**IPE COVID Community Health Scenario**

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**Patient Summary**

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| Name: Thomas, Ann Age: 65  DOB: 3/5/1955  MRN: 5054010  DNR: No  MOLST: Yes (Medical Order of Life Sustaining Treatment)  Discharge weight: 184  Height: 64 inches  BMI: 31.4  PMH: COVID 19 Pneumonia; Right Cerebral Vascular Accident (CVA); Obesity, Type II Diabetes Mellitus (NIDDM), Hypertension, Osteoarthritis bilateral knees  PSH: Bilateral total knee replacements (TKR) | **DEMOGRAPHICS**  Gender Identity: Female Religion: Catholic Household Members: Husband, daughter and one grandchild  Occupation: Retired secretary  Marital Status: Married  Race/Ethnicity: Hispanic  Primary language: English  Postal Code:10455 (Bronx)  Other: Husband lost his deli business during COVID pandemic | **ALLERGIES: NONE**  **Current MEDICATIONS:**  Enalapril 2.5 mg by mouth daily (Hypertension)  Aspirin 81 mg by mouth daily (circulation)  Metoprolol 25mg twice a day by mouth (hypertension) Pantoprazole 40mg daily by mouth (treats and prevents blood clots)  Colace 100mg twice a day by mouth as needed for constipation Tylenol 650mg by mouth as needed for pain scale of 4-6  Alprazolam 0.25mg po 1 tab three x daily by mouth prn anxiety  Paroxetine (Paxil) 20 mg by mouth bedtime (anti-depressant)  Metformin 500 mg by mouth daily (diabetes) |
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| **Current HISTORY OF PRESENT ILLNESS:**  65-year-old person identifying as female initially admitted to the hospital COVID ICU about 16 days ago after respiratory decompensation due to COVID 19 Pneumonia. She was immediately eligible for and treated with Dexamethasone plus Remdesivir following CDC policy. Prior to her hospitalization, patient was also s/p acute right CVA. Due to the early antiviral treatment, patient only needed to spend 4 days in ICU then transferred to an inpatient medicine unit, and discharged to an inpatient rehabilitation facility. During her inpatient rehab stay, she was diagnosed with Post Traumatic Stress Disorder (PTSD) and received inpatient psychiatric services. Patient has made steady progress in rehabilitation with no further respiratory difficulties. She is currently awaiting her first COVID vaccination as per CDC protocol following her COVID 19 pneumonia. Patient’s blood sugars have been stable ranging 70-90 and she no longer requires insulin coverage. She was discharged home 2 days ago with plans to follow-up with her primary care provider, therapists, and public health professionals. Patient and family members are concerned about patient home care needs due to financial difficulties; post-COVID follow up care and potential ARDS relapse concerns, vaccine protocol and family member needs/education for vaccination. Family also expressing concern about patient receiving the vaccination due to conflicting stories about patients with natural COVID immunity not requiring the vaccine. The Public Health interprofessional team is meeting to meet and address patient public health needs; patient/family safety during the post-discharge period; implications of epidemiological & demographic health disparities; need for community education | | |
| **Hospital/ Rehab Discharge Diagnoses:**  COVID-19 Pneumonia, Right CVA (cerebral vascular accident), PTSD, New onset cognitive deficits, Hypertension, NIDDM, Osteoarthritis (OA) bilateral knees | | |
| **SOCIAL HISTORY:**  Patient with new cognitive deficits. Lives with spouse in an elevator building with 3 steps to enter. Recently retired. Spouse lost deli business several weeks ago. Social drinker with friends now & then. Has 2 grown children and 3 grandchildren. One daughter and granddaughter also live with patient. Patient and family concerned about patient care needs in the home and verbalize financial difficulty. | | |
| **PROGRESS NOTES (ASSESSMENT AND EVALUATION FROM EACH DISCIPLINE)** | | |
| |  | | --- | | **PHYSICIAL THERAPY EVALUATION**  **Objective:**  Mental Status: Pt cooperative. A&O x 4  Integumentary: skin intact  Compression stockings in place  Vital Signs: HR 75, BP 130/80, RR 14  Reflexes – L LE 3+, Modified Ashworth Tone 0  RLE ROM WFL, MMT >/= 4/5 T/O  RUE ROM WFL, MMT >/= 4/5 T/O, Grip strength 25Kg  LLE PROM WFL except L ankle DF = 5 degrees. AROM presents w/ isolated control of hip and knee in the 3/5 range. Pt is demonstrates active initiation of DF in the 2/5 range.  LUE ROM WFL, AROM presents w/ active control across shoulder flexion and abduction to 110 degrees. Partial control noted at elbow, wrist and fingers.  Patient is I in all bed mobility. Patient able to tolerate sitting EOB x 15 min with stable hemodynamic response  Sit to Stand with supervision only secondary to impulsivity. Transfers bed to chair also require S due to impulsitivity.  Amb 150’ with SBQC with CGA. Left foot drop persists. Pt reports occasional SOB upon ambulation. Pt demonstrates fair balance still having a risk for fall secondary to mild perceptual deficits and mild impulsivity.  Pt. left seated in kitchen chair. VS stable    **Assessment:** Pt presents s/p ARDS and R CVA with good potential for further recovery. Pt can tolerate functional activities within the home but endurance remains limited. She is I in with bed mobility but requires supervision for all transfers and ambulation secondary to impulsivity and decreased balance. Endurance remains poor. Pt remains a risk for falls due to limited balance, LE weakness, and perceptual deficits. Expect pt to make good progress with daily PT to increase safety and mobility skills. Recommend PT 3x/week. Recommend OT and P&O follow up for L AFO.  **Long Term Goals**: Pt will require S for all transfers in 2 weeks. Pt will amb 150’ indoors w/ SBQC and a L AFO with S; Pt will ambulate 50’ outdoors with SBQC, CGA and a L AFO in 2 weeks. Evaluate stair negotiation as appropriate.  **Plan:** PT 3x/week to include deep breathing exercises, functional mobility training, balance training, ther ex. To assess for stair negotiation as tolerated. | | | |
| **NUTRITION EVALUATION**  **Diet:** Regular  **BMI:** 31.4  **Height:** 5 ft 4  **Hospital admission weight**: 204lbs.  **Hospital discharge weight**: 190lbs  **Current weight**: 184 lbs, BMI 31.4  **Wt loss:** 20 lbs (9.8%)  Pt dx’d with COVID-19, hospitalized, s/p intubation and R CVA, now d/c’d to rehab. Pt had delayed nutrition support while in the ICU and poor intake/appetite upon discharge. Net 6 lb pound wt loss x 2 weeks. Pt is currently on Regular diet (seen by SLP). Pt is tolerating however, as stated, intake is inadequate. Pt lives with spouse, however, works full time.  **Malnutrition Screening Tool**: Pt scored 3 on weight score and 1 on appetite score for an MST score of 4, which indicates the pt is at high risk for malnutrition.  **Plan:** Will need to assess pt’s ability to obtain and prepare meals daily. Possibility exists that pt may need home health care or community program assistance (e.g. Meals on Wheels); will collaborate with interdisciplinary team. Will provide oral nutrition supplement at this time to increase intake.  **Goals**: Pt will be able to obtain and prepare food within 3 days. Pt will have no further weight loss. Pt will increase intake to 75% of meals within 2 weeks. | | |
| **SOCIAL WORK CLINICAL PROGRESS REPORT**  NAME: Ann Thomas DATE: 2020  LENGTH OF SESSION:  30 MINUTES  45-50 MINUTES  60 MINUTES  90 MINUTES  Start Time:\_1:00pm\_\_\_\_\_\_\_\_\_\_\_\_End Time:\_ 2:30pm\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PURPOSE OF SESSION:  Initial Session  Individual Counseling  Crisis Intervention  Suicide Assessment  Incident Follow-up  Group Counseling  Family Counseling  Addiction-Specific Counseling    **Subjective:** “I was healthy so how did this happen to me?...I don’t like feeling like this…I feel like I’ve lost so much”  **Objective/Mental Status**:  Alert/Oriented:  x4  Person  Place  Time  Situation  Attention/Concentration:  Poor  Fair  Good  Psychomotor:  Slow  Calm  Agitated  Hyperactive  Other \_\_\_\_\_\_\_\_\_\_  Speech:  Normal  Slurred  Rapid  Pressured  Slowed  Mute  Mood:  Irritable  Angry  Sad  Euthymic  Elevated  Euphoric  Anxious  Thought Flow:  Logical  Goal Directed  Tangential  Circumstantial  Loose Association  Thought Content:  WNL  Suicidal Ideation  Homicidal Ideation  Delusions  Hallucinations:  None  Auditory  Visual  Memory:  WNL  STM Impairment  LTM Impairment  Slightly Impoverished  Grossly Impaired  Impulse Control:  Poor  Fair  Good  Insight:  Poor  Fair  Good  Judgment:  Poor  Fair  Good  CURRENT MEDICATIONS: Medication assessment to be completed  Compliant: Yes  No  N/A  **Assessment & Recommendations:**  Ann completed the 7-item Generalized Anxiety Disorder (GAD-7) and scored a 17/21 placing her in the severe range for anxiety. She also completed the 9-item Patient Health Questionnaire (PHQ-9) and scored an 11/27 placing her in the moderate range for depression. She completed the 7-item Insomnia Severity Index (ISI) and scored an 18/28 placing her in the moderate range for insomnia. She completed the 22-item Impact of Event Scale–Revised (IES-R) and scored a 60/88 placing her in the severe range for traumatic stress. Therapist further explored her level of anxiety, depression, insomnia, and traumatic stress. She denied suicidal ideations, feelings, intentions and plans and was able to contract for safety. She was able to identify no reasons to die but identified several reasons to live. She was able to identify her presenting problems. The therapeutic process was again explained. We explored further the information that was gathered during her stay in the hospital. Ann discussed her great desire to be free of her current mental health symptoms which is causing her distress. She is willing to discuss medication regimen with a therapist.  **Follow-up Plan:** Ann requires a full bio-psycho-social-spiritual assessment and a medication assessment to further  determine her treatment needs. Ann is referred to therapist in her community and has an appointment scheduled  for day 5 after discharge.  Clinician: Therapist Jones, LCSW-R | | |
| **PUBLIC HEALTH EVALUATION/PROGRESS REPORT**  **Preferred Name:** Annie  **Primary Language:** English  **Income/Occupation:** High School Teacher  **Residential Street Address and Neighborhood:** TBD  **Phone # and/or email (ok to text and/or email): □**718-876-544,**□** [ann.t@gmail.com](mailto:ann.t@gmail.com)  **Social medial handle(s):** Ann.t (Facebook)  **Pre-existing health conditions:** HTN  **Other risk factors:** Possible stress related symptoms  **Date of symptom onset:** TBD  **Date of testing:** TBD  **Duration of illness:** 18 days  **Activity history during elicitation window:** Pt attended several social gatherings during the two weeks prior to diagnosis  **Exposure location:** Pt. reports possible @ family picnic    At initial diagnosis, pt’s travel, work, and social history should have been collected.  At that time the patient should have reported her symptom history and the contact elicitation window should have been estimated.  All persons who were in close contact with the patient (i.e. within 6 ft. for at least 15 minutes) should have been contacted and referred for follow up (including, co-workers, spouse, and children).  Assurance should be given to the pt that unless she gives permission, her name will not be revealed to those she came in contact with.    Demographic and locating information should be gathered to help monitor the pt and to better understand her living situation so that appropriate support is offered.    **Plan:** Provide pt with information about community services and social supports available in her neighborhood (i.e. food delivery, home care, mental health services, case management).  Provide education to patient about what to expect upon discharge.  Provide additional support and education to family members and close contacts.  **Goals:** Refer pt to needed services and follow up to assess additional needs post-discharge.  Advocate for the pt if needed.  Educate pt and family.  Reinforce public messages about COVID-19. | | |
| **NURSING Hospital PROGRESS NOTE**  **Situation:** Patient is alert and oriented X 3 but reports feeling fatigued. Vital signs: Temp 98.5, BP- 142/84, HR- 86, RR-24, O2 sat 95% on room air. Patient reports feeling SOB only when ambulating. Lower extremities with slight ankle edema (1+). Pain level 0/10  **Background:** Patient is a 65-year-old with a history of HTN, diagnosed with Covid-19 and respiratory failure requiring intubation and a 10-day stay in the ICU. The patient had a right cardiovascular accident during hospitalization. The patient was discharged home 2 days ago from rehabilitation facility.  **Assessment**: Patient’s BP is slightly elevated. Breath sounds slightly diminished at bases with slight rales. No coughing and no chest tightness reported. Abdomen soft, no distension, Bowel sounds present in all 4 quadrants. Patient states appetite is decreased, and she has no sense of taste. Pedal pulses palpable and equal bilaterally. Skin intact. Pt has left sided weakness and balance is altered when ambulating.  **Recommendations/Plan of Care**:   * Review all patient’s medications and time schedule including when the last dose of Enalapril was given * Elevate lower extremities when sitting * Instruct patient to use incentive spirometer 10 times every 2-4 hours and deep breathing and coughing exercises * Teach patient to get up slowly and use assistive device (if any) when ambulating * Teach patient infection control practices * Provide psycho-social care & offer emotional support * Review follow-up appointments with providers including follow-up for Covid19 testing * Educate family and patient about PTSD, post-COVID care and s/s ARDS, COVID vaccine | | |
| **RECREATIONAL THERAPY**  Summary: The client, Ann Thomas is a 65 year old female who has been home for two-weeks after a hospitalization for COVID-19, a CVA, and six-week stay in a short-term rehabilitation center. She reports high levels of anxiety and post-traumatic stress related to the hospitalization. She does not report pain, but does report feeling fatigued, and demonstrates balance impairments and left-sided weakness. Pt is on a special diet due to difficulty dieting and hx of diabetes. No hx of seizures. Notable medications include anti-anxiety, antidepressant and anticoagulant, and precautions should be taken for potential medication-related sun sensitivity. Recreational Therapy 1x/week focused on improving long-term health leisure habits is recommended for the next six weeks.    Prior to discharge from the rehabilitation center The Recreational Therapist administered the Bandi-RT and the Vitality Through Leisure Assessment. While in the rehabilitation facility Ann participate in group chair zumba and chair yoga. Pt reported using yoga breathing to manage anxiety before trying to sleep. Additionally, pt used music listening to help cope with anxiety. Pt used social media to connect with people in her religious congregation.      BANDI-RT  Special Considerations for RT: Pt has a fall risk and left-sided weakness. Pt is on a special diet due to difficulty dieting and hx of diabetes. No hx of seizures. Notable medications include anti-anxiety, antidepressant and anticoagulant, and precautions should be taken for potential medication-related sun sensitivity. Mental Status: Pt was interviewed and was oriented 4x. She demonstrated adequate short term (3/3) and long term (6/6) memory but demonstrated poor recall (3/6) for an overall cognition score of 12/15. Pt shows higher levels of anxiety since initial discharge, but no significant changes in cognition.  Recreation/Leisure History and Interests: On the leisure interest survey Ann indicated that she used to enjoy playing softball and attending baseball games, attending religious services, making jewelry, listening to music, and dancing. Constraints to leisure participation include limited opportunities to engage with the community due to the ongoing pandemic, financial constraints, and mobility restrictions. Facilitators to leisure include family members who are supportive of engaging with her in activities, access to technology including a smart phone, computer, and Nintendo switch, access to games and craft supplies. Treatment Considerations:No behavioral issues. Communication issues include: mild aphasia, word finding problems. Supportive family members (husband, daughter, grandchildren) but low contact due to COVID-19 restrictions withing the facility. Functional: requires mobility support.    VITALITY THROUGH LEISURE  Ann scored a 79 on the Vitality Through Leisure assessment, which is within the average range. However, evaluating the subscales indicate strength and opportunities for improvement for Ann’s leisure time. Ann scored a 15 (low score) in the broaden-and-build subscale indicating an opportunity to engage in more leisure that improves affect and broadens experience. She scored a 10 (low score) on the physical conditioning subscale indicating an opportunity to increase leisure activities that positively impact physical condition. She scored a 27 (high) in the relaxation and stress control sub-scale indicating she has a strength in using leisure to manage stress. She scored a 17 (average) on the optimal arousal subscale indicating an ability to use leisure to prevent boredom. Finally, she scored a 10 (average) on the personal betterment subscale indicating she is able to use leisure as a self-improvement strategy.    Recreational Therapy Goals:  Goal: Pt will use leisure activities to help cope with anxiety and traumatic stress.   * When asked pt will be able to identify one instance during the week the music playlist was used to manage anxiety. * Pt will practice deep breathing techniques to cope with anxiety, * Pt will explore other mindfulness practices to help cope with anxiety.   Goal: Pt will participate in physically active leisure to improve physical conditioning subscale scores.   * When asked, pt will be able to identify fall risk precautions to ensure safe physical activity. * Pt. will participate in a synchronous group virtual chair Zumba group once per week. * Pt will participate in individual physically active leisure activity for at least 15 minutes five days a week.   Goal: Pt will participate purposefully participate in leisure to enhance positive emotions and mood and increase broaden and build subscale score.   * Pt will identify and participate in one novel leisure activity per week. * When asked, pt will purposefully engage in leisure that promotes at least five minutes per day. | | |
| **SPEECH-LANGUAGE PATHOLOGY**  **Subjective:** Ann was warm and welcoming and expressed anticipation in working with the team of therapists. Ann reported that she feels her speech has improved but noted difficulty completing reading activities for leisure like following her favorite recipe, and reading emails received. Ann also expressed interest in writing a birthday card to send to her grandchild. Ann denied difficulty with memory and attention but her husband reported both as issues in activities of daily living. Additionally, Ann’s husband reported her lack of safety awareness in the home environment in trying to walk without support strategies.  **Objective:**  Oral Motor Evaluation: Patient has full natural dentition. No overt weakness or incoordination noted during most recent oral motor exam. Adequate ROM for all structures.  Swallowing: Ann demonstrated mild oropharyngeal dysphagia during her hospitalization but was advanced to thin liquids and a regular diet before being discharged. However, Ann continues to be impulsive during self-feeding and requires occasional verbal cues and intermittent supervision to implement safe swallow strategies to reduce aspiration/choking risk. Education was provided regarding use of safe swallow strategies to reduce aspiration risk including positioning upright to 90 degrees when eating/drinking/taking medications, small bites/sips, alternating solids/liquids during meals and avoiding straws.  Voice: Mildly hoarse vocal quality noted during hospitalization; however, at present clear, strong vocal quality is noted.  Speech intelligibility: Mild dysarthria characterized by slow speech rate and decreased articulatory precision was noted during hospitalization; however, this was targeted at inpatient rehab and is now independent in using speech strategies to improve intelligibility.  Expressive and receptive language skills: Ann follows multistep directions, answers yes/no questions and simple open-ended questions during conversation independently. Discourse-level impairments were noted including tangential comments, disorganized narratives and reduced ability to identify and repair conversational breakdowns. She also demonstrated difficulty with interpreting and using figurative/nonliteral language (e.g., humor, sarcasm). Reading and writing skills were informally assessed. Findings reflect difficulty following written directions. While comprehension of written directions was observed to be adequate, Ann was observed to follow steps out of order, reported forgetting which steps to include, and was unaware that she had repeated steps. Writing is judged to be disorganized reflecting inappropriate word choices, grammatical errors, and incomplete information.  Cognitive-communication skills: Mild cognitive-communication deficits were noted in the areas of attention, higher-level problem solving and safety awareness. Ann was observed to be impulsive at times and required frequent verbal cues to implement safety strategies as noted like attempting to walk without using support strategies, forgetfulness and inattention during cooking tasks like not turning the burners of the stove off.  Pragmatics: Appropriate social greetings, facial affect, and eye contact. Ann does, however, present with a lack of boundary awareness.  Summary of goals:   1. Ann will implement strategies to decrease impulsivity and rate of intake during feeding to improve swallow safety / reduce aspiration and choking risk during all PO intake, given cues <25% of time. 2. Ann will complete home-based functional problem-solving tasks (e.g., money-management tasks, route finding, sequencing) with 80% success, given cues <25% of the time. 3. Ann will demonstrate comprehension of multi-paragraph age appropriate written information with 90% success given independent use of strategies. 4. Ann will demonstrate adequate error detection during written tasks in 70% of opportunities given cues 25-50% of the time.   **Assessment/Plan**  Ann presents with mild cognitive-communication disorder characterized by impulsivity, decreased insight/safety awareness, and decreased organization of verbal and written output. Her post-extubation dysphagia has improved and she is now tolerating a regular diet with thin liquids. However, she remains at increased risk for aspiration due to impulsivity when self-feeding. Given PLOF and response to therapy, Ann is expected to continue to make good progress with ongoing SLP services targeting improving cognitive-communication skills and increasing independence during functional daily tasks to increase independence within the community. | | |
| **OCCUPATIONAL THERAPY EVALUATION**  **Occupational Profile:** Ann is a 65yo Hispanic female s/p COVID-19, ARDs, s/p RCVA w/ L hemiparesis. PMH: HTN.   * Occupational History: Prior to admission, Ann was working as a secretary. She enjoys spending time with her grandchildren and occasionally helped with childcare as needed. She also has previously enjoyed attending baseball games, making jewelry, and dancing. * Social Hx: lives in elevator building with husband, one adult daughter and granddaughter. Additional adult daughter and grandchildren live nearby. * Contexts that present as potential facilitators: supportive family, supportive church community. * Contexts that present as potential barriers:environmental factors of the home, work demands, needs for DME and adaptive equipment.   **Subjective:** Ann reports feeling fatigued easily. She reports she is happy to be home with her spouse  **Objective:** Ann participated in OT evaluation at home with spouse present. She was AAOx4. Vitals prior to start of session: HR 78 NSR, BP 130/80, RR 14, Sat 95% on 2 L O2. RUE AROM WFLs, MMT = 4/5 throughout, grip strength 25kg; LUE PROM WFLs, LUE AROM shoulder flexion 110, partial active movement noted at elbow wrist and hand. Ann was able to make a partial fist with LUE.  Ann exhibited decreased attention to task and mild impulsivity throughout the session. She required verbal prompts for safety awareness and to incorporate her LUE as a functional assist throughout the session. The OT evaluation was initiated in the kitchen. Ann was able to ambulate with CGA with SBQC from the kitchen to the half bathroom located on the same floor (distance = 30’). She was able to complete grooming activity to wash her face independently when items were placed on right of midline. She required verbal prompts for safety and thoroughness to brush her teeth and to locate grooming items on the left side of midline. Ann was able to don a button-down shirt with minimal assistance. She was able to don pajama pants with minimal assistance. She required minimal assistance to incorporate her LUE as a functional assist while performing ADLs. In the kitchen, she required maximal assistance to complete simple meal preparation to make toast. She required verbal prompts for safety and to locate items to the left of midline.  **Assessment:** Ann requires assistance for ADLs and IADLs and requires set up and verbal prompts for safety awareness and to locate items to the left of midline. She requires assistance to incorporate her LUE as a functional assist during ADLs and IADLs. She demonstrates potential to improve her independence with ADLs and IADLs. She also demonstrates ability to learn new information and incorporate safety and compensatory strategies during ADLs and IADLs.  **Plan:** Recommend OT 2 x/week at home to facilitate independence with ADLs and IADLs and to provide patient/caregiver education/training for safety and compensatory strategies during ADLs and IADLs. Recommend tub transfer bench and hand-held shower head to improve safety with functional transfer for bathing. Ann would benefit from leisure exploration/participation to promote balance of occupations. Further evaluation of cognitive impairments is recommended to determine impact on Ann’s work occupation as a teacher. Recommend referral to Recreational Therapy for leisure exploration and engagement.  **Goals:**  Ann will complete grooming activities to brush teeth independently within 2 weeks.  Ann will don a button-down shirt independently with compensatory strategies within 2 weeks.  Ann will don pants independently after set up within 2 weeks.  Ann will complete simple meal preparation with supervision within 2 weeks.  Ann will incorporate her LUE as a functional assist 80% of the time with occasional verbal prompts during ADLs. | | |