates on a point someone else makes. Clarifies the point and adds to it.
Compromiser	Looks for the common ground between team members who disagree with one another. States the compromise position that he or she sees to the team.
Supporter	Shows acceptance and support for ideas and opinions that may differ from the majority.
Consensus Taker	Listens for the emergence of positions that the whole team can accept. States the position and sees if everyone on the team agrees.
Gatekeeper	Watches for members who are trying to speak but are cut off by others. Calls on the member to speak. Asks others to wait.
Encourager of Team	When the team is having difficulty making decisions, expresses his or her belief that a compromise can be found. Gives energy to the team.

SOURCE: "Assessing Your Skills in Team Leadership", Howard Garner, 1999. Virginia Commonwealth University, Richmond, Virginia.

X. Team Leadership

A. Shared Leadership Roles: Although one or more individuals may have a formal designation as group leader or facilitator, teamwork is most effective when all members are willing to share the responsibilities of leadership. Such responsibilities can include:

1. Scheduling, arranging and conducting meetings.
2. Preparing agenda and ensuring that it is followed during the meeting.
3. Helping to clarify and identify team goals.
4. Identifying common topics and summarizing the ideas discussed to maintain direction of discussion.
5. Encouraging everyone to participate throughout the discussion.
6. Ensuring that all team functions are assigned to various team members.
7. Emphasizing the importance of being open to new and different ideas without becoming immobilized by conflict.
8. Making the group aware of its own resources and how best to use them.
9. Helping the group evaluate its progress and development.

XI. Team Meeting Process

A. Guide to meeting process: The following seven-step meeting process provides a guideline for facilitating an effective interdisciplinary team meeting with optimal outcomes for the patient:

1. Clarify objectives
2. Review roles
3. Review agenda
4. Work through agenda

5. Plan next steps

6. Evaluate meetings

XII. Team Communication [6,18]

A. Importance of effective communication. Particularly in an interdisciplinary setting where team members do not always possess a basic understanding of each other's knowledge, skills and professional and personal values, it is possible that *misunderstandings will result*.

B. Encouraging and Reinforcing Responses

1. Be *succinct* and avoid long anecdotes or examples.

2. Make an effort to use positive *body language* such as head nodding, eye contact, and leaning toward the speaker.

3. In order to show interest, *repeat one or two key words from the person's last sentence*. This encourages the speaker to continue talking and enhances his or her sense of being heard.

4. To ensure that the message is understood, *paraphrase and reflect* by repeating a person's statement in his or her own words.

5. *Avoid using technical jargon if possible*; if a condition is best described in technical terms, however, members should make sure that everyone on the team understands those terms.

XIII. Resource Material

The following is a list of resources selected from material provided by the John A Hartford Geriatric Interdisciplinary Team Training Program (GITT)

1. GITT Implementation Manual. Hyer K, Flaherty E , Fairchild S, Bottrell M , and Fulmer T . This comprehensive manual provides summary information about the National Geriatric Interdisciplinary Team Training Initiative funded by the John A. Hartford Foundation, Inc. Drawing on lessons learned and materials provided by the eight sites, content includes information critical for the development, implementation and evaluation of a successful GITT Training Program. Chapters address such topics as institutional planning, structuring didactic and clinical practicum training, and assessing the effectiveness of GITT training.
(http://www.gitt.org/products/products.htm.)

2. GITT Curriculum. Hyer K, Flaherty E, Fairchild S, Bottrell M, and Fulmer T. A cross-site curriculum includes six chapters with teaching resources on: teams and teamwork, care planning, ethics and teams, communication and conflict resolution, multiculturalism, and team member roles and responsibilities. More information about this can be found on their web site. (http://www.gitt.org/products/products.htm.)

3. Geriatric Interdisciplinary Team Training: A Curriculum from the Huffington Center on Aging at Baylor College of Medicine: Long D and Wilson N (Eds.) (2000). This curriculum includes materials in hard copy text format, and floppy disks that contain 9 chapters of core geriatric interdisciplinary team topics, along with training resources, a PowerPoint slide floppy disk, a CD-ROM that includes embedded hot links, and video and audio sections covering the nine core geriatric interdisciplinary teams interacting around four different cases. (To order or for more information, contact the Huffington Center on Aging through their website:http://www.hcoa.org, or by phone: 713-798-5504)

4. **Geriatric Interdisciplinary Team Managed Care Training of Trainers Program: Kaiser Permanente and the University of California-Los Angeles (1997).**
This training curriculum was developed to prepare facilitators for team training and includes five content areas: principles of team care, team stages, structure and leadership, information sharing and communication, problem solving, and conflict management and evaluation. A training manual includes student handouts, trainers' notes and brief team lessons. (To order a copy, contact Pamela Jackson-McCall, California Geriatric Education Center, UCLA School of Medicine, 10945 Le Conte Avenue, Suite 2339, Los Angeles, CA 90095-1687)

5. **Mount Sinai Geriatric Interdisciplinary Team Training Resource Manual.** This 74-page manual provides information on Geriatric Interdisciplinary teamwork for preceptors, faculty, and trainees. It is a compilation of material developed by GITT sites

around the country and includes an overview of roles and responsibilities of team members, case studies, exercises, teambuilding games, readings, and web resources. (Contact Kristy Kime at 212-241-6353)

6. Geriatric Interdisciplinary Team Training Workbook. Miller, C. L., (1999). This workbook consolidates key interdisciplinary health science team principles into five objectives to be practiced and learned in this GITT course. The five learning objectives are: goal and process, roles and responsibilities, structure and process to outcome, client/family's interests, and verbal and non-verbal behaviors. (To order a copy or for more information, contact Ernestine Kotthoff-Burrell at 303-315-8234 or by email at ernestine.kotthoff-burrell@UCHSC.edu)

XIV. Geriatric Training Tools

A. Hospice/Palliative Care Training for Physicians: UNIPACS 1-5: A series of self-study curricula developed by The Academy of Hospice and Palliative Medicine. *UNIPAC Five, Caring for the Terminally Ill: Communication and the Physician's Role on the Interdisciplinary Team* has been successfully used in HGITT workshops. (For more information, contact Kendall/Hunt at http://www.kendallhunt.com or by calling: 1-800-338-8290)

B. Geriatric Syndrome Learning Modules. The Great Lakes GITT Team developed four curriculum modules on the geriatric syndromes (end of life treatment goals, urinary incontinence, delirium and falls) using an interdisciplinary approach for in-depth study. (Available online at http://www.129.22.12.42/framea.html or by contacting the Great Lakes GITT)

C. Geriatrics at Your Fingertips. A small (4"x 6") portable booklet designed so that practicing clinicians spend a minimum amount of time searching for specific information. It provides assessment instruments, recommended diagnostics tests, and management strategies. Published by the American Geriatrics Society through Kendall/Hunt. (More information can be found at http://www.americangeriatrics.org or by calling 1-800-247-4779. It can also by ordered ($9.95) by calling Kendall/Hunt at 1-800-338-8290)

D. Core Curriculum in Ethnogeriatrics, 2nd Ed. This curriculum was developed by the members of the Collaborative on Ethnogeriatric Education. It includes five modules covering culturally appropriate geriatric care: Overview, Patterns of Health Risks, Knowledge, Assessment, and Health Care interventions. (The modules can be downloaded in Adobe Acrobat format from the website: http://www.stanford.edu/group/ethnoger)

XV. Multimedia Resources

A. Geriatric Medicine Self-Instruction Modules. Now in its third edition, this Windows-based CD-ROM contains 17 self-paced multimedia modules on topics important in geriatric care, including HGITT's interdisciplinary teams. Hot links embedded in text and graphics, plus animation, video, and audio allow the users to progress through the clinical topics at their own pace and "toward" specific material that they wish to access. Modules include learning objectives, self-tests, up-to-date educational content, case studies, patient information materials, and references. This CD was developed by Thomas A. Teasdale, Dr. P.H., through the John A. Hartford Foundation Geriatrics Residency Training Initiative. Dr. Teasdale is an assistant professor in the Department of Medicine at Baylor college of Medicine in Houston and affiliated with Baylor's Huffington Center on Aging.

These modules were developed in response to medical residents' requests for more geriatric content in this program. The modules use an interdisciplinary approach for in-depth study and discussion of the topics by the teams of practitioners and students.

Some titles of modules included in this CD-ROM are: Geriatric Assessment, Falls and Mobility, Hormone Replacement Therapy, Confusion, Involuntary Weight Loss, and Elder Abuse.

The format used for the modules includes:

- A case study
- An interdisciplinary discussion guide
- Learning assessment questions
- Articles on the topic from the literature of the primary disciplines

(Currently, production is underway for the fourth edition. More information can be found at http://www.hcoa.org/hcoa)

B. **GITT Videos/Scripts.** These video scripts include the text of five 5-minute videotaped geriatric interdisciplinary team meetings developed by the GITT Case Studies Work Group. The scripts are found on the web at http://www.gitt.org. Actual videotapes of the meeting are available from the GITT Resource Center at New York University. Each script includes multiple clinicians and a variety of clinical issues and examples of positive and negative team behaviors in the domains of: meeting behavior/style, conflict management, teaching/learning, leadership style, defining the patient/family problems, and recognition of roles of professionals, patient and family. Questions for students to consider are provided after each videotape.

General Teaching Guidelines:

- Identify key issues and questions for trainees to focus on during video viewing
- Show video

- Have students discuss their responses to questions for students in small groups
- Conduct large group discussion with students

C. The Colorado Geriatric Interdisciplinary Team Training (GITT) Project Videotape and Guide. This video presents a case from patient interview through the team meeting used to develop a care plan. The accompanying video guide provides the objectives, learning points, and discussion questions. (To order a copy or for more information, contact Ernestine Kotthoff-Burrell at 303-315-8234, or by email at ernestine.kotthoff-burrell@UCHSC.edu)

D. GITT Pocket Cards. These downloadable "interdisciplinary team training pocket cards" were developed by GITT Special Interest Groups and designed to help clinicians work in teams. Topics include: 8 Principles of Successful Teamwork, a 7-Step Meeting Process, how to be an effective team member, team dynamics checklist, and guidelines for using different conflict handling styles. (Cards are available through the New York University GITT Resource Center at http://www.gitt.org/products.html)

E. **GITT Nurse Practitioner Clinical Preceptor Guide.** This 3-fold clinical preceptor guide was developed by the GITT Nursing Special Interest Group. It describes the role of the preceptor, microskills for clinical teaching, setting up expectations for student performance and expected progression of a nurse practitioner student from beginning through advanced. (Guides are available through the New York University GITT Resource Center at http://www.gitt.org/products.html)

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APPENDIX A

Houston Geriatric Interdisciplinary Team Training Manual: Team Members Overview*

Discipline	Practice Roles/ Skills	Education/ Training	Licensure/Credentials
Nurse	Licensed vocational nurse (LVN)- basic nursing skills that are dictated by the facility; and under the supervision of a registered nurse (RN)- associate degree, BS or higher. RN has increased scope of practice, including planning for optimal functioning, coordination of care, teaching, and direct and indirect patient care.	LVN- 1 year of training; RN with associate degree- 2 years of training, usually in a community colleges; BS, RN- 4 years in college: MS/MA, RN-2 years of graduate specialty study; PhD/DNSc/EdD. RN- 3 to 4 years of doctoral studies.	LVN – exam required for licensing, CE requirements in some states. RN- can be RN; BS, RN; APN; MS, GNP or other specialty RNs; PhD RN: all must pass the national licensure exam and in some states are required to have a prescribed number of CEUs per year. In New York, CEUs are not required.
Nurse Practitioner	Health assessment, health promotion, histories and physicals in outpatient and acute/home/long-term care settings; order, conduct, and interpret lab and diagnostic tests; prescribe medications, teaching and counseling.	Master's degree with a defined specialty area such as gerontology (GPN) or a post-master's certificate program.	In addition to RN licensure, NPs pass a National Certification Exam in the appropriate specialty area (e.g. gerontology or family practice). In New York, NP is licensed as an RN and certified by the State Education Department as an NP.
Physician	Diagnose and treat diseases and injuries, provide preventative care, do routine checkups, prescribe drugs, and perform some surgery.	Physicians complete medical school (4 years) plus 3 to 7 years of graduate medical education.	State licensure required for doctor of medicine degree; exam required and possible exams required for specialty areas. CE requirements.
Geriatrician	Physician with special training in the diagnoses, treatment, and prevention of disorders in older people; recognizes aging as a normal process and not a disease.	Completion of medical school, residency training in family medicine and internal medicine, and 1-year fellowship program in geriatric medicine.	Completion of fellowship training program and/or passing examination for Certificate of Added Qualifications in Geriatric Medicine. (CAQ). Re-certifications by examination required every 6 years.
Physician Assistant	Practice medicine with the supervision of licensed physicians; exercise autonomy in medical decision-making and provide a broad range of diagnostic and therapeutic services; practice is centered on patient care.	Specially designed 2-year PA program located at medical colleges and universities. Most have bachelor's degree and over 4 years of health care experience before entering a PA program.	State licensure or registration plus certification by NCCPA. Re-certification every 6 years by examination. Requires 100 hours of CME every 2 years.

Social Worker	Assessment of individual and family psychosocial functioning and provision of care to help enhance or restore capacities; this can include locating services or providing counseling.	There is a 4-year college degree (BSW); 2 years of graduate work (MSW), and doctoral degree (PhD); 15 hours of continuing education is required every year.	The LMSW (for master's level); LSW (BS level); SWA is a social work associate with a combination of education and experience. ACP- signifies licensure for independent clinical practice. In New York, after obtaining the MSW, a social worker may take the state licensing examination and, if successful, is recognized as a certified social worker (CSW).
Psychologist	Assessment, treatment, and management of mental disorders; psychotherapy with individuals, groups, and families.	Graduate training consists of 5 years beyond undergraduate training; most coursework includes gerontology and clinical experience.	PhD Or EdD or PsyD are degrees awarded. State licensure; the American Psychological Association has ethics codes as do most states.
Psychiatrist	Medical doctors who treat patients' mental, emotional, and behavioral symptoms.	Medical school and residency specializing in psychiatry. Residency includes both general residency training and 2 to 3 years in area of specialization (e.g. geriatrics, pediatrics).	State exam to practice medicine; board of Psychiatry and Neurology offers exam for diplomat in psychiatry.
Pharmacist	Devise and revise a patient's medication therapy to achieve the optimal regime that suits the individual's medical and therapeutic needs; information resource for the patient and medical team.	Pharmacists can receive a baccalaureate (B.S.) – 5-year program; or doctorate degree (PharmD). Annual CEUs required range from 10-15 hours.	National exam (NABPLEX); given every quarter; board certifications in specialties available (pharmacotherapy, nuclear pharmacy, nutrition, psychiatric and oncology in near future).
Speech-Language Pathologist[19]	Assessment and treatment of full range of speech, language, and swallowing disorders; functions within ambulatory or inpatient clinical settings; provides individual or group therapy to maximize individual's functional communication and swallowing ability	Masters Degree and completion of 9 month Clinical Fellowship Year (CFY) post-M.A./M.S. required to practice nationwide. Annual CEU's required.	CCC-SLP (Certificate of Clinical Competence in Speech Language Pathology) awarded by American Speech Language Hearing Association following completion of National Examination (NESPA) and CFY. State licensure required in 45 states
Audiologist[19]	Identification, assessment, and management of auditory and balance disorders; audiological rehabilitation; selection, fitting, and	Masters Degree and completion of 9 month Clinical Fellowship Year (CFY) post-M.A./M.S. required to practice	CCC-A (Certificate of Clinical Competence in Audiology) awarded by American Speech Language Hearing Association

	dispensing of amplification systems; consumer education	nationwide. Annual CEU's required.	following completion of National Examination (NESPA) and CFY. State licensure required in 47 states
Occupational Therapist	One who utilizes therapeutic goal-directed activities to evaluate, prevent, or correct physical, mental, or emotional dysfunction or to maximize function in the life of the individual.	BS or MS in OT with a minimum of 6 months of field work; for OT assistant, an associate degree or OT assistant certificate is required with a minimum of 2 months' fieldwork. 36 PDUs are required every 3 yrs.	National certification exam required for the credential of OTR. (Occupational Therapist Registered). Exam also required for COTA (Certified Occupational Therapy Assistant). These computerized exams are given year-round.
Physical Therapist	The evaluation, examination, and utilization of exercises, rehabilitative procedures, massage, manipulations, and physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound in the aid of diagnosis or treatment	Entry level graduate degree (masters or doctorate) in physical therapy is required to sit for the licensure exam. Requirements for CEUs vary state by state.	PT is the credential that is used by licensed physical therapists and PTA is the credential for licensed physical therapist assistants. To use either of these titles, one must pass a state exam..
Chaplain	Provide visits and ministry to patients and family.	Master's degree in theology, plus a minimum of 1 year of clinical supervision, if fully certified. Can work in some settings without being fully certified.	Certification is through the Chaplaincy Board of Certification – credentials for this are BCC; however, credentials are not normally used. Most chaplains are ordained ministers, but not all. CEUs required are 50 hours per year.
Dietitian	Evaluate the nutritional status of patients; work with family members and medical team to determine appropriate nutrition goals for patient.	BS in food and nutrition and experience are required to be eligible for exam; CEs are required for both the LD (6 clock hours/year) and RD (75 clock hours year every 5 years); MS degree available also.	RD is the credential for a registered dietitian. For RD, must pass the national exam of the American Dietetic Association; LD is the credential for a licensed dietitian; same exam is required but processing of paperwork/fees is different.
Client/Patient	Consumer	Provide information necessary for assessment planning of care. Bring their needs and perspectives on illness, treatment and what they view as the major goals of care. Care goals must be endorsed by the client/patient in order to achieve successful adherence to a therapeutic	Illness - Cognitive status – Important to remember that while global decision-making may be diminished; capacity in specific areas can be retained. While unable to manage financial matters, may retain ability to determine end-of-life decisions.

		plan.	
Family caregiver Spouse/Children	Consumer Advocate for client Provider of direct care	Provide a wealth of information regarding the client/patient - pre-illness functioning, hobbies, interests, and concerns. Offers direct input about ability and willingness to assist in care.	May not have detailed knowledge of disease process or the roles and function of the professionals on the team. May not live close to the client. Family history and/or dynamics may interfere with knowledge of client and ability to participate.
Caregiver outside family/Neighbor/ Friend	Advocate for Client Provide direct care for client	Provide information regarding the client/patient - pre-illness functioning, hobbies, interests, and concerns. Offers direct input about ability and willingness to assist in care.	May not be identified.

*This chart has been adapted; Texas-specific information was deleted and New York-specific information was added; Speech-Language Pathology and Audiology disciplines were also added.

Reproduced from Geriatric Interdisciplinary Team Training: A Curriculum from the Huffington Center on Aging at Baylor College of Medicine, edited by Dianne M. Long and Nancy L. Wilson (New York: John A Hartford Foundation, Inc., 2001).

APPENDIX B

From the University of Colorado Health Sciences Center's Geriatrics Interdisciplinary Team Training Workbook:

Forming, Storming, Norming, and Performing

A. **Forming:** creation of the feeling of being a group through a transition from individual to group member status.

1. Goal of this stage is to reduce ambiguity and discover acceptable interpersonal behaviors and actions of the other group members.

2. Members get to know each other.
   a. Superficial sharing of name and background information
   b. Sizing-up -and testing each other
   c. Categorization of one another, with outside-of-team roles and status determining team roles
   d. Relationships are guarded, more impersonal than personal.

3. Uncertainty regarding purpose
   a. Attempt is made to define task and methods.
   b. Lofty, abstract discussions of concepts and issues are common.
   c. Discussion of problems related to team function are common.
   d. There may be difficulty in identifying the problems, which are most relevant to the team's purpose.
   e. Complaints about the organization and the barriers to accomplishing tasks begin to surface.

4. Goal formation should be the primary task.
   a. A shared sense of mission is needed to establish the basic conditions required for cooperation, collaboration and interdependent function.
   b. Goals provide a rationale for the team's development.
   c. Goals provide incentive for team members to re-prioritize individual and discipline interests.

5. Conflict is usually neither discussed nor addressed at this stage of development.

B. **Storming:** Most difficult and conflictual stage. Task and roles begin to be perceived as different and more difficult than members originally anticipated.

1. Goal of this stage is to resolve the internal conflicts and focus on the task at hand.

2. Difficulty in understanding the goals and purpose of the team; attempt to establish common goals

3. Role overlaps become evident.
4. Concerns about excessive workload.
5. Conflicts are present but are covered up or glossed over.
6. Arguing among members is common, even when they agree on basic issues.
    a. Questioning the wisdom of those who selected this project and appointed the members of the team.
    b. Defensiveness and competition lead to development of factions, sides are chosen.
    c. The implicit or explicit hierarchy, which had developed earlier, is often challenged, which commonly leads to disunity, tension, and jealousy.

C. **Norming:** The establishment of norms and patterns for regulation of the group process, reconciliation of competing loyalties and responsibilities, and acceptance of roles and team rules.

1. The goal of this stage is to develop cohesiveness and overcome any resistance in an effort of pulling together.
2. Establishing and maintaining ground rules and boundaries
    a. Attempt to achieve harmony by setting norms -and avoiding conflict.
    b. Determine norms for acceptable group behavior and methods for dealing with group problems.
    c. More friendliness begins to be seen, with members confiding in each other, sharing personal problems, discussing the team's dynamics.
3. Preliminary agreement on shared goals is usually achieved.
    a. A sense of team cohesion develops, with a sense of purpose and common goals.
    b. Decision is made as to what information needs to be gathered.

D. **Performing:** When a strong sense of group identity and each member's role is developed, useful work can finally be consistently performed.

1. The goal of this stage is to resolve structural issues and generate energy to the task at hand
2. Focus of group meetings is on problem solving.
    a. Relationships and expectations are finally clear.
    b. Common goals for patient outcomes are agreed upon across disciplines.
    c. A mechanism exists that enables all to contribute and share information essential for effective patient care.
    d. Protocols are established which ensure that care plans are implemented, services are coordinated, and the performance of the team is evaluated.

3. Conflicts begin to be seen as normal and are used as impetus for improvement.
    a. Differences are generally understood and appreciated.
    b. Each member recognizes, accepts, and respects the roles of the others.
    c. Mechanisms for conflict management are in place.

E. **Bringing new team members on board** (Rubin, et.al, 1975)

1. Invest time in the joining-up process. Don't expect that a new member can be brought up-to-speed immediately. It is not a "one shot" effort but an effort over time. Don't expect too much from the newcomer right away.

2. Orientation is best accomplished through face-to-face interactions between the team members and the new member. Written materials alone are an inadequate orientation.

3. Orientation should include:
    a. Team goals
    b. Team members and their roles and responsibilities
    c. Team functioning: problem solving, decision making, conflict resolution
    d. Unique aspects of the team

4. If adequate time is not taken to incorporate a new team member, the following may occur:
    a. New members will experience considerable confusion and uncertainty about the way many of the things which you have learned to take for granted are supposed to be done on the team.
    b. Old members will experience disappointment in the new member who does not seem "to know anything" and may be hesitant to use the new member's resources.
    c. Morale, satisfaction, and productivity may be reduced.
    d. The new member might quit because he never quite felt like s/he belonged on the team.

F. **Adjourning:** When either a member leaves the team or the team disbands, the termination process is important.

1. Individual leaves
    a. Team and departing member may avoid the difficult and unpleasant work of termination.
    b. Depending on the circumstances, the team and the departing member may feel anger, disbelief, anxiety, relief, etc.
    c. The team may place subtle pressure on a member not to leave group.
    d. Team may regress to an earlier phase of team development.

2. Team terminates
   a. Teams may decide to disband (i.e., conflicts within team) or they may be forced to disband for external reasons (i.e., need no longer exists, funding for group is no longer available)
   b. When team-disbands, members experience a sense of loss. To deal with feelings of loss and anxiety team members tend to avoid these feelings in a number of ways: withdrawal, devaluing the importance of the team, anger toward the team leader or other team members, silence and inactivity, leaving the team prematurely.
   c. Feelings are expressed as testimonials (i.e., review of team's accomplishments or outstanding contributions of individuals to the team)
   d. Team membership is affirmed as a valuable experience

3. Termination issues need to be addressed
   a. Review the team's/departing members experience and goals. Verbalize what has been accomplished
   b. Formally acknowledge the change by allowing team members to say their good-byes and plan for the transition.
   c. Address feeling of loss, anger, or relief rather than avoiding them
   d. Finish unfinished business with the departing member/the whole team
   e. Give feedback to each other on what they have learned
   f. Generalize what has been learned from the team experience so that it can be applied elsewhere.
   g. Notify patients of the team disbanding or change in team composition. Acknowledge loss for patient. Reassure patients that their continued care (by individual providers or the remaining team) is addressed.

Rural Geriatric Education and Mental Health Curriculum

Module #2: Introduction to Geriatrics

Rural Geriatric Education and Mental Health Curriculum

Module #2: Introduction to Geriatrics

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Rural Geriatric Education and Mental Health Curriculum

Module #2: Introduction to Geriatrics

Overview: Our country is on the brink of a longevity revolution. The elderly population in the United States is growing rapidly in comparison to younger age groups. By 2030, the number of older Americans will have more than doubled to 70 million, or one in every five Americans. By 2050, that number will grow to 80 million Americans over 65, with 18 million over 85 years of age.

It has also become evident that not only is the population aging, but also that most older adults can expect to develop one or more chronic illnesses with which they may live for many years, often with physical and psychological symptom distress and progressive functional dependence and frailty. The growing number and proportion of older adults will therefore place increasing demands on the public health system and on medical and social services.

Chronic diseases exact a particularly heavy health and economic burden on older adults due to associated long-term illness, diminished quality of life, and greatly increased health care costs. Although the risk of disease and disability clearly increases with advancing age, however, poor health is not an inevitable consequence of aging. Geriatricians use the term "healthy agers" to describe the large population of highly functional community dwelling older adults. Even in the face of serious and chronic illness, these individuals remain physically and mentally active and socially engaged with family and friends

Learning Objectives:

1. Discuss the demographic imperative for increased care of the elderly.
2. Identify the living arrangements and sites of care for the older population.
3. Differentiate between normal aging and diseases.
4. Discuss myths and stereotypes about aging.

I. The Demographic Imperative for Increased Geriatric Care

A. U.S. population is aging. The older age group (65+) is growing rapidly and there is an increased need for practitioners with geriatric training.

1. As of 2003, 35.9 million people reached 65 years of age. This was an increase of 9.5% from 1993.[i]

2. The world's annual growth rate for the geriatric population is 1.5% compared to the annual growth rate for adults 65+, which is 2.7%.[ii]

3. There were 50,639 people aged 100 or more in 2003, which is a 36% increase from 1990.

4. See attached US Department of Health and Human Services, Administration on Aging, "A Profile of Older Americans: 2004" for an overview of the older population in the United States with respect to living arrangements, racial and ethnic composition, income, employment status and other indicators.

B. Previous demographic trend: Growth rate of the aging population had slowed due to a decrease in birth rates during the Great Depression.

C. Factors leading to current increasing numbers of older Americans: The older population will grow exponentially between 2010 and 2030 as the "baby boomers" reach 65. This rapid increase is due to a global decline in mortality rates, higher post-war fertility rates, improved medical technology, and increased life expectancy.

II. Living Arrangements and Sites of Care

A. Community predominates: The majority of the elderly live in the community (87%).

B. Impact of gender: Of all nursing home residents, 72.2% are women. This is due to the fact that women live longer and are more likely than men to have lost a spouse and live alone.[iii] Additionally, the major reason for admittance to nursing homes is FALLS, resulting in some type of fracture. As women are 4 times more likely to suffer from osteoporosis than are men, they are therefore more susceptible to hip fractures and the frequent complications which follow.

C. Demographics of older adults and their living arrangements:[iv]

1. An estimated 70% of older adults live in privately owned single-family housing.

2. 67% of non-institutionalized older adults live in a family setting.

3. 22% of U.S. households are headed by people 65 years and older.

4. 49% of older women are widowed and live outside of a family setting.

5. Approximately 300,000 older adults reside in "board and care" homes.

6. An estimated 300,000 older adults reside in assisted living residences, most of which are for-profit operations.

7. Approximately 350,000 older adults reside in "life care" or continuing care retirement communities (CCRC's).

8. Of those people over the age of 65, slightly less than 5% (approximately 1.5 million) are in nursing homes.

9. Universally, older adults prefer to receive health care in their home or some kind of home-like environment rather than a nursing home.

D. Definitions: Living arrangements and services that are available to older adults: [v]

1. Own domicile: with or without home-based or community-based support.

2. Independent Housing: apartments designed to enable the older adult to live independently.

3. Enriched Housing: is a specific kind of "adult care facility" that provides independent housing with light housekeeping and laundry services and congregate meals.

4. Shared Housing: older adults can share their home, or share the home of another who may or may not be an older adult.

5. Senior Communities: this type of community restricts entry to people who are at least 55 or over, or 62 or over. Amenities,

services and activities associated with senior communities tend to be oriented toward an active lifestyle.

6. "Seniors Only" Apartments: living in this environment frees older adults from the burdens of private home maintenance.

7. Mobile Home Communities: like "seniors only" apartments, these communities may have full-time residents or those who reside only part of the year.

8. ECHO (Elder Cottage Housing Opportunity) Housing: also known as "accessory units" and "granny flats", the older adult shares a single-family house or a separate apartment with another person or family.

9. Continuing Care Retirement Communities (CCRCs): targeted for active, "younger" seniors, CCRCs offer an independent lifestyle with some degree of "wrap-around" personal, health care, rehabilitation and skilled nursing services – varying with the entrance fee and monthly charges.

10. Congregate Facilities / Housing: these domiciles offer independent living in private or shared apartments.

11. Board & Care/Residential Care/Adult Care Facility/Adult Home: Generally provided in a private home that has been converted to accommodate 4 – 8 older adults (two in a room), board and care homes purport to offer a homelike setting and service with some supervision.

12. Assisted Living: also known as "adult care facility" in some states, residence in assisted living gives an older adult access to assistance with personal care, supervision of medications, congregate meals, light housekeeping and laundry services, some (but minimal) social activities, transportation, and on-site personnel who are trained to monitor and managed unplanned adverse events. Rooms may be private or shared.

13. Nursing Home: eligibility and access to a nursing home is dependent on a prior hospital stay and skilled nursing and rehabilitation needs and consists of short-term "sub-acute care" or long-term care for those individuals who cannot be maintained safely and appropriately through a combination of community (formal) and home (formal and informal) services.

E. Eligibility: With the exception of Medicaid and Medicare-reimbursed home care and nursing home care, there are no specific eligibility or access requirements in any of the living arrangements other than ability to pay.

F. Barriers to access: Specific eligibility criteria that may be a barrier to access can be related to:

1. ADL functionality and need for assistance or supervision
2. IADL functionality and need for assistance or supervision
3. Cognitive disability and need for supervision
4. Psychosocial needs
5. Medical needs, including subspecialty consultations
6. Therapeutic diet needs
7. Ability to pay
8. Informal or family support
9. Number of chronic diseases/medical syndromes (and prognosis for deterioration)

G. Housing change: When a housing change is contemplated, the following issues should be addressed: [vi]

1. The older adult's preference for a living/housing setting that is sensitive to his culture and/or religious background.

2. Analysis of the individual's desire for independence in comparison with the ability to be independent; understanding of the risks involved with various living arrangements.

3. Assessment of family roles and responsibilities, including the ability of family members/significant others to visit the older adult in their new home and the older adult's expectations of family involvement and care giving.

4. Ability to maintain access to the older adult's preferred primary health care provider and tertiary care institution.

5. Preference for an age-integrated versus an age-segregated environment.

6. Options available if the "wrong" living arrangement was made.

III. Normal Aging Patterns vs. Disease

A. **Normal aging** involves universal changes inherent in the process of advancing biological age. These changes are the results of both intrinsic (developmental and genetic) and extrinsic causes.

Table 1. Normal Physiologic Changes Associated with Aging

Integumentary System
Decreased vascularity of the dermis
Decreased melanin production
Decreased sebaceous and sweat gland function
Decreased collagen and subcutaneous fat
Decreased thickness of epidermis
Increased capillary fragility
Thinning of hair
Decreased rate of nail growth
Thickening of connective tissue

Respiratory System
Decreased number of cilia
Decreased gas exchange
Decreased lung capacity
Thickening of alveoli

Musculoskeletal System
Decreased bone calcium
Decreased blood supply to muscle
Decreased muscle mass
Decreased muscle mass
Decreased tissue elasticity

Nervous System
Decreased number of brain cells
Decreased reflexes
Decreased balance and coordination
Decreased motor responses
Decreased sensory perception

Table 1. Normal Physiologic Changes Associated with Aging (con't)

Cardiovascular System
Decreased heart size
Decreased cardiac output
Increased arteriosclerosis
Thickening and fibrosis of mitral and aortic valves
Decreased elasticity of heart muscle and blood vessels
Decreased tear production
Increased sensitivity to glare

Hematopoietic and Lymph System
Increased plasma viscosity
Decreased red blood cell production
Decreased immune response

Gastrointestinal System
Decreased gag reflex
Decreased salivary production
Decreased gastric secretions
Decreased esophageal and gastrointestinal peristalsis
Decreased sphincter tone

Sensory Changes
Visual:
Decreased color perception
Decreased peripheral vision
Decreased night vision
Thickening of the lens, presbyopia

Hearing
Decreased ability to distinguish high frequency sounds
Decreased number of hair cells in inner ear
Thickening of eardrum - decreased ability to hear

Taste and Smell
Decreased number of taste buds
Decreased production of thyroid stimulating hormone - decreased basal metabolic rate
Decreased production of parathyroid hormone

Reproductive System

Female
Decreased estrogen levels
Decreased vaginal secretions
Decreased size of uterus and ovaries
Decreased vaginal length and width
Increased vaginal alkalinity

Male
Decreased testosterone levels
Decreased rate and force of ejaculation
Decreased speed gaining erection
Decreased circulation
Decreased muscle tone

Urinary System
Decreased urinary filtration rate
Increased concentration of urine
Decreased bladder capacity
Increased volume of residual urine

Changes Affecting All Body Systems
Decreased body fluid
Decreased tissue elasticity
Decreased blood supply

B. Rate of aging: Different organs in the same person age at different rates. Determinants of rates of aging include genetic make-up, life style choices, environment exposures, and other factors.

IV. The Breaking Down of Old Myths

A. Ageism: One of the major social problem confronting older Americans today is still how they are viewed by the general population. A crucial determinant of well being, at any age in life, is how we are defined by others in our social environment. For senior citizens, myths can become self-fulfilling prophecies. For society as a whole, myths can skew social and economic decisions, generating policies that are not consistent with facts.

Myth #1: ***To be old is to be sick.***

Facts:

- Only 5% of the elderly population lives in nursing homes.
- Elderly may have chronic diseases but they still function quite well.
- Only 23% of elderly claim to have a disability.

Myth #2: ***You can't teach an old dog new tricks.***

Facts:

- The less people are challenged, the less they perform.
- Elders therefore need to stay mentally active and stimulated. The 3 key factors predicting strong mental functioning in old age are
    1. Regular physical activity
    2. A strong social support system

3. A belief in one's ability to handle what life has offer (underscores why myth is harmful)

- Conditions of successful learning are different for older people than for the young.
- Learning institutions are not flexible particularly concerning the elderly.

Myth #3: ***The horse is out of the barn.***

Facts:

- Bad habits do not always produce irreparable damage.
- It is never too late to start good lifestyle habits of diet and exercise.

Myth #4: ***The secret to successful aging is to choose your parents wisely.***

Facts:

- Heredity is a factor, but environment and behavior choices strongly influence how well an elderly person functions.

Myth #5: ***The lights may be on, but the voltage is low.***

Facts:

- Sexuality does decrease with age but there are tremendous individual differences among the elderly.
- The definition of sexuality and intimacy needs to be redefined and broadened.

Myth #6: ***The elderly don't pull their own weight.***

Facts:

- The belief that the elderly are unproductive is false.

Robert Kahn at the University of Michigan found in his studies (as cited in T. Franklin Williams, "A New Scope on Retirement") of productive activity (defined as "any that might be remunerated under certain circumstances") that "on average, 'retired' people are making more contributions in terms of dollar value than they are receiving in support from society, at least up to age 75."

- The measures for productivity are wrong; paid employment should not be the only measure. Senior citizens are volunteering in droves. An Elderlearning Survey, designed as part of the research for a book, Elderlearning, by Lois Lamdin

with Mary Fugate, found that 72 percent of the respondents reported volunteer activities, with 43.1 percent of them volunteering either full-time or at least one to three days per week.

- There is job discrimination against the elderly.

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Appendix A

The Facts on Aging Quiz[1]

1. The majority of old people (65+) are senile (have defective memory, are disoriented, or demented). ___ True ___ False

2. The five senses (sight, hearing, taste, touch, and smell) all tend to weaken in old age.
___ True ___ False

3. The majority of old people have incomes below the poverty line (as defined by the federal government).
___ True ___ False

4. The majority of old people have no interest in, or capacity for sexual relations.
___ True ___ False

5. Lung vital capacity tends to decline in old age.
___ True ___ False

6. The majority of old people feel miserable most of the time.
___ True ___ False

7. Physical strength tends to decline in old age.
___ True ___ False

8. The majority of old people works or would like to have some kind of work to do (including housework and volunteer work).
___ True ___ False

9. At least one-tenth of the aged are living in long-stay institutions (such as nursing homes, mental hospitals, homes for the aged, etc.).
___ True ___ False

10. Old people tend to become more religious as they age.
___ True ___ False

11. Aged drivers have fewer accidents per driver than those under 65.
___ True ___ False

12. Older workers usually cannot work as effectively as younger workers.
___ True ___ False

13. Over three-fourths of the aged are healthy enough to carry out their normal activities without help.
___ True ___ False

14. The majority of old people are unable to adapt to change.
___ True ___ False

15. The majority of old people say they are seldom irritated or angry.
___ True ___ False

16. Old people usually take longer to learn something new.
___ True ___ False

17. Depression is more frequent among the elderly than among younger people.
___ True ___ False

18. The health and economic status of old people will be about the same or worse in the year 2010 (compared to young people).
___ True ___ False

19. Older people tend to react slower than young people.
___ True ___ False

20. In general, old people tend to be pretty much alike.
___ True ___ False

21. The majority of old people say that they are seldom bored.
___ True ___ False

22. Over 20% of the population are now age 65 or over.
___ True ___ False

23. The majority of old people are socially isolated.
___ True ___ False

24. Old workers have fewer accidents than younger workers do.
___ True ___ False

25. The majority of medical practitioners tend to give low priority to the aged.
___ True ___ False

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Appendix B

The 'Facts on Aging' Quiz: Answer Key

1. False
2. True
3. False
4. False
5. True
6. False
7. True
8. True
9. False
10. False
11. True
12. False
13. True
14. False
15. True
16. True
17. False
18. False
19. True
20. False
21. True
22. False
23. False
24. True
25. True

Rural Geriatric Education and Mental Health Curriculum

Module #3: Providing Health Care for Elders in Rural Communities

Rural Geriatric Education and Mental Health Curriculum

Module #3: Providing Health Care for Elders in Rural Communities

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Rural Geriatric Education and Mental Health Curriculum

Module #3: Providing Health Care for Elders in Rural Communities

Overview: As America has become more urbanized, certain myths and beliefs regarding rural life have evolved. Rural communities are thought to be idyllic places, with little stress and strong family and community networks, where those growing older enjoy high levels of health and life satisfaction.[1] However, research has suggested that there is a different reality for rural dwellers, and in particular, the rural elderly. This section will provide information about rural designation, demographics, and concerns important when providing care to the rural elderly.

Learning Objectives:

1. Understand the ways "rural" is defined by researchers and those developing public policy.
2. Describe the demographic differences between the rural and urban elderly.
3. Identify specific issues and/or problems concerning the rural elderly.
4. Understand the barriers to health care service within a rural community.

I. Defining "Rural": Researchers and those developing public policy use several ways to define and measure what is meant by the term "rural."

A. U.S. Census Bureau (1990) definition of 'rural' is a geographic region outside places of 2,500 or more inhabitants or outside an urban area, with a population density of fewer than 100 persons per square mile^2.

B. 'Rural' is used to describe all population and territory that is not an urbanized area (UA) or urban cluster (UC).

1. Urbanized Area (UA): Consists of contiguous, densely settled census block groups (BG) and census blocks (at least 500 people per square mile) that together encompass a population of more than 50,000.

2. Urban Cluster (UC): Consists of contiguous, densely settled BGs and census blocks (500 ppsm) that together encompass a population of at least 2,500 people but less than 50,000 people.

C. Geographic entities, such as census tracts, counties, metropolitan areas, and the territory outside metropolitan areas, are often "split" between urban and rural territory.

1. The population and housing units contained in these areas often are partly classified as urban and partly classified as rural.

D. Office of Management and Budget (OMB) uses a "metropolitan" or "non-metropolitan" distinction.

1. "Non-metro" areas are rural.

2. "Metro" areas must include at least one city of 50,000 or more, or a Census Bureau defined urbanized area and a total metro population of at least 100,000 or more.

3. The county with the largest city becomes the central county and any adjacent county that has at least 50% of its population in the urbanized area surrounding the city would be considered metro.

4. Additional outlying counties are included in the metro area if a substantial amount of the employed population commutes to the central place to work.

II. Demographic Differences: The demographic differences between the rural and urban elderly include the following factors:

A. Rural areas tend to have a higher percentage of persons over 65 years of age than urban areas (18% to 15%). [3]

1. A slightly higher proportion of elderly age 85 years and older live in rural areas.

2. Non-metro areas have an older age structure than metro areas (63 years old versus 34 years old)

3. Non-metropolitan areas have experienced a significant rise in the older age group due to aging-in-place, out-migration of young people, and the immigration of people over 65 years of age from metropolitan areas.

B. Females account for 60% of the population age 65 years and older in general.

1. Females out number males in all areas except rural farm areas.

2. In non-metropolitan areas, women account for 53% of the population between ages 60 to 64 years, increasing to 63% in the group age 85 years and older.

C. Rural elders are predominantly white, with whites comprising 92% of the older population in non-metropolitan areas [4].

D. The majority of rural elders are married and living with their spouse (53.6%), while 35% are widowed, 5% are divorced or separated, and 4.3% report they have never married.

E. There is a striking difference in the level of education between rural and urban elderly. In rural areas, 46.7% of the elderly report completing high school compared to 56.2% of the urban group. In fact, 36% of rural elders report less than an 8th grade education in contrast to 27% of urban elders [5].

F. A higher proportion of rural elderly live below the poverty level than their urban counterparts (27% vs 18%).

1. Older rural women are more likely to be poor than older rural men. In 1990, women age 60 years and older accounted for 71% of the rural poverty in this age group.

G. Although most older adults under the age of 85 years rate their health as good, the percentage of persons rating their health fair or poor is higher in non-metropolitan areas, increasing from 31.2% in the 60-64 year age group to 56.3% for those age 85 years or older.

III. Rural Issues Affecting the Elderly: Specific issues and problems which have a negative impact on the health and welfare of the rural elder population include:

A. Lower levels of education, and higher proportion living below the poverty levels combine to create life-threatening risk factors for rural elderly.

1. Health problems related to inadequate nutrition are more prevalent in rural areas

a. Food cost is a barrier to obtaining adequate nutrition for rural elderly, as low economic resources affect the quantity and quality of food purchased.

b. Lower levels of education have been associated with inadequate nutritional intake in the elderly, as understanding is low and pride is high.

c. Poor nutrition exacerbates medical conditions and increases disability while extending hospital stays.

2. Prevalence of alcohol and drug abuse

B. Geographic isolation

1. Creates barriers to social services and health care for many
Examples of service barriers include:

a. The low population density of rural areas often means there isn't a sufficient number of clients to have a funding base for staff, facilities, and services.

b. The concept of respite care, especially preventive rather than crisis-oriented, is still relatively unknown in some rural areas.

2. Isolation made more critical by lack of reliable and low cost transportation.

C. There are considerable differences in the amount and type of formal

health care services offered to rural elders, when compared to urban population.

1. Disparities are in areas of mental health, substance abuse, public health outcomes, and oral health

2. The lack of health promotion and disease prevention resources and services is a major factor in rural health issues.

3. The lack of collateral services compounds rural communities' difficulties and means they pay a greater proportion of the social and economic costs associated with gaining access to human services than do urban population.(See Bibliography: McKenzie 1987; Lawrence and Williams 1990; Collingridge 1991)

4. Service problems are compounded by insufficient critical mass, distance and dispersed demand.

D. Rural areas do not have the capacity to utilize economies of scale that are possible in densely populated areas do.

E. There is frequently a lack of advocacy coalitions in rural areas, making it more difficult to overcome barriers to good health care.

1. Minority groups receive little advocacy support in rural areas.

F. Important to take into account the distinctive features of particular rural populations, and of particular social and physical environments. Strategies include:

1. In rural and remote areas, there needs to be more emphasis on imaginative approaches to community management.

2. There is an urgent need for rural coalition building, the use of peer education and volunteers, the provision of services through religious institutions, and self-care.

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3. Importance of technology and its growing role in rural health care delivery:

a. Example: Initiative developed in Michigan is a "Regional Virtual Intensive Care Unit," which will connect a cyber-network of five small rural hospitals with a centralized team of doctors and nurses who specialize in intensive care, trauma and emergency

procedures. Communicate will take place via remote video cameras, teleconferencing and computers hooked up to patients' medical monitoring equipment. [6]

IV. Specific barriers to Rural Health Care Services:

A. The population of elderly in rural areas has grown markedly as the result of aging-in-place, out-migration of young persons and the in-migration of urban elderly to rural retirement spots. Thus the issue becomes the availability of services for this increasingly fragile, vulnerable population.

1. Age, because of its relationship to increased levels of chronic illnesses, is the single biggest determinant of functional dependency and the strongest predictor of acute care and long-term care use.

2. Not all rural communities are the same, and varying levels of support exist. Some rural seniors have much stronger social support networks and others receiving woefully inadequate care. In most cases, however, the services do not equal those available for urban elders.

B. Rural areas lack major health services, such as hospital beds and physician services. Contributing factors include:

1. Measures to contain national health costs have lead to the consolidation and closure of rural hospitals.

2. The difference in Medicare reimbursement rates places remaining rural institutions in financial straits.

3. Medicare continues to reimburse urban hospitals more than rural hospitals for the treatment of the same illness, even though there have been numerous initiatives to phase out this inequity.

4. Rural hospitals tend to have more nursing home patients in their beds at any given time than do urban facilities. The reimbursement for long-term care depends on Medicaid for payment, leaving rural hospitals with the dilemma of providing non-acute care in a more costly setting. [7]

C. Impact of hospital closures: Factors mentioned above have contributed to high closure rate of small rural hospitals.

1. Dramatically reduces access to care for elders in declining health and

diminished functionality.

2. Results in the need to travel long distances for emergency or acute care in many rural communities.

3. Failure to access timely care contributes to health care crises that are preventable, distressing to caregivers, and costly for the individual and the health care system.

D. Rural areas also do not have adequate resources to support independence in the elderly population:

1. The lack of third-party reimbursement and the particular characteristics of the rural environment (e.g. geographic isolation and inadequate transportation) limit the development of programs for elders

2. Rural areas therefore less likely to have community-based out-patient services, senior centers, adult day care centers, nutrition programs, visiting nurse or homemaker services.

E. Rural areas find it difficult to recruit and retain health care providers. This shortage of health care professionals in turn contributes to inadequate health care coverage for elderly.

1. Although rural areas have 24% of the nation's population, only 18% of nurses and 12% of physicians work in these regions.

2. Medicare reimbursements are higher for nurses and physicians practicing in urban areas than for rural practitioners.

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Rural Geriatric Education and Mental Health Curriculum

Module #4: Geriatric Rural Mental Health

Rural Geriatric Education and Mental Health Curriculum

Module # 4: Geriatric Rural Mental Health

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Rural Geriatric Education and Mental Health Curriculum

Module # 4: Geriatric Rural Mental Health

Overview: The graying of America has resulted in a dramatic change in the health care system due to the increased utilization of health services because of an increased prevalence of chronic conditions in the older population. Older people are at increased risk of serious mental illness, particularly depression and anxiety, in the face of bereavement, living alone, weak social supports, anxiety, physical function deficits and limitation of activities, all of which are exacerbated particularly for the elderly in times of disaster and trauma. [1,2] Prevalence ratios of clinically significant depression have been estimated to be in the region of 10 to 15% of the general elderly population ([3]Gurland & Toner, 1982; [4]NIH, 1992), 30 to 40% among elderly psychiatric patients in short-term treatment settings, ([5]Gurland & Cross, 1982), and 12 to 43% among elderly residents of Long-Term care facilities. ([6]Abrams , Teresi, & Butin, 1992), [7]

Specialized training of health care professionals and allied health care providers in mental health, and particularly mental health of older persons, is essential to meet the increasing heath needs of this growing population.

Learning Objectives:

1. Discuss the spectrum of normal mental health, as well as psychopathology in the elderly
2. Identify the ways in which psychological disorders present differently in the elderly compared to younger populations.
3. Describe and define the major mental disorders seen in the elderly population.
4. Appreciate how the rural context impacts on case finding, assessment and treatment, and service delivery.
5. Describe barriers to mental health care to rural elderly.
6. Discuss strategies to improve delivery of rural mental health services.

I. Demographics:

A. Government projections indicate that from 2000 to 2030 the population 65 or over in the United States will grow from 35 million to 70 million and from roughly 13% of Americans to 20%.

B. Based on current illness prevalence estimates, from 2000 to 2030 the number of older adults with mental illnesses will grow from approximately 7 million to approximately 14 million.

C. Researchers estimate that up to 63% of older adults with a mental disorder do not receive the services they need. Studies suggest that only 3% of older adults report seeing mental and behavioral health professionals for treatment.

D. Although the prevalence of mental illness in the elderly in New York State corresponds with the national rates, the size of the New York State population, and consequently the numbers of mentally ill residing in the state, makes it a special case.

E. Exposure to some types of traumatic events may be higher in rural areas. For example, injury-related death rates are 40% higher in rural populations than in urban populations. Many rural older adults experience low levels of social support and high levels of isolation. Rural areas often have fewer resources, such as transportation, community centers, and meal programs, which foster social contact.[8]

II. Barriers to Mental Health Care:

A. Poverty
B. Inadequate health insurance
C. Fragmented, uncoordinated, and inaccessible services
D. Inability to identify cases early in the course of disorder
E. Inadequate public awareness of the scope of mental illness in seniors
F. Stigma due to mental illness and advanced age
G. Lack of adequate preventive interventions
H. Many older adults do not openly identify their problems as "mental health concerns," and may instead present with a physical complaint to their medical professional
I. Primary care issues

1. Approximately 70% of all primary care visits are driven by psychological factors (e.g., panic, generalized anxiety, major depression, somatization, stress, and adjustment disorders).

2. Many health professionals are not adequately trained to assess and treat

behaviorally based and psychosocial problems. Up to 75% of primary care patients with depression do not receive appropriate care.

3. Symptoms of depression in elders can be overlooked and untreated because they often coincide with other medical illnesses or life events that occur as people age (e.g., loss of loved ones).

J. Rural residents tend to under-utilize the mental health services that are available.[9-12]

1. Some rural residents will not seek or utilize mental health care because of a lack of anonymity in treatment, the stigma associated with treatment, and clashes between treatment and traditional rural values such as independence and privacy. [13-16]

2. Denial of mental illness by the individual or family also impedes service utilization and can result in the future need for much more extensive care and decreased likelihood of a positive response to treatment. [17,18]

K. Barriers to care cited by 2003 President's New Freedom Commission on Mental Health identified as: [19]

1. Fragmented service delivery system.

2. Out of date Medicare policies.

3. Mismatch between services that are covered and those preferred by older persons.

4. Lack of professionals educated in geriatric mental health.

III. Clinical Themes:

A. The spectrum of "normal"
B. Aging and diversity, definition of what is abnormal
C. Functional status and change from baseline
D. Onset of the disorder
   1.Important to identify chronic mental illness, such as a recurrent major depression in an older person versus late onset psychosis, delusional disorder or dementia

2.Determine if it is a new set of symptoms and signs such as a first depressive episode, or a relapse of underlying psychopathology such as a decompensation of chronic schizophrenia

E. Vulnerability and frailty of segments of the geriatric population

1. Extent of premorbid physical and psychological pathology as risks for decompensation

2. Frailty

3. Regression and use of inadequate coping strategies

4. Non adherence to treatment plans

5. Social Isolation

IV. Geriatric Mental Health Assessment

A. Mental Status

1. Appearance, grooming, hygiene
   a. Emphasize the importance of observation. What is the person wearing, are they malodorous, hygienic.
   b. The mental status examination of the older patient should be described in context to where the person is seen-in their own home by a home visiting team, in a residential or nursing facility, in a medical clinic, in a hospice.
   c. Try to paint a word picture in the mental status to be as descriptive as possible so that the reader captures the person.
   d. It is important to describe the surrounding i.e. the client was living in a squalid, foul-smelling single room; the client's home was impeccable

2. Affect and mood

   a) Fear, terror, rage, guilt, despair, depression, hopelessness

   b) Range of affective response-constricted, labile, volatile

   c) Modulation or changes in mood

3. Suicidal ideation and intent

4. Motor activity associated with behavioral disturbances, e.g.

psychomotor agitation, restless, withdrawn, agitated, anxious

5. Cognitive disturbances

a) Confusion, bewilderment, "stunned" response

b) Impaired memory, concentration, or global impairment

c) Disorganization of thought process

(1) Thought content

(a) delusional beliefs

(b) Somatic preoccupation

(2) Thought process

(3) Perceptual disturbances, e.g. auditory, visual, tactile hallucinations

(4) Insight and judgment: use specific clinical examples and include these in written reports

V. Major mental disorders in the elderly

A. Delirium or Acute Confusional States

1. Vulnerability of the frail elderly in the community

2. Risk Factors

a) Inadequate self-care or supervision

b) Compromised nutrition, hydration, electrolyte disturbances

c) Improper medication administration

(1) Excess sedative, analgesics, digoxin, steroids

(2) Failure to take prescribed medication i.e. thyroid hormone

d) Unwitnessed falls, trauma

e) Inadequate management of diabetes, COPD

f) Hypoxia

g) Substance abuse: ETOH, sedatives, intoxication and withdrawal

h) Infections: UTI, Pneumonia, Influenza

i) Dangerous behavior

3. Clinical features of delirium

a) Acute mental status change

b) Inattention

c) Global cognitive impairment

d) Withdrawal, agitation or mixed presentation

e) Perceptual disturbances-visual, tactile hallucinations

4. Delirium is a medical emergency with over 15% mortality from all causes

B. Dementia

1. Incidence and prevalence

2. Clinical features

a) Global cognitive impairment with gradual deterioration over years: memory, language, spatial orientation

b) Predisposition to delirium

c) Attention usually unaffected until late stages

3. Vulnerability

    a) Trauma does not cause dementia but can exacerbate symptoms of cognitive impairment due to increased anxiety, lack of care and available supervision

    b) Community elderly with early phase of dementia may significantly worsen in an emergency disaster setting

4. Alzheimer's Dementia

    a) Over 50% of all dementia

    b) Shows a linear decline in function over years

    c) 40% of population over 80 years old have some form

5. Vascular or multi-infarct dementia

    a) 35% of dementia cases

    b) Shows a stepwise deterioration in function

    c) Associated with multiple medical risk factors: hypertension, diabetes, CVA, vascular disease, heart disease

6. Parkinson's and other degenerative disorders

C. Depressive disorders and Bipolar Disorder

1. Incidence and prevalence

2. Clinical features of major depression

    a) Persistent feelings of intense sadness or emptiness

    b) Anhedonia, inability to experience pleasure

c) Disturbance of sleep, appetite and sexual drive

d) Marked ambivalence and diminished energy

e) Indecisiveness

f) Sense of guilt, hopelessness and helplessness

3. Vegetative disturbances of PTSD such as insomnia and loss of appetite are found in depressive illness and may be co morbid

4. Major depression is a recurrent disorder and can likely be triggered or uncovered by trauma

5. Bipolar mania and depression can also be triggered by trauma

D. Suicide in the Elderly

E. Somatoform disorders

1. Co-morbid with anxiety and depression in the elderly
2. Need to differentiate from psychotic depression with somatic delusions
3. Preoccupation with one or a list of physical symptoms, e.g. headache, chronic pain, gastrointestinal distress
4. Risk of excessive reliance on opiate analgesics and sedatives
5. Over utilization of emergency rooms and repeated visits to primary care MDs

6. Depression and anxiety is often overlooked as patients who are "complainers" or "difficult."

7. Psychologically distressed, frightened, in need of attention and care

8. Somatization

9. Hypochondriasis

10. Conversion disorders

F. Alcohol and Substance use disorders

1. Patterns of use in the elderly

2. Co morbidity with other psychiatric disorders

3. Inappropriate prescribing of prescription medications\

4. Over the counter medications

G. Schizophrenia and psychotic disorders

1. Review of the clinical features

a) Positive and negative symptoms

b) Thought disorder

c) Co morbid physical illness and cognitive impairment

2. Functional status and need to review treatment plans and identify providers in the community

3. Risk for relapse in traumatic situations: paranoid delusions, hallucinations, functional impairment

H. Anxiety disorders

1. Acute Stress Disorder

a) Exposure to a traumatic event

(1) Threat of death, serious injury or threat to physical integrity of others

(2) Response involved intense fear, helplessness or horror

b) Dissociative symptoms

(1) Numbing, detachment, absence of emotional response

(2) Reduced awareness of surroundings

(3) Derealization

(4) Depersonalization

(5) Dissociative amnesia

c) Re-experiencing the traumatic event

(1) Recurrent images, thoughts, dreams

(2) Distress on exposure to reminders of the event

(3) Reliving the experience

d) Avoidance of stimuli

e) Anxiety and arousal

(1) Sleep disturbances

(2) Poor concentration, cognitive decline

(3) Startle response

(4) Hypervigilance and reactivity to reminders

f) Disturbance causes clinically significant distress

(1) Impaired functioning and self-care

(2) Vulnerability of frail and marginally functioning elderly

(3) Regressive behavior

(4) Impairment of ADLs and IADLs

g) Disturbance lasts at least 2 days up to 4 weeks and occurs within 4 weeks of the traumatic event

h) Reactivation of previous traumatic experiences: Combat veterans, POWs, holocaust survivors, victims of natural disasters, victims of abuse

i) Risk factors include: severity of exposure, symptom profile, loss of family, friends, housing, finances; prior physical or psychiatric illness

2. Post traumatic Stress Disorder

    a) Differentiate between acute and post traumatic stress disorders

        (1) PTSD-duration more than 1 month

        (2) Acute PTSD less than 3 months

        (3) Chronic PTSD- 3 months or more

    b) The event is re-experienced

        (1) Recurrent and intrusive distressing recollections of the event trough images, thoughts or perceptions

        (2) Recurrent distressing dreams

        (3) Flashbacks

        (4) Psychological distress at exposure to internal or external cues that remind of the event

    c) Avoidance and numbing of responsiveness

        (1) Avoiding thoughts, feelings, conversations

        (2) Avoiding activities, places, people that arouse recollections

        (3) Inability to recall important aspects of the event

        (4) Diminished interest in pleasurable activities

        (5) Detachment

        (6) Sense of foreshortened future

    d) Increased arousal

        (1) Difficulty falling or staying asleep

        (2) Irritability

        (3) Cognitive impairment (pseudo-dementia)

        (4) Hyper-vigilance

        (5) Exaggerated startle response

e) Significant clinical distress or impairment in function

f) Victims of prior trauma such as veterans of combat, Holocaust survivors may have uncovering of PTSD symptoms with the onset of cognitive decline.

3. Type of Trauma Significant: Behavioral disturbance may relate to nature of traumatic experience. For example, combat veterans with dementia are more likely to be aggressive and violent.

a.) Symptoms can be intermittent, persistent, time-limited or chronic

b) The elderly do not appear more predisposed to develop PTSD than younger population

c) Current PTSD severity appears to be related to cumulative lifetime trauma in studies of Holocaust survivors

d) For WWII veterans admitted for other major psychiatric disorders:

- 54% had prior PTSD
- 27% had current PTSD in addition to other major psychiatric disorder
- The elderly may likely have some features of PTSD and show significant functional impairment
- Differentiate panic anxiety with its discreet episodes

I. Chronic, generalized anxiety

1. May be difficult to discern in the context of PTSD

2. Understand the risk of increased substance and ETOH use

3. Timely referral for medical evaluation of anxiety which may be a manifestation of: Coronary artery disease, COPD and hypoxic states, Alcohol and Substance abuse disorders

VI. Role of Primary Care Providers:

A. Role of primary care providers: 1984 report found that non-psychiatrist physicians provided 48% of the patient visits resulting in the diagnosis of a

mental disorder

1. Primary care physicians (i.e., general practitioners; family physicians; and general internists) accounted for 77% of these diagnoses. [20]

2. The DHHS also found that 28% of primary care visits were for psychological problems, and anxiety/nervousness accounted for 11% of the reasons people give to visit a physician.

3. More recent studies have purported that generalist physicians provide up to 60% of the mental health services received by a population [21]

B. Shortage of mental health specialists: As populations in rural areas continues to dwindle, it will become less feasible to recruit additional local mental health specialists (psychiatrists, psychologists, psychiatric nurses, and psychiatric social workers) to these regions.

C. Nurses, social workers, and occasionally family therapists or ministers with some mental health training are currently working in rural areas, but primary care physicians are still the most numerous service provider in these areas.[22] Thus, in the immediate future, rural mental health services are most likely to continue to be in the hands of primary care physicians.

D. Recommendations to address the shortage of mental health specialists in rural areas:

1. Rather than put a premium not on rural recruitment of psychiatric care givers, devote resources to developing rural networks of care linking primary care providers, mental health professionals, and non-physician providers.

2. Improve medical and continuing medical education to better inform primary care physicians on mental health care issues.

VII. Strategies to improve delivery of rural geriatric mental health services: It is important that rural older adults are assured access to an affordable and comprehensive range of high quality mental health and substance abuse services including outreach, home and community based care, prevention, intervention, acute care, and long term care. These services should be age appropriate, culturally competent, and consumer driven. Specific recommendations include:

A. The development and implementation of home and community-based care as an alternative to institutionalization through a variety of public and private funding mechanisms should be pursued.

B. Screening for co-occurring mental and substance use disorders by primary

health care providers should be promoted.

C. Older adult mental health and substance abuse services research should be promoted.

D. Parity for mental health services under Medicare: Currently, Medicare only reimburses for 50% of outpatient mental health care as compared to 80% for medical care.

E. Integration of older adult mental health and substance abuse services into primary health care, long term care and community-based service systems should be supported.

F. Collaboration among aging, health, metal health, and substance abuse consumer organizations, advocacy groups, professional associations, academic institutions, research entities, and all relevant government agencies should be encouraged for more effective use of resources and to reduce fragmentation of services.

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Rural Geriatric Education and Mental Health Curriculum

Module #5: Cultural Competency and Communication

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Module #5: Cultural Competency and Communication

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Rural Geriatric Education and Mental Health Curriculum

Module #5: Cultural Competency and Communication

Overview: As the United States becomes more ethnically diverse, health care providers must learn about the perspectives and values of a variety of cultural groups. The risk of cross-cultural misunderstanding is increasing as encounters between patients and providers of different backgrounds are becoming more common. There are serious ramifications of ignoring the impact of cultural diversity in the delivery of health care services. When different cultures collide and are not recognized, acknowledged and identified, common reactions of patient, family and health care provider may include denial, depression, isolation, avoidance, fear, frustration, guilt, anger, and resentment.

It would be impossible for health care providers to be educated about every culture's health care and treatment beliefs, particularly in the area of mental health care for the elderly. Therefore it is imperative that health care providers understand and recognize their own cultural beliefs and background, and most importantly, have communication skills which enable them to understand the cultural beliefs of all individuals they encounter in a health care setting. Communication techniques which seek to overcome ethnically-based conflict and misunderstandings are particularly essential in the area of palliative and end of life care.

Learning Objectives

1. Define “cultural competence” and the principles of cultural competence.
2. Describe why it is important to consider the historical experiences of older ethnic populations when working with them.
3. Describe the different factors which health care providers must be aware of when working with different cultural groups.
4. Delineate the main components of a cultural assessment.
5. Understand the impact of cultural differences in the delivery of all health care services, and especially in care at the end of life.
6. Understand and recognize their own cultural beliefs and background.

I. Definitions

A. *Culture* is "the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people."[1]

B. *Cultural competence*:

1. "Cultural competence is a set of cultural behaviors and attitudes integrated into the practice methods of a system agency, or its professionals, that enables them to work effectively in a cross-cultural situation."[2]

2. Cultural competence in geriatrics is the ability to give health care in ways that are acceptable and useful to elders because it is congruent with their cultural background and expectations.

3. "Culturally sensitive health care is a phrase used to describe a health care system that is accessible and respects the beliefs, attitudes, and cultural lifestyles of professional and of patients."[3]

C. *Cultural Diversity* refers to differences between people based on treasured beliefs, shared teachings, norms, customs, language and meaning that influence the individuals' and families' responses to illness, treatment, death and bereavement.[4]

D. *Situational Ethnicity* refers to the fact that patients may reveal more of their traditional culture and beliefs depending on the social setting.

E. *Intraethnic Variation* explains that a person's life never encompasses all aspects of one culture but is an approximation, a conglomeration of pieces of that ethnic culture. Practitioners must be especially responsive to subtleties within ethnic classes, for example Puerto Rican vs. Dominican.

II. Demographics[5]: The percentage of this country's minority citizens is growing:

A. In 1970, 16% of the population in the U.S. was a member of a minority group. In 1998, the proportion grew to 27%, and it is projected that it will be 50% by the year 2050.

B. In 2000, approximately16% of persons age 65 and older in US were of minority status.

- 8.1% African American
- 5.3% Hispanic origin
- 2.3% Asian or Pacific Islander
- Less than 1% American Indian or Native Alaskan

C. On average, elders from most ethnic groups use formal health care services and long-term care services to a lesser extent than their white counterparts, with the exception of emergency room visits and acute care.

D. Minority Population in New York State:

- New York State, with 18.1 million people, ranks third in population among the states and the District of Columbia (NYS Office for the Aging, 1999). The state is expected to gain 3.9 million people by 2025 through in-migration from abroad- the second largest rate in the nation (NYS Office for the Aging, 1999).
- Most striking is that that New York State is projected to have a 30 % increase in the minority population between 1995 and 2025
- Minorities will comprise 47 % of all New Yorkers by the year 2025, compared to 33 percent in 1995.
- The minority population 60 and older will increase 145 % between 1995 and 2025, comprising 35% of New Yorkers 60 and older (NYS Office for the Aging, 1999).
- Although the prevalence of mental illness in the elderly in New York State corresponds with the national rates, the size of the New York State population, and consequently the numbers of mentally ill residing in the state, makes it a special case.

III. The Acculturation Continuum [6]

A. The Acculturation Continuum is a term used to describe the degree to which an older person is acclimated to American culture.

B. Providers should be aware of the vast range in acculturation found among elders within each ethnic population. There are many different domains of culture and a person may differ in degree to which he or she is acculturated to the different domains affecting health care.

C. Indicators of acculturation include use of the English language, length of time in the United States, and the process of adaptation. However it is important to note that length of time in this country may have no bearing on how “traditional” or “American” the patient may be.

IV. Components of Cultural Assessment: Domains of patient, family and community cultural assessment include[1]: (See also Table 1)

- Birthplace
- Ethnic identity, community
- Decision making
- Language and communication
- Religion
- Food preferences/prohibitions
- Economic situation
- Health beliefs re: death, grief, pain
- Gender and power issues
- Views of patient and family about location of death
- Degree of fatalism or activism in accepting or controlling care and death
- How hope is maintained
- Sources of support within the community

V. Impact of Cultural Differences on Health Care Attitudes and Beliefs [7]

(See also Table 2)

A. Different cultures have varying perceptions of issues which are relevant to treatment choices, goal of care setting, and decision making. It may be helpful to discuss these perceptions with the patient early on in the provider-client relationship

1. Relationships and hierarchy
   - Role of the elder, child, caregiver, provider, etc.
   - Trust/Mistrust and deference towards the healthcare provider.
   - Relationships among family members.

2. Death and Dying
   - What constitutes a good death?
   - What happens after death?
   - Attitudes towards life-sustaining treatment, advance directives.

3. Pain
   - Reason for pain (biological vs. punishment)
   - Behaviors concerning pain
   - Medication issues
   - Surgery

4. Independence
   - Value of independence with old age.

- Medical decisions made independently or within a family context.
- Preferred caregiving setting and other issues care delivery
- What older people should be told about their illnesses: some cultures prefer that medical information, particularly that of a life-threatening prognosis, be given to the family and not to the patient.
- Informed consent.
- Treatment of dementia.
- Long-term care.

5. Traditions and Rituals
   - Coordinating biomedical interventions, while honoring traditional therapies or rituals.

VI. Culture and the Patient-Practitioner Relationship[7]

A. Aspects in which cultural differences can affect the patient-provider relationship:

~ Language and cultural barriers between providers, patients, and patients' families.
~ Explanatory models of illness.
~ Dietary habits.
~ Medication compliance.
~ Alternative (non-Western) practices (e.g. herbal medicines)/belief in existence of non-biomedical illnesses or in the efficacy of scientific treatments.
~ Role of religion, with ethical dilemmas of life-sustaining interventions conflicting with religious beliefs.
~ Cultural attitude of some communities and families concerning expectations that patients should be cared for at home.
~ Western emphasis on "independence" as a goal of therapy.
~ Unrealistic expectations.
~ Different expectations as to entitlement to good medical care.
~ Difficulty establishing trusting relationships.
~ Ignorance of how the American medical system works and lack of skills in navigating it.
~ Patient is unable to verbalize his or her symptoms in detail.

B. Discrimination and racism: it is important that the healthcare provider be aware of his or her own feelings toward other cultures.

VII. Domains of Cultural Competence[7] (See also Table 3)

A. Values and Attitudes

1. Avoid stereotyping and misapplication of scientific knowledge.
2. Be knowledgeable about cultural differences and their impact on attitudes and behaviors.
3. Be sensitive, understanding, non-judgmental and respectful in dealing with people whose culture is different from your own.
4. Be flexible and skillful in responding and adapting to different cultural contexts and circumstances.

B. Communication Styles

1. Be creative in finding ways to communicate with population groups that have limited English-speaking proficiency.
2. Spend time listening to needs, views, and concerns of the community.
3. Ask the older patient for his or her preference for decision making early on in care.
4. Use the language and dialect of the people you serve.
5. Use communication vehicles that have value and use by your target audience.
6. Use a cultural broker or cultural guide from the elder's ethnic or religious. background.

C. Use of Interpreters

1. Recognize cultural differences related to:
   - Conversation style
   - Personal space
   - Eye contact
   - Touch
   - Time orientation
   - View of healthcare professionals
   - Learning styles

D. Appoint a spokesperson

1. Ask the older patient to identify a family spokesperson.
2. In emergencies, ask the family to appoint a spokesperson.
3. Respect the appointment, even if the person is not a family member or does not live nearby.

E. Role of Family**:**

1. Who makes the decisions?
2. Who is included in discussions?

3. Is full disclosure acceptable?

F. Community/Consumer Participation:

1. Include community input at the planning and development stage.
2. Get to know the community, its people, and its resources to identify strategies for service delivery.
3. Establish partnerships and relationships with key community resource people.
4. Report the results of your initiatives to groups and individuals that help you in the process.

G. Physical Environment

1. Create culturally, linguistically friendly interior design, pictures, posters, and artwork to make facilities more welcoming.
2. Display material and information with recognizable props that hold significance, value, and interest for your target audience.
3. Put props in the hands of people that will maximize their distribution, circulation.

H. Institutional Policies and Procedures

1. Mission statement must articulate principles and rationale for culturally competent service delivery.
2. Develop structures to assure community participation in planning, delivery, and evaluation of services.
3. Institute procedures to recruit, retain, and train a diverse and culturally competent workforce.
4. Familiarize the interdisciplinary health care team with cultural explanatory models of the elder's conditions.

I. Staff training and professional development

1. Provide informal opportunities for staff to explore their attitudes, beliefs, and values.
2. Recognize that cultural sensitivity occurs on a continuum.
3. Provide specialized training for interpreters.

J. Be culturally sensitive during physical examination and assessment

1. Cross-gender physical examinations are unacceptable in many cultures.
2. Consider preference of presence of family member.
3. Ask permission to examine various areas of the body.
4. Preferred amount of information provided to the patient and family oftentimes varies.
5. Symptom recognition, report, and meaning may vary.

VIII. Health Professional's Self-Assessment[8] (See Also Table 4)

A. What are your own beliefs about illness and death and how do they influence your attitudes?

B. How significant is religion in your attitudes toward illness and death?

C. What kind of death would you prefer?

D. If diagnosed with a terminal illness, whom would you want to tell?

E. What efforts should be made to keep a seriously ill person alive?

F. How would you want your body disposed of?

G. What is your experience of participating in rituals to remember the dead?

IX. Proactive Attitudes and Activities of Cultural Sensitivity[9]

A. Seek information to enhance cultural awareness.

B. Consider own attitudes and behaviors that enhance or hinder relationships.

C. Evaluate use of terms of phrases that may be interpreted as degrading or hurtful.

D. Attended workshops on cultural diversity.

E. Openly disagree with racial, cultural or religious jokes, comments or slurs.

F. Create a culturally supportive environment with colleagues and patient/families.

X. Effective Communication with Patients From Other Cultures

A. Spend a few minutes in small talk at the beginning of the visit before getting down to the medical task at hand. This can be done in English, or if your language skills are sufficient, in the patient's native tongue.

B. Show respect for the patient's beliefs about illness and health care.

C. Don't assume the patient dislikes you, doesn't trust you, or isn't listening because he or she avoids eye contact.

D. Determine what other culturally determined heath care resources and methods the patient has used or continues to use while under care.

E. Verify how the patients will take the medication or follow the treatment plan.

G. Don't assume that the patient understands you and will follow your medical advice simply on the basis of his or her nod and a verbal, "Yes, yes."

H. Be aware of the basic beliefs, values, and mores of various cultures.

I. Understand the value of the family's presence and role in the illness and recovery process.

J. Use an interpreter whenever appropriate.

K. Don't stereotype cultures ("All Mexican Americans like to be touched, all Asians do not")

XI. Approaches to Multi-cultural Communication in End-of-Life Care:

The following are strategies for improving communication about end-of-life issues with patients and families of diverse backgrounds. These strategies were developed for the in-patient setting, but are easily adapted for use in ambulatory or home-care situations.

A. Try to elicit patient/surrogate values in broad terms
~This will help you understand the patient's emotional state and how this influences decision-making
~You may learn how they lived their life until this point – and whether decisions being made are consistent with prior values

B. Use open-ended questions:

"What are your hopes (fears) for the future?
"How is the treatment going for you (your family)?
"What concerns you most about your illness"

C. Questions for a surrogate decision-maker might be:
"What is most important to your mother (husband, daughter etc) in her life?"
"How has she lived her life?"
"How do you think she feels about her current situation?"

D. Have patient or surrogate repeat back important details to be sure communication was clear
~Use interpreters when English is not native tongue
~Never assume that silent nodding of head means "I understand"

E. Try not to follow bad news with immediate discussion of limiting interventions in favor of comfort care
~A discussion on limiting care may make people suspicious of motives
~May be interpreted in many ways:
- It costs too much money
- Patient is not worth it –too old, too poor
- Patient brought this on him/herself

F. Be aware of your own judgments. Why do you feel uncomfortable with continuing treatment?
~Is it because of the patient's suffering or something else?
~Are you being paternalistic or realistic?
~Concepts of Beneficence and Non-maleficence
~Duty to act in patient's best interest – "first do no harm"
~Explain to family why you feel a certain therapy is not beneficial and might harm patient.

G. Using Palliative Care
~Reinforce that stopping life prolonging care does not mean "doing nothing"
~DNR does not mean do not treat!
~Get a palliative care team involved if available

H. Agreeing to a time limited trial for a certain therapy can be helpful
~Agreeing not to withdraw therapies, but also not to ADD therapies may reassure family
~Make clear commitment to treating pain or other distressing symptoms

I. " Take Home Points":
~Remember that people who do not share your culture(s) may have different needs for themselves and their loved ones at the end-of-life
~Learn about cultural needs common to cultures seen frequently in your practice
~Elicit what is important to them and see what is possible

~End of life situations always benefit from a team approach
~Use the resources of your hospital - the social worker, chaplain, palliative care team, ethics committee etc.
~Do not underestimate the importance of clear communication and active listening

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XIII Appendices

Table 1: Multicultural Outcomes: Guidelines for Cultural Competence

Domain	Description
Ethnic Identity	Country of origin, ethnicity/culture with which the group identifies, current residence, reasons for migration, degree of acculturation/assimilation, and level of cultural pride.
Communication	Dominant language and any dialects, usual volume/tone of speech, willingness to share thoughts/feelings/ideas, meaning of touch, use of eye contact, control of expressions and emotions, spokesperson/decision maker in family.
Time and space	Past, present, or future orientation; preference for personal space and distance.
Social organization	Family structure; head of household, gender roles, status/role of elderly; roles of child, adolescents, husband/wife, mother/father, extended family; influences on the decision-making process; importance of social organization and network..
Workforce issues	Primary wage earner, impact of illness on work, transportation to clinic visits, health insurance, financial impact, importance of work.
Health beliefs, practices, and practitioners	Meaning/cause of cancer and illness/health, living with life-threatening illness, expectations and use of Western treatment and healthcare team, religious/spiritual beliefs and practices, use of traditional healers/practitioners, expectations of practitioners, loss of body part/body image, acceptance of blood transfusions/organ donations, sick role and health-seeking behaviors.
Nutrition	Meaning of food and mealtimes, preferences and preparation of food, taboos/rituals, religious influences on food preferences and preparation.
Biological variations	Skin, mucous membrane color, physical variations, drug metabolism, laboratory data, and genetic variations-specific risk factors and differences in incidence/survival/mortality of specific cancers.
Sexuality and reproductive fears	Beliefs about sexuality and reproductive/childbearing activities, taboos, privacy issues, interaction of cancer diagnosis/treatments with beliefs about sexuality.
Religion and spirituality	Dominant religion; religious beliefs, rituals, and ceremonies; use of prayer, meditation or other symbolic activities; meaning of life; source of strength.
Death and dying	Meaning of dying, death and the afterlife; belief in fatalism; rituals, expectations, and mourning/bereavement practices.

Oncology Nursing Society (1999). Oncology Nursing Society Multicultural Outcomes Guidelines for Cultural Competence. Pittsburgh, Pa. Reprinted with permission.

Table 2: Major Systems of Culturally Based Health Beliefs

Biomedical Model (Western, Allopathic)	Biomedical model of medicine and nursing, the primary healing system of the dominant culture/group in the United States. Based on scientific reductionism and characterized by mechanistic model of the human body; separation of mind and body, and discounting of spirit or soul.
Traditions from American Indian Nations	Health beliefs and views of death predate European immigration and vary by tribe. Many are characterized by mind-body-spirit integration, spiritual healing, and use of herbs from native plants. Harmony with natural environment (e.g., animals, plants, sky, and earth) was important for health. Illness is sometimes seen as a result of an individual's offenses, to be treated by a ritual purification ceremony or a ceremony by a medicine person. In many tribes, life and death are viewed in a circular pattern rather than linear as in European traditions.
Traditions from Africa and Early African American Heritage	Various African traditions frequently integrated with American Indian, Christian, and other European traditions. In the variety of systems, most illness could be seen as: • a natural illness, which is a result of a physical cause, such as infection, weather, and other environmental factors; • a occult illness, which is resulted from supernatural forces, such as evil sprits and their agents (e.g., conjurers); or • a spiritual illness is a result of willful violation of sacred beliefs or of sin, such as adultery, theft, or murder Common characteristics of healing include: • healing power of religion, Christian in some cases; and • use of herbs, or " root working". In some Caribbean Islands, African traditions evolved into strong beliefs in power of spirits and use of healers to maintain health and treat illnesses. However, those beliefs probably have a weak influence on most urban African Americans today. Many current African American elders, particularly those from the rural South, grew up using alternative practices of self-treatment, partly in response to lack of access to mainstream care. Experiences of segregation and memories of the Tuskegee experiment may make the current cohort of older African Americans skeptical and distrustful of mainstream medicine, especially when making decisions about care at the end-of-life.
Traditions from Asia	Classical Chinese medicine influenced traditions in Japan (Kampo), Korea (Hanbang), and Southeast Asia. It is characterized by

	• need for balance between *yin* and *yang* to preserve health, especially through the use of herbs and diet; • unblocking the free flow of *qi*, (chi) or vital energy, through meridians in the body by acupuncture, *tai chi*, moxibustion, and cupping; and • interaction of basic elements of the environment (e.g. water, fire, earth, metal, and wood). In parts of Asia, Taoism and Buddhism have influenced the healing traditions. • Taoism emphasizes the need to adapt to the order of nature, and • Buddhism emphasizes meditation for spiritual and physical health. Ayurvedic medicine practiced in India: • is shaped by Hinduism and traditional Indian culture. • includes basic elements of the environment (e.g., air, water, and wind) which have analogues in the body. • is characterized by the use of yoga, meditation, herbs, and by integration of mind-body-spirit. Traditional Hmong health beliefs are characterized by: • interventions of a wide variety of spirits that promote health or cause illness; and • risk of loss of soul that brings illness. For many Asian American elders, traditional healers' offices serve as meeting places to socialize with other elders. The socialization function of traditional healing parallels the traditional Chinese medical view that illness should be addressed not only through medicine, but also through social and psychological aspects of life. End-of-life decisions about care may be characterized by: • family vs. individual decision making—even if the elder is competent to make decisions, family members might feel that it is their filial duty to take the decision-making role; • non-disclosure of terminal illness to protect the elder; and • placement of the dying person or the body—wanting to "go home to die" and the practice of not disturbing the body reflecting reluctance of organ donation or autopsy.
Traditions from Latin America	Most Latino Americans practice the biomedical model, but among some elders there may be reminiscences of other beliefs.

	• Beliefs rooted in models developed from Native American, European, and African practices form an intricate cultural blend. Examples are *Santeria, Espiritismo,* and *Curanderismo,* in which religion is an important component of the system. • CAM practices are seen as exogenous, and in opposition, to the biomedical model. There is an integration of elements from both practices forming a complex cultural product. Latino Americans are less likely than European Americans to: • make individual decisions on end-of-life issues or complete advance directives, • endorse the withholding or withdrawal of life prolonging treatment, • use hospice services, • support physician-assisted death, and organ donation. Cultural themes that can influence beliefs and practices concerning end-of-life decisions may include the emphasis on the well-being of the family over the individual; respect for hierarchy; and the emphasis on the present as opposed to past or future.
Other European American Systems	Folk healing systems from European countries predating biomedicine, many of which include religious healing and use of herbs, may still be practiced in some areas of the U.S. Variations on the belief systems of allopathic medicine, or competing health philosophies have emerged in the U.S. in the past century. Two of the major ones are: • Osteopathy, similar to allopathic medicine, but deals with the "whole person" and emphasizes the interrelationship of the muscles and bones to all other body systems; • Homeopathy emphasizes the healing power of the body, and relies on the "law of similars" to choose drug therapy.

Yeo, G. et al. Core Curriculum in Ethnogeriatrics, 2000. Second Edition. Stanford University, California. Module 3.

Table 3: Competencies Important for Ethno-geriatric Practice

Practitioners should be able to:

1. Describe their own cultural values and discuss the effect of those values on their behavior and beliefs.

2. Assumes and acknowledge the heterogeneity within categories and groups of ethnic elders.

3. Assess clients' position on the continuum of acculturation in relation to their perceptions, definitions, and explanatory models of health and illness and their health behaviors.

4. Demonstrate interviewing skills which promote shared decision-making and mutual respect between the ethnic client and the health care provider.

5. Communicate effectively and elicit information from elders of any ethnic background.

6. Explain the importance of cultural and historical experiences (e.g., racism and discrimination) and describe their effect on the older client's help-seeking behavior.

7. Identify the resources within older individuals and the ethnic community for promoting and maintaining elders' health, and support those resources in a respectful way.

8. Advocate for the institutionalization of policies and practices that facilitate ethnically sensitive health care within organizations and professions.

Developed by: Stanford GEC Core Faculty for Enhancing Ethnic/Cross-Cultural Competence

Table 4 : Cultural Self-Assessment

1. Where were you born?
   If an immigrant, how long have you lived in this country?
   How old were you when you came to this country?
   Where were your grandparents born?

2. What is your ethnic affiliation and how strong is your ethnic identity?

3. Who are your major support people: family members, friends?
   Do you live in an ethnic community?

4. How does your culture affect decision regarding their medical treatment?
   Who makes decisions - you, your family, or a designated family member?
   What are the gender issues in your culture and in your family structure?

5. What are your primary and secondary languages, speaking and reading ability?

6. How would you characterize your nonverbal communication style?

7. What is your religion, its importance in your daily life, and current practices?
   Is religion an important source of support and comfort?

8. What are your food preferences and prohibitions?

9. What is your economic situation, and is the income adequate to meet the needs of you and your family?

10. What are your health and illness beliefs and practices?

11. What are your customs and beliefs around such transitions as birth, illness and death?
    What are your past experiences regarding death and bereavement?
    How much do you and your family wish to know about the disease and prognosis?
    What are your beliefs about the afterlife and miracles?
    What are your beliefs about hope?

Adapted from: Zoucha, R (2000). The keys to culturally sensitive care. American Journal of Nursing, 200:24GG-2411.

XIV. Case Studies

Case # 1 : "Mrs. Mendez"

(Cultural attitudes and beliefs have significant impact on end of life care)

Mrs. Maria Mendez is a 72-year-old Hispanic patient with advanced left breast cancer with metastasis to the lungs and bones. She is referred to your home care agency for wound care services. She has seven children: five daughters and two sons (all living in California). Her five daughters live within the Los Angeles area. Her eldest son lives in San Diego and the younger son has been distant from the family and has not had contact with the family for the last 18 months. Mrs. Mendez's husband died seven years ago of lung cancer. Since that time she has lived with her youngest daughter, Maria.

Initially, Mrs. Mendez discovered the breast lump herself but did not seek medical care for over a year. When Mrs. Mendez was diagnosed, her disease was considered advanced. She refused to have a mastectomy based in part by her cultural belief that the soul resides in the breast and should not be removed. At the urging of her children, she did undergo chemotherapy but recently has experienced increased bone pain and decided to discontinue the treatment regimen. The tumor in the left breast is now approximately the size of an orange with malodorous, purulent drainage. Home care was initiated for wound care and other symptom management services. Under the terms of her managed care/Medicare insurance plan, her care is referred back to her family care practitioner in her local community rather than her oncologist since she is no longer receiving cancer treatment.

Mrs. Mendez's condition continues to decline and her physician encourages her to seek hospice care. Mrs. Mendez has become very close to the home care nurses who provided the wound care and requests that her care continue with the home care agency rather than a referral to hospice. At this time, changes in her living arrangements are also made. Living with Maria over the last seven years has been very positive, but Maria has three young children and the intensive care of her mother at this stage of the illness is becoming a problem. The family emphasizes that Mrs. Mendez should move in with her eldest daughter, Gloria, who no longer has children living at home. Although her daughters have always been close to their mother and more involved in her care, the eldest son of the family, Jose, who resides in San Diego, is consulted for all decisions and has been the father figure of the family since Mr. Mendez's death. Mrs. Mendez's managed care plan allows for only two RN visits per week and must be reevaluated every three weeks by the case manager. In addition to the symptom management provided by the home care agency, Mrs. Mendez and her daughters use many alternative therapies which includes "cat's claw", herbs, and visits by a healer. Mrs. Mendez is religious and uses prayer to help cope with her illness. Her middle-daughter, Christina, is devout in her religion and is in absolute denial that her mother will die. Christina comes nightly and holds a

prayer vigil with her mother and also brings herbs and remedies that "will cure the disease". Mrs. Mendez becomes increasingly withdrawn as conflicts arise among her children. Gloria and Christina are at odds because Gloria is most accepting of her mother's impending death. Gloria was also the primary caregiver during her father's illness with lung cancer.

After three weeks of care by the home care agency (HCA), Gloria calls requesting that a nurse come as soon as possible because her mother's pain is worse. On physical assessment, the nurse notes that the breast tumor remains dry, however the tumor mass has increased and the breast is inflamed. The pain is described by Mrs. Mendez as an intense pressure pain at the site of the tumor in the base of the breast. She also describes a sharp stabbing pain in the left upper quadrant of the breast. In addition, Mrs. Mendez complains of intense pain in her mid-back which has made it very difficult to lay in bed and she has been unable to sleep for the last week. She has been taking one to two Vicodin every four hours PRN although yesterday Gloria reports that out of desperation the Vicodin was given approximately every two hours until Mrs. Mendez became extremely nauseated. The nurse recalls that morphine was ordered for the patient a few weeks ago in anticipation of increased pain not controlled with the Vicodin. Upon questioning, the daughter states that they have not used the morphine as they were "Saving it for the end." Gloria also reports that the family is trying to minimize the use of the medicine since their mother is extremely constipated. Gloria continues to relate that the reason her mother is constipated is because Mrs. Mendez has not been able to continue her herbal remedies due to nausea. Mrs. Mendez appears very stoic with minimal expression of pain. Her only complaint is that she no longer is able to have her grandchildren over to visit due to her declining condition.

Mrs. Mendez is initiated on a regimen of long-acting morphine, 60 mg at bedtime with 15 mg morphine immediate release (MSIR) for rescue dose. Over the next week, the long-acting morphine is increased to 120 mg BID supplemented with Imipramine 50 mg BID and Ibuprofen 800 mg TID. Christina has now moved into Gloria's home and continues her evening prayer vigils. Jose calls several times a day to dictate his wishes regarding his mother's care but has not been able to visit often from San Diego as he is in risk of losing his job. Gloria seems increasingly burdened with her mother's care and her siblings' involvement. Gloria follows the home car nurse to the car weeping because of the stress.

Approximately one week later, the nurse receives a call from Gloria reporting that her mother has seemed to decline rapidly over the weekend. Mrs. Mendez awoke during the night with difficulty breathing and has been terrified of the possibility of suffocation. On exam, the nurse notes that Mrs. Mendez has developed extreme shortness of breath. She is also increasingly fatigued and the combination of exhaustion, dyspnea, and general decline has resulted in minimal intake of foods or fluids. Jose called this morning with strict orders that his sisters continue to feed their mother at all costs. He hopes to be able to come up from San Diego the following weekend to visit. Mrs. Mendez relates to the nurse that she knows she is dying and does not want to continue being a burden to her family.

Mrs. Mendez's physical condition has greatly improved due to aggressive symptom management by the HCA. The morphine does has increased to 240 mg BID supplemented with 40 mg of MSIR approximately every two hours for dyspnea. With her breathing improved, she as been able to take sips of water and occasional amounts of other liquids. Mrs. Mendez's

condition, however, continues to decline and the home care nurse anticipates that she will die within the next two weeks. The HCA schedules a meeting with the primary nurse and social worker to discuss the growing tension in the family. Four of the daughters are now present in the home taking shifts to be at Mrs. Mendez's bedside at all times. To make the family situation more difficult, Jose has learned that the young brother Pablo is living in Los Angeles and asks Pablo that he please visit his mother before she dies. Christina continues her prayer vigils and has asked members of her church to visit daily to hold prayer meetings with her mother. Mrs. Mendez tells the nurse that she cannot discuss her impending death with her family because they do not want to talk about it or hear that she is dying. At this point, Mrs. Mendez is very withdrawn and has little interaction with her family. Mrs. Mendez has now developed a pressure ulcer on her buttocks and requires a Foley catheter due to incontinence, which has intensified the physical care demands of her care.

The HCA receives a call on Saturday evening requesting assistance with Mrs. Mendez as her condition is declining rapidly. The younger son, Pablo, arrived two days ago and has had a very tearful reunion with his mother and his sister, Gloria. The social worker and the nurse were very successful in the family meeting with facilitating communication among the children and establishing common goals for Mrs. Mendez's comfort. All of the children with the exception of Christina, seem accepting of the impending death. Gloria's husband, Michael, has been quite supportive of his mother-in-law's care throughout her illness, but has strong feelings against death occurring within his home.

The priest is called to give Mrs. Mendez communion and the Anointing of the Sick. The extended family is at Mrs. Mendez's bedside, except for Christina who is in the kitchen crying.

Source: HOPE: Home care Outreach for Palliative care Education Project. (1998). Funded by the National Cancer Institute. B.R. Ferrell, PhD, FAAN, Principal Investigator. (in. ELNEC Curriculum. 2000. Module 5, p18-20.)

Case #2: Mr. Seaung

(Cultural issues have an impact on decisions about a plan of care.)

This case centered around a Cambodian client was developed by
Rom Seaung is a 75-year-old widower from Cambodia who arrived in the United States in 1981. He lives with his 50-year-old widowed daughter and his three grandsons, ages 18, 20, and 22. His 20-year-old grandson's wife, who attends the University of Houston studying business administration, works and also lives in the home. The total number of persons in the three bedroom Heights' pier-and-beam home is six. Mr. Seaung's 72-year-old sister lives with his niece in Southwest Houston.

Mr. Seaung, who is unable to speak English, has his daughter, Ms. Veth, interpret in broken English. She is the one who made the clinical appointment for her father. Ordinarily, he frequents the traditional pharmacy and visits a shaman for health problems. Mr. Seaung prefers to visit the traditional healer rather than utilizing the Western medical system.

Ms. Veth reports that her father refuses to bathe, is not eating, and has bladder incontinence. She also reports that he has insomnia and at one time was diagnosed at an emergency room as having a stomach ulcer. The traditional healer removed the evil spirits, according to Mr. Seaung, and his ulcer problems seemed to dissipate. Mr. Seaung's appearance is disheveled. He appears to be quite skinny and is reluctant to participate in the examination. Ms. Veth reports that she wants her son's wife to assist with respite and supervision of her father. You feel uncomfortable because the daughter seems to be answering for Mr. Seaung and also seems in your opinion to intimidate her father, through you cannot be sure. Ms. Veth continues to complain that her daughter-in-law will not assist in bathing Mr. Seaung or providing assistance with her grandfather-in-law's care.

Mr. Seaung is living on Supplemental Security Income (SSI) and also has a Medicaid card. He also benefits from his family's paying most of the household expenses. His daughter is presently unemployed. In Cambodia, she was a seamstress and utilized those skills from 1985 to 1990 in the United States. She left work to take care of her sick husband who died a year later (1991). She never returned to work. She appears to be the only person providing informal support for her father.

Mr. Seaung's 18-year-old grandson is completing his last year of high school and is working to save money to attend a college out of state. His 22-year-old grandson graduated from Houston Community College and is working as a draftsman, while his 20-year-old grandson is also working and pursuing premed studies at the University of Houston. He hopes to attend medical school next year.

Upon examination, the nurse practitioner discovers that this patient has bruises up and down his arms and back. The bruises resemble large hematomas. Mr. Seaung's blood pressure is 100/60 mm Hg, and he has a slow irregular heartbeat and a temperature of 100°F.

Developed by Robin S. Goldberg-Glen of Widener University in Chester, Pennsylvania. Reproduced from *Geriatric Interdisciplinary Team Training*: A Curriculum from the Huffington Center on Aging at Baylor College of Medicine, edited by Dianne M. Long and Nancy L. Wilson (New York: John A. Hartford Foundation, Inc., 2001).

Case # 3: Mr. Vega

(Cultural attitudes and the stress imposed on a Hispanic family by caregiver burden)

Mr. Vega is an 83-year-old Hispanic with a history of dementia with alcoholic psychosis. Mr. Vega comes from a traditional Mexican background with an extended family that reflects a blending of traditional and acculturated views about family values, roles, and responsibilities. Mr. Vega also has a history of using folk remedies for ailments as complementary therapies to conventional health care. Mr. and Mrs. Vega were both born in Mexico and became naturalized; however, all their children were born in the United States. Mr. Vega worked as a mechanic and Mrs. Vega was a homemaker and on different occasions worked as a domestic worker. He has been diagnosed as having alcohol-related dementia, Alzheimer's disease, seizure disorder, and hypertension. Monthly income comprises his Social Security ($687) and his wife's Social Security benefits ($258). They have no other liquid assets. He scored 18/30 on the Mini Mental State Exam (MMSE) administered at the outpatient clinic. His wife, also a clinic patient, reports Mr. Vega has had a continuous cognitive decline, which was first noted several years earlier. He has an unsteady gait, and has fallen several times. He also exhibits condescending and aggressive behavior, particularly toward his wife and two daughters. The youngest daughter, age 45 and single, is employed and resides with the couple, but usually is only home at bedtime and provides no patient care assistance. The other daughter, the eldest, resides across town and provides transportation to the couple for medical appointments. She is divorced and is the sole provider for three children. Mr. Vega frequently berates this daughter for her inability to keep her husband in the home.

The couple also has three sons (two reside in Houston and one resides in Austin) who provide little daily assistance due to family commitments. No relationship between Mr. Vega and his sons appears to exist, at least in part because of his history of drinking and abusiveness. Other reasons may relate to their perceptions of family caregiving and their commitment to provide for their own families first. Mr. Vega's psychotic symptoms include being verbally explicit with his sons and imagining a sexual relationship between his wife and a man whom Mr. Vega "sees" frequently in their home. In fact, Mr. Vega's inappropriate sexual comments and behaviors almost resulted in a physical altercation with one of his sons; therefore, Mrs. Vega has requested that the children no longer visit. Mr. Vega has a 20-year history of becoming intoxicated daily before returning home from work. He allegedly had numerous extramarital affairs and was frequently verbally and physically abusive to his wife. Mr. Vega requires assistance with most activities of daily living. Mrs. Vega is medically stable, but is experiencing severe caregiver burnout. She scored 10/15 on the Geriatric Depression Scale (GDS) at the time of initial assessment. She refuses nursing home placement for Mr. Vega. She keeps the outside gate locked to prevent Mr. Vega from walking to the local bar. Mr. Vega has a Medicare health maintenance organization (HMO).

One month ago Mr. Vega was admitted to a skilled nursing facility for physical therapy after being diagnosed with a compression fracture, secondary to falling. The facility had a contract with Mr. Vega's HMO. The family has experienced difficulty in dealing with any long-term placement decision due to cultural, social, and economic reasons. The case was referred to the interdisciplinary team for staffing.

Throughout the following year, the social worker became the primary mediator of conflicts between Mr. Vega and his wife, Mr. Vega and the adult children, and Mrs. Vega and the adult children. Multiple referrals for psychosocial intervention were made by the interdisciplinary team to various agencies. Mr. Vega's cognitive status continued to decline, affecting his physical status. His MMSE score is 10/30. As the result of a fall, Mr. Vega has been readmitted to the skilled nursing facility for physical rehabilitation. Mr. Vega has become almost totally dependent on the facility's care. His aggressive behavior has lessened.

Mrs. Vega scores 6/15 on the GDS. She states that she feels stronger emotionally; however, she acknowledges the progression of the dementia and her own physical exhaustion, which prevents her from providing optimal care for her husband. She reports that, most family members are working and are unable to provide any daily assistance.

** Developed by Patti Savage of Bridgehaven Hospice and Steven Lozano Applewhite with the University of Houston Graduate School of Social Work. (Reproduced from Geriatric Interdisciplinary Team Training: A Curriculum from the Huffington Center on Aging at Baylor College of Medicine, edited by Dianne M. Long and Nancy L. Wilson (New York: John A. Hartford Foundation, Inc., 2001).