Staying Connected

"Mary", an 86-year-old African American, had not sought out medical care in years prior to her enrollment in our geriatric clinic. She had been living by herself in a second-floor apartment for the past 30 years. Two of Mary's church members who have known her through the congregation for many years accompanied her to the clinic. Mary was reluctant to come. She denied any medical concerns or cognitive impairment. During the visit, Mary was guarded and agitated, and was resistant to any discussion regarding her care and living situation. She was repetitive and clear about her values and preferences: "I want to keep my individuality! …and I will stay in my own home."

Mary was referred to our geriatric clinic in December 2010, by members of her church for medical evaluation. Our Geriatric team, consisting of doctors, social workers, and nurses, is linked to a county hospital and a medical school. As an integral part of our clinical practice, comprehensive geriatric evaluations are conducted through the CAT (Capacity Assessment and Treatment) Program. Our practice is enriched by a dedicated community that enhances a senior's quality of life. Mary represents a wide range of vulnerable elders evaluated and followed within our daily practice. The following story illustrates the uniqueness of this collaborative effort.

Upon her initial visit, Mary had a strong body odor, soiled underwear, and an unkempt appearance. The church members disclosed that utility bills had been unpaid for several months and her home was cluttered and filthy. Mary had experienced weight loss, financial exploitation, and forgetfulness. They noted that she had written checks totaling several thousand dollars to a cab company for unclear services and shared concerns about Mary's ability to handle her affairs and personal care. Her medical evaluation included hypertension, incontinence and dementia. Functionally, Mary required assistance with some of her activities of daily living and extensive assistance with personal care, housekeeping, handling affairs, and cooking.

Mary has been single all her life and had no children. She earned a master's degree in education and has a teacher's retirement pension. Upon retirement, Mary failed to secure health insurance benefits and did not receive Medicare or other health insurance coverage. Eventually Mary received access to health care through our county hospital.

Valuing her privacy, Mary did not allow others in her home. She had been very engaged in church activities in the past.

The geriatric team met with Mary and her support system to share their findings and concerns, and to make the following recommendations:

- Mary lacked decision-making capacity to live safely and independently.
- Mary required full supervision and extensive assistance within her home or in an assisted living facility.
- Church members or other designated party would monitor Mary's affairs with the support of the medical team.
- The geriatric team, with the support of the church members, would manage Mary's medical care, including medications and disease management.

Mary initially declined the geriatric team's recommendations but agreed to take medication and be followed in the clinic. Church members brought her prepared meals. Eventually, Mary allowed them to clean her home and assist with paying her bills.

Due to ongoing financial exploitation and her continued resistance to monitoring of her affairs, an application for guardianship was pursued. However, in March 2011, the church members convinced Mary to relocate into an assisted living setting. Even though Mary lacked decision-making capacity, she participated in her future plans. Mary trusted her church members and allowed them to step in. The probate court honored Mary's request to appoint them to handle her affairs and dismissed guardianship proceedings.

Mary continues to maintain her clinic visits, attends church, and has her basic needs met. I recall her first visit to the clinic once she was relocated to the assisted living. I could not recognize Mary. She looked like a 'queen', dressed elegantly, had gained weight, was more engaged in the session and restful. Mary seemed to be finally at peace. Her qualify of life has been significantly enhanced as she continues to live in the community. The collaboration between the court, our team and the church members has made such a significant impact on Mary's ability to stay connected– within her community.

“Success” in Mary’s story can be seen as the result of her dedicated support system as well as the thorough geriatric evaluation of the interdisciplinary geriatric team. Unfortunately, the self-neglect and exploitation seen in her story are prevalent phenomena among vulnerable elders with undetected underlying medical conditions, such as dementia.

In our clinical practice, we have found that a structured process for diagnosing these conditions, along with comprehensive assessment and close monitoring, is critical for effective outcomes and for promoting quality of life among vulnerable older adults. The CAT program provides this structured process to carry out an effective plan of care successfully.

Submitted by Tziona Regev, LCSW