Interprofessional Case Study 002 Learning Objectives and Study Questions

Learning Objectives:

1. Identify the health care settings involved in this case and describe how that will impact the identification of the team leader.
2. Describe how the patient's priorities and concerns can impact the intervention of the team.
3. Identify which health condition(s) should be addressed as a priority by the team.
4. Identify a person responsible for monitoring outcomes.

Guided Study Questions:

1. What are the health care settings involved in this case?

   Transition from an inpatient hospital facility to home or possibly an assisted living facility.

2. Who would be an ideal choice for a team leader in this scenario?

   Depending on the institution, a case manager or care coordinator, often a nurse, that coordinates discharges and transitions to other facilities (including home) would be an ideal choice in this situation.

3. What are some patient priorities and concerns and how will they affect the team's interventions?

   Identifying a translator to participate in the care of the patient while hospitalized would facilitate identification of the patient's priorities.

   Likewise, a full assessment of the patient's living situation needs to be performed to determine if it is suitable for her to return home or if alternate care facilities should be considered. If the patient is to return home, the following should be evaluated and resolved: the language barrier with the daughter in law, the safety of the living environment, educating the daughter in law on appropriate care of the patient including administration of medications, social activities, diet, and exercise.

   It is also clear that the patient's jaw or tooth pain should be addressed, especially in light of her elevated white blood cell count.

   Records should also be obtained to determine if the dementia and osteoarthritis have been worked up. Re-evaluation should be considered to maximize all therapies including medical, physical and occupational therapy.

   Assistance should be provided to the family to expedite Medicaid coverage. Several medications could be changed to less expensive generic alternatives (Lipitor to simvastatin and Diovan to losartan).

4. What health condition(s) should be addressed as a priority by the team?

   UTI and tooth abscess

5. Who will evaluate patient outcomes?

   Depending on the planned discharge setting (assisted living or back home) it would be best to communicate a care plan with goals to the patient, her family and an assigned care coordinator (this could be a home health nurse or a case manager at the assisted living facility). The care coordinator or home health nurse could be a point of contact for all providers that may need to follow up with the patient (dental, internal medicine, possibly neurology for a dementia consult). Referrals for physical and/or occupational therapy and counseling should be made at this time as part of the plan.