CASE STUDY #1: Sally

Clinical and Community Connections Improving Health Outcomes

This discussion exercise focuses on Sally, a patient needing an array of clinical and community related services and resources. Where are the gaps? Please have someone in your group take notes.

Sally is a 65 year old female who has been a patient in your clinic for 30 years. She presents for her annual Medicare Wellness Exam. She lost her husband to a heart attack one year ago. She is retired and now lives alone. Sally was very reliant on her husband to get her to her appointments and keep track of her medications. Her son and daughter live out of state. She states she will sometimes take her meds every other day in hopes that they will last longer.

Sally presents with a BP of 160/95 and a hemoglobin A1C of 10. She was told in the past that she may be a pre-diabetic but hasn’t been seen in the clinic for over 2 years. She is 50 lbs overweight and does not like to exercise due to chronic knee pain. She does like to cook and is interested in healthy eating.

Questions:

1. What do you know about Sally?

2. How could you work with her to get her BP and Hemoglobin A1C under better control and enjoy a better quality of life?

3. What community support services would Sally benefit from? And how would you refer Sally to those services? Have you had any successes in connecting your patients to community support services?

4. What challenges or barriers might you have connecting Sally to community support services?
CASE STUDY #2: Dan

Clinical and Community Connections Improving Health Outcomes

This discussion exercise focuses on Dan, a patient needing an array of clinical and community related services and resources. Where are the gaps? Please have someone in your group take notes.

Dan is a 55 year old man who presents with a BP of 170/100 with a history of depression and heavy alcohol use. He has been sober for 10 years. He had a heart attack at age 50 after a twenty year history of high cholesterol and high blood pressure. His fasting glucose suggests prediabetes. He was on a blood pressure medication but stopped taking it due to the cost of the medication which was expensive with his high deductible plan.

He states that he has a hard time paying all the bills. There were a few months this winter that they have had to choose between food, medication and heating their home. He reports a high level of stress between work and family.

He currently works as a trucker and works long hours driving. He rarely exercises. He currently smokes 2.5 packs of cigarettes a day. He lives with his wife who is disabled.

Questions:

1. What do you know about Dan?

2. How could you work with Dan to get his BP and prediabetes under better control and enjoy a better quality of life?

3. What community support services would Dan benefit from? And how would you refer Dan to those services? Have you had any successes in connecting your patients to community support services?

4. What challenges or barriers might you have connecting Dan to community support services?