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Interaction with Other Health Team Members in Caring for Elderly Patients

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An 85-year-old retired teacher experiences gradual memory loss over several years. She has hypertension, diabetes mellitus controlled with an oral hypoglycemic drug, and atrial fibrillation for which she takes warfarin to prevent stroke. Two years earlier she underwent successful total hip replacement. After careful medical and functional evaluation, her internist concludes that she is in the early stages of Alzheimer's disease. He is concerned about her ability to live alone and, in particular, to continue to manage her medications safely. Her daughter lives in another city but arranges a consultative visit with the physician to discuss her mother's future care. Because the daughter travels frequently for business, she and her mother decide that an assisted living facility near the daughter's home would provide the safest environment. This plan requires moving to a new city and establishing health care with new providers.

The United States population of adults aged 65 and older is projected to grow from 35 million in 2000 (12.4% of the total population) to 70 million in 2030 (20.6% of the population) [1]. As a result, dentists, physicians, and other health care professionals will care for an ever larger number of individuals living to an advanced old age, many of whom, like the woman described in the vignette, will become frail, suffer multiple chronic illnesses, and experience disability [2].

Furthermore, care of these complex patients occurs in multiple sites and is managed by multiple providers over time. Expert care of geriatric patients often depends on consultation and coordination of services with other professionals and care providers. Consequently, safe and comprehensive care demands teamwork. Understanding the contribution that other health

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team members make to the patient's care and how best to interact with them is an essential competency in geriatrics.

To appreciate the complexity of this challenge, it is helpful to address the following questions:

Who are health care team members?
What information should they collect and share?
How can that information be transmitted effectively to other team members?

Although answers to these questions depend in part on local relationships and resources, a general overview can serve to guide clinicians who are confronted with caring for an older patient.

The health care team

The patient and her daughter choose an assisted living facility owned and operated by a registered nurse who employs two nurse's assistants to care for 12 residents. The facility requires that all residents have a primary care physician, and state law requires that the patient be screened for tuberculosis and undergo a complete medical evaluation, including cognitive and functional assessments. The daughter arranges this evaluation with a local internal medicine group. The initial evaluation is a geriatric assessment performed by a nurse practitioner, which includes a complete physical examination, functional assessment, and coordination of other services based on the patient's needs. The nurse practitioner schedules the patient for a return visit with an internist in the group practice. She also asks the office staff to help the daughter schedule a comprehensive oral health evaluation with a nearby dental group.

Ideally, members of a dental or medical practice work as a team. Each member of the staff performs specific and necessary tasks in a well-coordinated fashion [3]. When the patient has few health problems, as is the case for most young adults, consultation and care coordination with other health care professionals and caregivers are rarely necessary. However, elderly patients, by virtue of disabilities or multiple chronic conditions, are often interacting with nurses, caregivers, and other health care providers simultaneously. As a result, these providers, who are not part of the dentist's or physician's immediate staff, must be included in health care decisions ranging from logistical planning, such as scheduling appointments, to evaluating complex treatment choices. Keeping them informed can be a daunting challenge. Nonetheless, it is vital for the provision of safe and effective care to vulnerable elderly patients.

Who are the members of the health care team? Sometimes the list is extensive. In some instances, clergy and social workers are active contributors. However, the most common participants, in addition to the physician, dentist, and their staff, are informal caregivers (ie, spouse, children, or friends), formal

caregivers (ie, registered and licensed practical nurses), and midlevel health care providers (ie, physicians' assistants and nurse practitioners).

Informal caregivers

Because aging so often is associated with increased physical dependency, many older individuals rely on others for assistance with activities of daily living (eg, personal care, including routine oral hygiene) or advanced functions (eg, arranging appointments, adhering to prescriptions). Depending on the patient's residence and health status, this assistance may be provided by informal caregivers (eg, family or friends) or formal caregivers (eg, nurses' aides). In the United States, spouses and children perform by far the greatest part of the care and assistance provided to elderly persons [4]. Although the care-giving role often is viewed as personally rewarding or as a duty, it may impose a significant burden on the caregiver's time and resources. Dentists and physicians should assess a caregiver's burden and watch for signs of fatigue or burn-out (eg, depression, self-neglect, elder abuse).

Patients with cognitive deficits sometimes rely on family or others for assistance with health care decisions. Older persons with mild-to-moderate dementia typically retain their capacity to make personal choices. However, as dementia becomes more advanced, many lose the ability to make difficult decisions (eg, choosing between different treatments). When the need to make difficult decisions arises, patients sometimes turn to informal caregivers for advice or defer to their spouses or children. In most instances, this surrogate decision-making is not delegated through a formal legal process but is stated as a preference by the patient or is implicit in his or her relationship to the caregiver. (An example would be a demented patient who lives with a spouse or child and is unable to make moderately complex decisions.)

When an informal caregiving relationship exists, it is important that the health care provider include the caregiving individual, when appropriate, in a discussion regarding the patient's care. This principle is usually self-evident for extreme dependency but is easily overlooked when the patient is less obviously dependent. For instance, a dentist or physician may not know that the family member or friend is assuming greater responsibility for the executive functions, such as banking or shopping, of an older patient who is well-groomed, socially appropriate, and living alone. Unfortunately, when patients like these are confronted with new information or tasks, they may become confused or forget what they have agreed to do (eg, change a medication dose). It is important, therefore, that health care providers check with caregivers regarding the patient's level of function before implementing patient care plans.

The health care provider should also ascertain the caregiver's ability to assist the patient. For example, a working child who is able to call a parent daily to check on medication compliance may not be able to assist the parent

physically with a daily oral care program. In this example, the dental team should work with the child to develop an alternative strategy.

Open-ended questions and nonjudgmental statements are useful for eliciting the caregiver's comprehension of diagnostic and therapeutic plans. One approach is to ask, "Can you tell me your understanding of the plan?" Sometimes a statement of empathy followed by a question is appropriate. For example, "I know that it is difficult to carry out a plan like this. Do you have any concerns?" Caregivers can use this opportunity to provide feedback and discuss barriers. Even straightforward plans (eg, taking an antibiotic three times a day for 1 week) should be reinforced with a brief written instruction provided to the patient or caregiver. A copy should be kept for the patient's dental or medical record.

Long-term care staff

Although most adults over age 65 live independently, more than 1.5 million individuals live in nursing homes, and more than 600,000 individuals live in assisted living facilities. Although the number of nursing home beds has actually declined in the last decade, the number of assisted living facilities and retirement communities is increasing [4].

Individuals in nursing homes and assisted living facilities are generally sicker than in years past, and residents consequently require a high level of personal and medical care. Typically, resident care is provided directly by aides under the supervision of registered or licensed nurses. Nurse administrators provide facility oversight, and physicians spend relatively little time directly overseeing the daily care of long-term care patients.

Although nurses supervise and implement treatment care plans, nursing assistants and aides with various levels of training provide the bulk of personal care to nursing home and assisted living residents. For this reason, aides often are the most reliable resource for assessing the patient's daily care, such as oral hygiene, food intake, and other personal care functions. These important members of the health care team should be considered when trying to ascertain a patient's care needs or when formulating a treatment plan. A telephone call or discussion with the patient's aide during rounds may provide key information or buy-in to a therapeutic plan. The aide's insight into the patient's behaviors and other aspects of the patient's care often proves invaluable, and his or her commitment may be the factor that ensures a care plan's success.

Increasingly, nurse practitioners (also referred to as advanced practice nurses) and physicians' assistants perform day-to-day medical evaluation and management of institutionalized patients. They are also assuming a larger role in ambulatory primary care and specialty practices. Studies indicate that nurse practitioners and physicians' assistants, working as part of a coordinated team with physicians, reduce the hospitalization rates of nursing home residents [5]. Nurse practitioners and, in most states,

physicians' assistants can prescribe medication and perform specific procedures under the supervision of a physician. In some states, nurse practitioners are licensed to practice independently. The range of services provided by nurse practitioners and physicians' assistants varies with the practice setting but includes routine and urgent patient visits, home visits, nursing home and assisted living facility visits, primary health screening and counseling, uncomplicated preoperative evaluations, consultative visits (eg, urinary incontinence evaluation, wound care evaluation and management), and follow-up visits after physician evaluation.

Because nurse practitioners and physicians' assistants increasingly perform routine medical care, they may be the providers with the most intimate knowledge of a patient. It has also become more common for midlevel providers to carry their own panel of primary care patients. In these instances, the nurse practitioner or physicians' assistant takes primary responsibility for communicating directly with other professionals (eg, dentists, cardiologists) about medical evaluation, management, and consultation.

Essential health care information

Health care information should be sufficient to provide a clear understanding of the patient's health status and goals. Providing this information is more challenging for older patients, who frequently have altered function and whose health care goals may change with their general health. Furthermore, health care information must generally include a description of the patient's social support, which is needed to coordinate care with multiple providers (eg, time patient care with caregiver availability, plan pre- and postappointment consultation with another specialist) and support diagnostic and therapeutic plans. Therefore, in addition to the usual elements of the history and physical, physicians and dentists should create a patient care database that includes a functional assessment, detailed social history, and description of the patient's general health care goals. Capturing and transmitting this information requires extra effort, but it is well spent. The contents of a consultative request or report depend solely on the clinician's judgment, but both dentists and physicians should consider the functional assessment, social history, and goals in addition to the traditional elements of the history and physical when formulating a recommendation.

The basic elements of the health record for older adults include

- Active and past medical illnesses, including major procedures and hospitalizations
- A complete list of prescription drugs, over-the-counter medications, and herbal preparations
- Adverse drug reactions, specifying the type of reaction (eg, anaphylactic reaction to penicillin, nausea with codeine)
- Social history

Functional and cognitive assessment
Advanced care directives
Physical examination
Special studies (eg, laboratory and radiographic tests)

Depending on the nature of the communication and the needs of the patient, the physician or dentist should extract from this database all information that is essential for the other provider to consider when developing a diagnostic or therapeutic plan. Although most items are self-explanatory, the social history, functional and cognitive assessments, and goals of care, including advanced care directives, deserve special mention.

Social history

The social history should provide contact information for formal and informal caregivers and a description of the geriatric patient's living situation (eg, private residence, assisted living or nursing home), living companions, typical activities, driving habits or transportation, personal habits (eg, tobacco and alcohol use), and advanced care directives, if any (eg, Living Will, Durable Power of Attorney for Health Care). Even when older adults live with a companion or spouse, it is useful to ask for the name and contact information of another individual to whom they would turn if they needed help. It also is important for office staff to notice whom, if anyone, the patient wants notified about test results, appointments, or other communications.

Functional assessment

A functional assessment should be included in the health record for all older adults. It should be reviewed initially and updated periodically or after a significant change in health status. The two most common designations of function are activities of daily living (ADL) and instrumental activities of daily living (IADL). ADL include basic functions of self-care (eg, dressing, toileting, transfer, bathing, eating, and grooming, including oral care), whereas IADL designate advanced or executive functions (eg, cooking, driving, bill paying). Usually these activities are designated as independent (I), needs assistance (A), or dependent on others (D).

As adults age, cognitive problems, difficulty with balance, unsafe driving, depression, polypharmacy, bowel changes, and urinary incontinence occur with increasing frequency. Because dentists may be the first point of primary care contact for some older patients, screening questionnaires that include these items may be the best chance for someone with failing health to get early help. Screening for memory loss, often the first sign of dementia, is recommended. An inability to recall three words without error after 1 minute is an indication for further cognitive testing. Falls or driving problems, sadness persisting for more than 2 weeks, changes in bowel habits, troublesome urinary incontinence, excessive alcohol use, and use of sedating

medications or dangerous combinations of medications should all be noted. If any of these problems is new or has not been medically evaluated, referral to a primary care provider is indicated. Elder abuse or neglect is unfortunately more common than many health professionals realize. If suspected, it should be reported to the primary physician or other proper authorities.

Decisional support and advanced directives

As with younger patients, there is considerable variation in values and goals among older patients. However, as individuals approach the end of life, their health preferences typically shift from an emphasis on longevity to preserving function, comfort, and dignity. Furthermore, individuals with decisional capacity have the right to make personal choices and the right to change their minds [4]. Consequently, it is important to assess health care goals initially and update them periodically.

When evidence suggests that an older patient needs a higher level of assistance or is a danger to him- or herself or others, the dentist should refer the patient for comprehensive medical and functional assessment.

In many instances, the failing older person retains the capacity to make personal decisions, but he or she or the family needs guidance. Areas of common concern to caregivers include cognitive decline and behavioral abnormalities, inadequate access to food, self-neglect, loneliness produced by social isolation, unsafe driving, depression, alcohol abuse, and need for additional support in ADL. Local departments of aging, Meals on Wheels, and other organizations that address the health and social needs of older adults provide valuable services. Primary care providers should be able to assist dentists and their older patients in accessing these agencies.

Decisional capacity is determined on the basis of a patient's ability to understand the consequences of his or her decision. In most instances, caregivers who have a standing relationship with patients help them with treatment decisions. Their participation in decision making should be noted in the record. When individuals are incapable of making health care decisions, as occurs during advanced stages of Alzheimer's disease, either statutory law determines who has decisional rights regarding a patient's health care (eg, spouse) or this person is designated through a Durable Power of Attorney for Health Care or determined by the presence of a Living Will. Existence of these documents also should be noted in the patient's health record.

Effective communication

The nurse practitioner discovers significant gingivitis and gum recession as part of the patient's nutritional and oral health care screening. She has the patient's daughter make an appointment for an oral examination with a nearby dental group and sends the dentist a consultative request. In it she provides a summary of the patient's medical history and asks that the dentist address specific questions about the patient's oral health and care plan.

In an ideal health system, complete, accurate patient care information would flow to all providers easily and quickly. This efficiency would be a major step in the direction of providing safe care for all patients, especially for those who are old and frail. However, until a system like this becomes commonplace, health care teams (including office staff) must continue to collect accurate, timely patient care information and communicate it to all providers who make patient care decisions. Although the effort may seem burdensome, accurate and timely information increases patient satisfaction, reduces error, and improves office efficiency.

Communication with informal or formal caregivers and nursing staff usually involves a written or telephone communication to discuss a medication change or other therapeutic plan. Verbal medication orders to nursing staff in long-term care facilities are usually transmitted by telephone. A copy of the order is sent to the physician or dentist's office for signature. Telephone conversations and changes in the medication and treatment plan should be documented in the patient's chart [6].

Communication between dentists, physicians, and, increasingly, nurse practitioners and physicians' assistants often involves consultative requests or reports. Telephone calls are appropriate when the information must be obtained quickly, as may occur in an emergency, or the problem is complex and requires discussion.

Sometimes a telephone call is needed for clarification following a written consultation. Medical and dental staff should adopt a policy of notifying dentists and physicians when another professional calls. This policy should include nurse practitioners, physicians' assistants, and licensed nurses performing home health evaluations who are involved in direct patient care and who need to discuss immediate patient care issues. In some cases, providers are traveling from one site of care to another (eg, nursing home, assisted living facility, home visit). As a result, they may need to make a patient care decision or give a caregiver patient care instructions. If the call cannot be taken immediately, the office staff should arrange for the dentist or physician to return the call as soon as possible. In general, a written record of telephone conversations about patient care decisions should be entered into the patient's chart. If the conversation required an important action by one of the parties, then a summary of the conversation should be made and sent to the other party for his or her confirmation.

Written communication, whether as a standard form or letter, should be complete, brief, and legible [7]. Standard forms are convenient and work well for consultative requests or reports of low complexity (eg, low-risk dental procedure in a patient with uncomplicated medical problems). They help ensure that the information recorded is uniform and complete. Most forms, however, have limited space and are not ideal for addressing complex issues. When patients have multiple and complex problems, reports, or requests, a letter, perhaps followed by a telephone call, is the best option.

For straightforward clinical problems, consultative communication usually follows the traditional format in which one professional, usually a dentist or primary care physician, requests service or an opinion of a specialist. Requests for consultation should pose clear, unambiguous questions to the consulting dentist, physician, or other health professional. A clear question should be posed or request for service made followed by a report. Requests that simply state ''Please provide a preoperative assessment for patient with heart murmur'' are not helpful. In this example, where a patient with a pending dental procedure reports the presence of a heart murmur, the dentists wants to confirm its presence and know whether, in the opinion of the physician, the heart valve abnormality poses a high, moderate, or low risk for bacterial endocarditis. Likewise, consulting dentists and physicians should make their recommendations clear and explicit. For example, if an oral surgeon requests a preoperative assessment of mortality and morbidity risks for a 75-year-old diabetic patient, the physician should state the risk using accepted preoperative assessment tools, such as the Goldman Index [8,9].

Dentists and physicians are responsible for their respective treatment decisions. Therefore, they should consider advice from consultants but should ultimately decide on a plan that is consistent with their best professional judgment. For example, a physician consultant may confirm or deny the presence of a heart murmur and offer an opinion as to the patient's risk for bacterial endocarditis. However, the decision to use prophylactic antibiotics lies primarily with the treating dentist.

In caring for geriatric patients with complex health problems, the consultative communication often goes beyond a simple request for an opinion or service; it becomes a dialogue in which information is exchanged and becomes part of a comprehensive health plan for the patient. Both parties, in effect, are consultants and contribute specific professional expertise. Each offers relevant opinions about those aspects of care for which he or she is responsible and must obtain clarification from the other on how best to proceed (Figs. 1 and 2).

In the same vein, the consultative letter may serve to introduce one provider to another, to establish one's role in the patient's care, to update the patient's health care database, or to educate a colleague about important standards of care in the consultant's area of expertise.

Two aspects of the consultative letter deserve specific comment. As a mechanism for updating the patient's health record and database, consultative letters reduce medical error and limit redundant testing. Second, consultative letters can educate professionals from different disciplines about important practice standards in the consultant's field. For example, many physicians caring for geriatric patients are unaware of the relative benefit and low cardiovascular risks of fractional doses of epinephrine used with local anesthetic, or of the low bleeding risks posed by most dental procedures. A consultative letter from the dentist that explicitly

Date

John Smith, DDS
Address
Telephone number

Re: Jane Doe
Date of Birth

Dear Dr. Smith,

I recently met and examined Mrs. Jane Doe. She is scheduled to see you on DD/MM/YY for a comprehensive oral assessment.

In summary, she is a delightful 85 year-old retired schoolteacher who plans to move into the Best Care Assisted Living facility on DD/MM/YY. Her medical problems include gradual functional decline over several years due to memory loss, hypertension, diabetes controlled with oral medication and atrial fibrillation for which she takes warfarin. She underwent successful total hip replacement in 2002. In addition, I noted on oral assessment that she has gingivitis and periodontal disease. I suspect that she has trouble performing oral self-care.

Currently, she lives with her daughter who assures that she takes her medication. Her daughter will accompany her to your office. We can monitor her anti-coagulation in our office. She is scheduled to see Dr. Mary Jones (internal medicine) in our office on XX/MM/YY to review her medical care plan.

In your consultative report, I would request that you address the following:

1. Can your office develop an oral care plan for the assisted living staff?
2. Does the patient need antibiotic prophylaxis for the hip prosthesis?
3. Depending on your recommendations, please advise regarding any recommended changes for the anticoagulant and hypoglycemic medications?

Included is a copy of my initial evaluation, including a list of her medications, and medical care plan. Dr. Jones and I look forward to working with you and your staff to coordinate her medical and dental care. Your staff has our office contact information. Please write or call if I can provide additional information that would be helpful.

Sincerely,

Martha Davis, CRNP

cc: (daughter)

enclosure:

Fig. 1. Example of consultative letter from nurse practitioner to dentist.

addresses these concerns is useful to the physician, nurse practitioner, or physician's assistant in planning medical aspects of the patient's care. It also is helpful when the consulting dentists include citations from dental scientific literature, policies produced by dental and other professional groups, and evidence-based guidelines to support their treatment recommendations.

Date

Martha Davis, CRNP
Address
Telephone number

Re: Mrs. Anyone
Date of Birth

Dear Ms. Davis:

I am writing in regard to our mutual patient, Mrs. Jones. As you know, she has hypertension, diabetes controlled with oral medication and atrial fibrillation for which she takes warfarin. Two years ago she underwent successful total hip replacement. For several years she has experienced gradual memory loss and decreased ability to manage her own affairs. She plans to move into the Best Care Assisted Living facility next month.

Her daughter confirms that she is taking hydrochlorthiazide 25 mg/day, lisinopril 5 mg/day and warfarin 5 mg/day. Our staff also discovered that she takes a non-prescription antihistamine for sleep. She has no history of adverse drug reactions.

My examination revealed gingivitis with extensive gum recession and two root caries. I agree that reduced oral care may be contributing to her periodontal and tooth disease. I also note that she has dry mouth, which may be exacerbated by the non-prescription antihistamine.

I recommend removal of the plaque and calculus and filling the caries. This will be performed over two or three visits. The procedures will require local anesthesia with a small amount of vasoconstrictor. This should not raise her heart rate or blood pressure. Significant bleeding is not expected if her INR is maintained in the therapeutic range. Our staff will schedule the patient to have her INR checked in your office one day prior to the procedures and your staff will fax the results to our office. She may eat and take her hypoglycemic medication before the procedures. She is at low risk for hip prosthesis infection, and therefore I do not recommend antibiotic prophylaxis.

My staff will help the assisted living staff develop an oral care program for the patient. I also recommend stopping the anti-histamine, if you agree.

Please contact our office to confirm the patientís history and antihistamine use. I would also appreciate your recommendations or any concerns you may have about the proposed dental plan.

I will await your reply,

Sincerely,

John Smith, DDS

Fig. 2. Example of consultative letter from dentist to nurse practitioner.

The structure of the consultative note depends on whether it is a request, a response, or some combination of the two. All consultative letters should contain

Patient and caregiver identification and contact information
A brief summary of the history, functional assessment, and social support
All medications and drug reactions

Physicians or dentists requesting consultation should remember that Medicare requires that bills submitted for a consultation identify the individual requesting it. The professional group name is insufficient.

Consultants responding to a request for consultation should address

The specific question being asked
Problem assessment
Proposed procedure, treatment, or management decisions, including the method and type of anesthesia or sedation
The outline of responsibilities (ie, who will do what by when)

Including these elements in the consultative letter provides each member of the health care team with an unambiguous map of the care plan.

Summary

Over the next several decades, dentists, physicians, nurses, and caregivers will be challenged to provide safe, efficient health care to a burgeoning number of older adults with complex needs. Although each profession will contribute a unique set of skills, none will be able to provide comprehensive care in isolation from the others. As a result, interaction among dentists, physicians, and others will rely on effective communication and collaboration. Ultimately, dentists, physicians, and nurses will serve geriatric patients best when working as well-coordinated health care teams.

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