**Care Coordination Case Studies**

Facilitator Guide

* **Time:** 30 – 45 minutes
* **Audience:** 1st year residents
* **Objectives:** Develop clinic systems and action plans with their care team to ensure a consistent level of access for their patients, even in their absence and in times of transition.
* **Procedures:** Cases can be done as a part of intern orientation in a group setting to get to know access to services, care coordination and team based care. Alternatively, a few months after continuity clinic and you could go more in-depth with the cases

**Case 1**

Ms. Alamuddin is a 37 year old woman who presents to your clinic because she has missed her menstrual period. She believes she may be pregnant.

You would like to order a urine pregnancy test.

**Who will do the test for you?**

After informing her of the result, you learn that the patient is very happy to be pregnant and wishes to continue the pregnancy.

**What is the next step to helping this patient establish prenatal care?**

**Where can the patient go for a dating ultrasound if the dating is uncertain?**

**Are there any other team members at the clinic to whom she should be referred?**

At 35 weeks, you do Leopolds and are fairly certain that the fetus is vertex. Nonetheless, clinic policy requires U/S confirmation of this.

**Who performs ultrasounds to confirm vertex presentation?**

**Case 2**

[](http://www.google.com/url?url=http://articles.baltimoresun.com/2011-11-07/entertainment/bal-review-louis-ck-at-meyerhoff-symphony-hall-november-4-20111107_1_opera-house-comedy-club-gay-slur&rct=j&frm=1&q=&esrc=s&sa=U&ei=PTOSU-PaOciIogTi_4DIBw&ved=0CCQQ9QEwAQ&sig2=oyn-S-G-6LCDFzooirDM1w&usg=AFQjCNEaRddzjgnQs1CDiY_khu-COIxqfA)Mr. C.K. is is a 56 yo man with HTN. As you are preparing for a follow up visit with him today, you receive the results of a screening. Hemoglobin A1C and learn that it is 10.0.

**After you have informed the patient of his diabetes diagnosis and performed initial education, who can help you educate the patient more extensively about diabetes?**

Over time, it becomes clear that the patient will require insulin to control his glucose levels.

**Who can help you initiate insulin for the patient?**

At a follow up visit, the patient endorses nausea and malaise. You want to order a fingerstick blood glucose and a urine test for glucose and ketones.

**Who can do that for you?**

After ordering a stat chemistry panel, you find that the patient has a large anion gap and acidosis. You diagnose DKA and decide to admit the patient to the hospital.

**Who will help you with that?**

After his hospitalization, the patient’s glucose is much better controlled. Unfortunately, at a follow up visit, his BP is 160/90. You increase his benazepril from 20mg to 40mg daily. You would like to follow up his blood pressure in the next few weeks to see if it is improved. Unfortunately, you do not have any openings for the next two months.

**Is there someone else you can check the patient’s blood pressure for you?**

After his medication is increased, the patient’s blood pressure is much better controlled. Before his next visit, you see that he is due for a diabetic foot exam.

**Who can do that for you?**

**Case 3**

Your patient, Ms. Poppins, is here for a follow up visit. Your team provides her with an annual PHQ2 screen as part of their regular protocol for all patients. She answers yes to one of the questions, giving her a positive score. Per protocol, your team provides her with a PHQ9 to follow up the positive screen.

She scores 16, which signifies moderate depression.

**To whom can you refer the patient for counseling?**

You follow the patient over the following years, during which her depression resolves. Unfortunately, the patient has an acute CVA. She is left with right arm and leg weakness. Though she would like to remain independent in her home, she has difficulty now with basic housecleaning and cooking. She is also finding it difficult to walk to and from the bus station near her house and misses an appointment as a result.

**Who can help her get more support at home and assistance with transportation?**

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Evaluation

1) I understand how to develop action plans with my care team to ensure a consistent level of access for my patients, even in my absence and in times of transition.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

2) This activity enhanced my understanding.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |

3) The information from this activity is relevant to my practice.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Strongly Disagree | Disagree | Undecided | Agree | Strongly Agree |
| 1 | 2 | 3 | 4 | 5 |