AgingWisely™
Comprehensive Care Management and Consultation

Assessment and Evaluation

Client Number and Name: #1800 - Susan
Assessment Date: September 20
Assessed By: S., Care Manager

Demographics

Current Living Arrangement: Stacy's (sister) apartment **Since:** 8/01/07
Address: 1200 Tampa Rd., Tampa, FL 33333
Phone#'s: cell: (813)888-9000

Previous: HealthSouth Rehab Hospital
Address: 901 N. Clearwater-Largo Road, Largo, FL 33770
Date of Admission: 7/09/07 **Date of Discharge:** 8/01/07
Phone: (727) 586-2999

DOB: 1/10/71
Age: 36
Social Security #: 222-222-2222
Marital Status: Divorced
US Citizen: Yes
Veteran: No
Religious Preference: None

Primary Caregiver: Stacy (sister, POA & Healthcare Surrogate)
Status of Caregiver: see summary
Stacy work phone: (813)900-0000
Stacy cell phone: (813)300-3000

Emergency Contacts:
1) Stacy **Relationship:** Sister **Phone:** above

Medical Information

Primary Physician: Dr. Peter Able
Note: (9/1/07) Susan saw Dr. Sanchez who made referral for PT therapy only (9/12/07). Dr. Ableman was not there on the date of Susan's first visit to N. Tampa Community Health Center. Mary Smith, ARNP, is the name on the referral.

Address:
North Tampa Community Health Center
1229 131st Avenue
Tampa, FL 33612
(813) 555-6666 FAX (813) 666-7777

Diagnoses (from HealthSouth Rehab, 7/10/07):
Primary: RT CVA
Secondary: Left sided Hemiparesis
Critical Care Myopathy
Peripheral Neuropathy
Incoordination
CAD
S/P CABG
Myocardial Infarction
CHF
A FIB
Diabetes
Hypertension

Allergies: Toradol, shellfish

Medical History:
Hospitalizations (beginning with most recent):

HealthSouth Rehab, Largo, FL (7/10/07 – 8/12/07)
Memorial Hospital
- 2-3 months w/pneumonia and complications from stroke

University Community Hospital, Tampa FL (after first heart attack)
- Location where open heart surgery was performed

Orlando Regional Hospital

From HealthSouth Rehab Discharge Summary, Dr. Littleman dictated 8/25/07 …

Susan is a 36-year-old white female who was transferred from St. Pete's Long-Term Care for comprehensive inpatient rehabilitation of impairments secondary to a CVA, decondition syndrome, questionable critical care myopathy, questionable critical care neuropathy, and chronic pain syndrome. She had been in the hospital for long-term care since February. She has a very complicated course. She has a history of coronary disease, MI, cardiomyopathy with an ejection fraction of 20%, and atrial fibrillation. She underwent a CABG apparently that was completed by a CVA x2. This primarily involved the left side of her body. She had respiratory failure requiring tracheostomy. This has resolved. She has a stat IV sacrococcygeal decubitus ulcer which underwent debridement SLAP on 5/31/07 by Dr. Napa. History of sepsis, Clostridium difficile, MRSA in the wound. She has diabetes. She has anxiety and depression. She has chronic pain syndrome, on weaning doses of morphine, on Dilaudid for breakthrough pain. She has a history of hypertension and hyperlipidemia.

Susan has multiple complicating conditions, including coronary disease and surgery, strokes, ulcer, degenerative spinal condition, chronic pain syndrome, a vicious flesh-eating bacteria and diabetes. She is anxious and depressed, especially in the perceived loss of control over her former health and life. Previously an accomplished business woman with management experience, Susan now finds herself dependent on the decisions of others and income that she does not directly control.

According to Susan …

The first heart attack was in February 2007. After that, they put stints in and that failed. Once that happened, another heart attack occurred. Then, open heart surgery. Once that happened, I had the first stroke, affecting my right side. I was improving, sitting by myself in my room. About a week later, another stroke set in. When that happened my right side came back, but I lost the left side. I couldn't talk at first, but this is starting to get better.

I went to HealthSouth where I started PT and ST. I'm now able to talk, but limited. PT has stopped now that I have come home. I need it desperately, because I can feel the loss of strength gained at HealthSouth. I have no home-based therapies now.

Discharge Summary from HealthSouth Rehab

The patient was discharged home with her family on 8/12/07. She was to continue on a 2000-calorie consistent carbohydrate/diabetic diet. Arrangements were made for home healthcare to follow the patient for PT and nursing. The patient is to have an INR every Monday and Thursday with the results to her primary care physician. Accu-Cheks to be closely monitored. The patient is to have a weekly CBC and BMP with the results to the patient's primary care physician.

Condition on discharge: Medically stable

Durable Medical Equipment Orders (7/25/07, Dr. Littleman)

- Rolling walker
- Wheelchair (light weight)
- Roho (low profile) seat cushion
- Shower chair w/back
- 3 in 1 commode

All of these have been procured.

Prescriptions from HealthSouth discharge orders (8/01/07):

Medication	Dosage
1. Humulin R insulin	Per sliding scale protocol
2. Cordarone	200 mg tablets 1 po daily at 8AM
3. Bumex	1 mg every evening at 1630 hours
4. Coreg	6.25 mg – 1 po twice daily
5. Lexapro	10 mg – 1po at noon

6. Pepcid	20 mg po twice daily
7. Feosol	325 mg – po twice daily with meals
8. Lantus insulin	20 units subcutaneous at bedtime
9. Prinivil	10 mg – po daily
10. Theragran-M	1 po after supper
11. Klor-Con	20 mEq po three times a day
12. Lycra	150 mg – po twice daily
13. Lipitor	10 mg – po at h.s.
14. Coumadin	4 mg – po daily
15. Zinc	220 mg – po at noon
16. Dilaudid	2 mg – po q.6h. as needed for pain, #40 dispensed with no refills

Insurance Information

Medicare #: None
Supplemental Insurance Carrier: None
Long Term Care Insurance Carrier: None
Florida Medicaid: 20000000

Legal Information

Health Care Surrogate: Yes, Stacy — **Copy of Document on File:** No
Living Will: No — **Copy of Document on File:** N/A
Durable Power of Attorney: Yes, Stacy — **Copy of Document on File:** Yes

Estate Plan (Will/Trust): Yes — **Copy of Document on File:** No

Special Needs Trust for Disabled Person under 65 Years Old:
ABC Trust Company
1 Packer Ave.
Chicago, IL 60606
Trust Officer: William Smith, (312) 700-7000, wsmith@abctrust.com

Financial Information

Income: SSDI check as of August 2007, ($954/month). Susan was previously qualified for SSI and received checks for $30/month for approximately six months prior to the SSDI award.

Special Needs Trust: Special Needs Trust for Disabled Person under 65 Years Old, approximately $550,000.

Assets: 2000 Dodge Caravan

Social History

Past relationships, occupations, interests:
Susan has been previously married and divorced following an abusive relationship. She has been single for several years and she has no children.

Susan has one sister, Stacy, who is a stable, caring presence in Susan's life. Stacy is also POA/Health Care Surrogate. Currently, Susan lives in her sister's apartment with their mother who suffers from bi-polar disorder, Stacy's son and his girlfriend, and Susan's two large dogs and cat. This is a very crowded household and it causes Susan much agitation and a sense of claustrophobia. She is extremely anxious to get a place of her own that can be functional for her needs, including the maintenance of her pets and the ability to have guests. She intends to have Tony, her boyfriend, reside with her and serve as her primary caregiver. This is also Tony's stated intention in a personal meeting with this evaluator.

Susan has been a highly capable professional person who provided onsite management for construction projects in the St. Petersburg area. She was employed by Widget Company, Inc. According to sister, Stacy, "they loved her." Stacy continued, "Susan could conduct her own business, i.e., check book, bills. She's a wheeler-dealer."

Stacy has been the primary caregiver for years, plus caring for their mother. Stacy confirms that Susan is able to self-medicate. It is helpful, though, to have Stacy provide the insulin injection in Susan's stomach. Susan could do this, but prefers someone else to do it for her.

Susan is able to do some work on the computer. She has an email address and is able to navigate the Internet. Typing is difficult, but not impossible.

Susan's father is re-married thirty years ago and lives in North Carolina. He set up the special needs trust through ABC Trust Company, administered from Chicago, IL. Bill Smith is the trust officer with ABC.

Cognitive Abilities:

Oriented (Person, Place, & Time): Intact
Mood: Agitated with others; angry about loss of control
Confused: No symptoms noted
Anxious: Yes
Depressed: Yes

Memory

Short Term: Intact
Long Term: Intact

Activities of Daily Living

As reported by Susan and affirmed by Stacy …

	Independent	Assist	Total Assist
Bathing/Grooming:	x		
Dressing:	x		
Toileting:	x		
Ambulating:	x		

Eating: x
Meal Preparation: x
Communication: x
Special Diet: Diabetes specific instructions
Weight: Stable

Susan is able to transfer to an automobile from her wheelchair for transport as a passenger. She is not doctor certified for driving. A wheelchair transport service is not necessary. A vehicle or taxi with wheelchair storage capacity is all that is necessary. Stacy indicates that Susan can now walk from the front door of the apartment to the vehicle.

The meals that Susan prepares for herself are easy prep, primarily micro-wave and sandwiches.

Therapies Summary as of HealthSouth Discharge (8/12/07)

Occupational Therapy	**Functional Level**
Eating	Supervised
Grooming	Moderate Assistance
Dressing – Upper extremities	Supervised
Dressing – Lower extremities	Min
Bathing	Minimal Assistance
Toileting	Minimal Assistance
Transfers (Bed)	Minimal Assistance
Toilet	Minimal Assistance
Shower	Minimal Assistance

Occupational Therapy Comments:

- Patient has made significant progress since admission. Patient receiving caregiver assistance at home. Patient has increased functional activity tolerance and endurance.
- Safety Summary: Fair
- Goals: Patient being discharged home with family

Physical Therapy	**Functional Level**	**Device**
Rolling (L)		
Rolling (R)		
Supine-Sit		
Bed-Chair	Minimal Assistance	
Car Transfer	Minimal Assistance	
Ambulation	Minimal Assistance	Rolling walker
Distance	> 150’	
Curb	Minimal Assistance	Rolling walker
Stairs	Minimal Assistance	Handrails
Balance		
Sitting	Supervised	
Standing	Moderate Assistance	

Physical Therapy Comments:

- Patient has made significant gains since admission … now functional at Minimal Assist level for transfers and ambulation
- Safety Summary: Fair
- Goals: Discharge to home with family

Nursing Assessment
Summary – Alert, well oriented and able to move all gross motor functions. Some localized edema in her feet. No heightened levels of pain.

Home Environment/Safety Issues

Currently, Susan is in a two bedroom apartment that is too small and too crowded for her mobility needs and emotional wellbeing. It is critical that she find and establish "a place of her own" as soon as possible without making a rash decision.

She shares a bedroom and bed with her sister, Stacy. The bathroom is attached to their bedroom. There are other residents in the apartment, including her mother with bi-polar disorder in the other bedroom, Susan's adult nephew sleeping in the dining area, and the two large dogs and a cat that are Susan's long-term pets.

The apartment is reasonably accessible from the outside; interior maneuverability is tight.

There are no hurricane supplies or an evacuation plan.

Estimated Budget

Item	Amount	Comments
Monthly		
Rent	$1,900.00	including lawn and house maintenance
Utilities	$250.00	water, sewer, trash, power
Cable TV/Phone/Internet	$115.00	
Homemaking Services	$200.00	
Groceries	$400.00	
Clothing/Personal Care	$100.00	
Auto Fuel	$160.00	
Auto Maintenance	$100.00	
Auto Insurance	$120.00	
Therapies - non Medicaid	$0.00	PT - Medicaid covered out-patient
OT Home care	$1,200.00	OT - 2x/week @ $150 ea
ST Home care	$1,200.00	ST - 2x/week @ $150 ea

Sub Total Monthly	**$5,745.00**	
Annually		
Adaptive Equipment	$500.00	
Other		
Vehicle Replacement	$25,000.00	approx. every 5 years

Presenting Problems/Issues

Identified by Client:

- Susan is clear and adamant in her stated need to continue with therapies.
- She is anxious to have her own home that will include mobility, accessibility, room for pets, family and friends. She wants to have control over her housing choice and is opposed to a rental situation, although, this is the position of ABC Trust Co.
- Susan wants to not be seen as a handicapped person, but to be fully respected as a person with the ability to manage her own life and tasks.
- Susan is receptive to the support of care manager.

Identified by Family:

Stacy:

- Susan could potentially live independently, but needs more rehabilitation. She is making great strides, is capable of managing her own affairs, and should be encouraged to have as much control over her life as possible. Stacy is not particularly concerned about Susan living as far away as South Tampa. She believes this is the kind of setting that Susan has in mind and that she and Tony can help with the necessary transportation needs for therapies.

- Tony's availability as caregiver/companion should not be the basis of Susan's decisions. However, Stacy is not opposed to Tony's involvement in Susan's life and recognizes the emotional and caregiving support that Tony provides Susan.

Identified by Care Manager:

Resumption of therapies, PT, OT and ST:

- Resolved, Medicaid will only pay for PT services; OT and ST services will be private pay.
- Resolved, the location for physical therapy will be Tampa General Hospital, beginning 9/24/07. Script from N. Tampa Health Center referred Susan here for Medicaid coverage. Susan has confidence in this provider, too.
- Resolved, means of transport will be taxi via MMG Transport, a Medicaid covered service.

Transportation

- Susan is able to transfer to a vehicle as a passenger. It will require further physician consultation to determine Susan's ability to drive on her own. Her current Dodge Stratus is too low for transfers to/from wheelchair. An alternative vehicle appropriately sized and prized will be important to Susan's mobility and independence.

Medical follow-up

- Continuing medical needs will require careful attention to follow-up doctor consultations. Dr. Lyleman has prescribed follow-up testing that needs to be addressed.
- The N. Tampa Health Center is the office for Susan's primary care physician. This is a very busy, community health center that is difficult to navigate for answers.

Recognizing and promoting Susan's strengths and independence.

- Helping Susan understand the possibilities and limitations of her trust.
- Helping Susan relate constructively to the offices and individuals involved in her trust administration, medical and therapy resources, and realtor/property management firm.

Optimizing resources

- Preserving assets
- Helping with a long-term view of trust disbursements
- Promoting productive relationships with caregivers and helping professionals

Updating Medicaid status now and Medicare at the appropriate future time

- Susan is not currently eligible for Medicare. In approximately two years she will be eligible to make application via her disability status.
- Susan has been approved for institutional Medicaid; now she needs to be transitioned to community-based Medicaid. She and care manager have made the first updates to her Medicaid account online. This needs additional follow-up.

Securing suitable housing that meets Susan's needs without jeopardizing trust funds and/or assistance from Medicaid.

Coordination of care and resources in this complex situation will require advocacy and support services.

Recommendations/Plan of Action

1) Recommend immediate attention to the acquisition of housing that is amenable to Susan and ABC Trust Co.
   - The house should provide wheelchair accessibility and internal wheelchair mobility.
   - Kitchen and bathroom access should be adaptable to Susan's minimum assistance equipment and caregiver assistance needs.
   - Recommend the house be at least 2 bedroom/2 bathroom with garage and a fenced yard ample for Susan's two large dogs.
   - Recommend desirable lease/option purchase arrangements be fully explored.
   - Recommend the property be managed by the landlord/management company to include all maintenance internal and external. Rent should include these costs.
   - Recommend the house be at a distance reasonably accessible to Stacy, since she remains Susan longest standing advocate and caregiver.

2) Recommend care management services to assist with:
   - Prompt resumption of therapies on an outpatient basis;
   - Thorough review of durable medical equipment needs in light of HealthSouth discharge instructions, Susan's self-determined needs, and recommendations and from new therapists at Tampa General Hospital;

- Coordination of transportation arrangements;
- Interface with Susan, realtor and trust officer in regard to housing selection;
- Promoting Susan's power to direct her life within constraints of her special needs trust parameters and medical and safety considerations;
- Periodic visits and oversight of Susan's progress and needs: Initially, a minimum of once/week telephone updates and once/month home visit. Eventually, this will taper off as Susan's situation stabilizes and her independent functioning is verified.
- Continuing liaison as needed to promote effective working relationship between Susan and the offices and people she must deal with to accomplish her goals of independence;
- Source of stand-by support for Susan, as needed.

3) Recommend selection and purchase of an alternative vehicle in consultation with PT and OT therapists who can address functional needs and abilities. Susan's Dodge Stratus is not a suitable vehicle for her accessibility and wheelchair storage.

4) Recommend creating an online "Life Ledger" account to maintain easy access of Susan's complex medical history/needs. Susan, her sister, and authorized care providers would be enabled to access this service.

5) Recommend a medication inventory be completed and outdated medications disposed of.

6) Recommend emergency contact numbers should be prominently displayed in the house.

7) Recommend a Hurricane Preparedness strategy and resources should be planned and put into place for Susan when she establishes her new living arrangement.

Susan demonstrates motivation, self-directed initiative and a compelling interest in demonstrating her independence. She fully participates in her plan of care and will make progress toward greater functional, emotional, psychological, and physical health with the wise investment of her resources and effective partnership with her care providers. It is a privilege to meet this fine person and to be of service to her in this endeavor.

Sincerely,
S.
Care Manager
Aging Wisely, L.L.C.