

1 Primary Prevention mothers/newborns [preterm birth in CT ~10.1% of all births]

Scenario #1

Chantal Davis, African American, age 16.

- Overweight, Undiagnosed Type 2 diabetes.
- 4 months pregnant, has not told her parents, has not had any prenatal care. Concerned if she seeks care/information that the ‘adults’ would force her to tell.
- Does not drive, relies on public transportation
- OB/GYN offices not easily accessible.
- Limited access to prenatal educational materials
- Several friends have had non-complicated, full term deliveries
- Both of her parents work full time. She has 4 siblings [ages 5, 7, 10, 14]. She is covered under her father’s Medical policy.

Chantal is at risk for gestational diabetes, preeclampsia, depression, preterm birth/complications. She will need social services/community services help once the baby is born so that she can complete high school.

Root Cause Issues:

- Culture
- Fear
- Access
- Finance

Possible Actions:

Scenario #2

Sophie Klemski, 1st generation polish immigrant, age 27

- English a second language
- Self employed, house cleaner
- Active participant of St. Lucian’s Polish/English speaking Catholic Church.
- Covered under husband Steven’s insurance. He works 3rd shift. One car.
- Second pregnancy, prior miscarriage.
- Culturally aligned with non-clinical midwives for assistance with pregnancy.

Sophie’s history of miscarriage places her in a high risk maternity situation. She is not accustomed to or familiar with medical services and treatments that can help prevent a subsequent miscarriage or pre-term birth. She is not likely to seek medical care unless something ‘is wrong’.

Root Cause:

- Cultural attitudes
- Language
- Health literacy
- Access to Care

Possible Actions:

2 Secondary Prevention/early detection

Scenario #1

George Hoffman, 57 y.o divorced executive

- Has a very stressful job and works on average 60 hours a week.
- “I don’t have time to go to the doctor...I feel fine”
- Fast Food and Restaurant take out.
- Overweight, minimal physical activity.
- Frequent Headaches
- Smoker.
- Family history of cancer.
- Lives alone

George needs an annual physical; alignment with a PCP. Baseline measures [Blood Pressure, BMI, Blood work]. George also needs a Colorectal screening exam. George needs work/life balance, physical activity, down time.

George is at risk for Type 2 Diabetes, Hypertension, Stroke, Colorectal cancer, Depression.

Root Cause:

- Convenience
- Personal Attitudes
- Nutrition/Exercise
- Lack of Social Support

Potential Actions:

<p>Scenario #2 Susan Davis. Age 54</p> <ul style="list-style-type: none"> • Mother died from breast cancer at age 68 • Single mother; 2 girls, age 17 and 22 • Susan does go annually to her OB/GYN for physical exam and cervical exam. • Susan had previous bad experience with Mammogram [painful, bruising] inexperienced tech. Has not had a repeat exam in 5 years. • Susan’s insurance has zero copay for preventive screenings. No out of pocket. • Susan has not had a baseline colorectal screening either <p>Susan has existing risk factors that predispose her to breast Cancer.</p> <p>Root cause:</p> <ul style="list-style-type: none"> • Fear /Pain • Fear/ unknown • Lack of positive influence <p>Potential Actions:</p>
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3 Risk Factor intervention – Obesity [Childhood overweight]

<p>Melody Garcia, age 11</p> <ul style="list-style-type: none"> • Significantly overweight, sluggish in school. • Difficulty keeping up in Gym classes • Melissa being targeted by bullies • Melissa’s parent’s comfort her with treats [ice cream, etc.] • Soda, chips, sweets, with sandwich a standard at lunch • Likely pre diabetes, or Type 2 diabetes [No existing blood sugar/A1C testing standards for children] • Both parents overweight with Type 2 diabetes. • Pediatrician ill equipped to deal with family overweight; no continuous oversight. • School ill equipped to deal with family overweight • Lives inner city; Corner markets - limited access to fresh fruits and vegetables. • Limited outdoor activities <p>Melody has an uphill battle. Family eating patterns and rewards aligned with food. School nutrition programs limited and focus only on children during school hours.</p> <p>Root Cause:</p> <ul style="list-style-type: none"> • Family dynamics. Poor health choices • Limited access to healthy choices [food/physical activity] • Limited ‘family based’ services [Medical/Educational] • Secondary impacts [teasing /bullying] <p>Potential Actions:</p>

Urology specialist's primary team. Surgery goes well, Mario placed on IV antibiotics. Stents and drainage devices in place. Ileostomy care taught to Mario and his wife.

Life changing. Mario is depressed, but no Behavioral/social services ordered/offered.

Transcription of Discharge orders 'missed' the necessary continuation of antibiotics.

1/10 Discharged from Hospital to Rehab/SNF. Mario walking, gaining strength, but 3 days later has severe fever and is readmitted to hospital. Diagnosed with MRSA. MRSA is especially troublesome in hospitals and nursing homes, where patients with open wounds, invasive devices, and weakened [immune systems](#) are at greater risk of [infection](#) than the general public.

Admitted to hospital under Infectious Disease consult. He is treated for 5 weeks with aggressive antibiotics. He has lost weight and is very weak. He's lost his appetite and is very depressed. He is in a teaching hospital, and the specialty teams of residents and interns rotate every two weeks. He is discharged to another SNF 2/18.

Mario is weaker and extremely depressed. He not walks with great difficulty with a walker. 5 days after arriving, he is now experiencing terrible stomach symptoms. Diarrhea several times a day, cramping. He is eating and drinking very little as it goes right through him. After 2 days his family insists he is returned to the hospital. This time, the GI team has him assigned as a patient. He is diagnosed with C-Diff . Another secondary infection that has become a common morbidity in hospitals and other health care facilities, where a much higher percentage of people carry the bacteria. C difficile can produce toxins that attack the lining of the intestine.

Each time Mario is admitted he has a new team of Doctors and specialty [not whole person] focus. Each time he presents, his 'baseline health' is assumed to be what it was prior to the event [not what it was when he entered the system]. And he is discharged once the immediate issue is resolved.

The repeat admissions continue each one with more debilitation of Mario's baseline function. Mario dies 7 months, 6 ER and hospital admissions later. Over \$750K has been incurred, and the family is left without a loved one who was functional prior to his first admission, not to mention great personal debt.

How many places did quality of care and care coordination fail?

NOTE: Consumer Reports May 2013 Article 'US Hospitals still not safe enough'

Scoring of US teaching hospitals against a 100 point scoring focused on 5 key measures: readmissions, complications, communication, overuse of CT Scans, and infections.

The University of CT Health Center, John Dempsey Hospital scored among the lowest with a score of 17.

The Average score for all teaching hospitals was 49. The highest scoring hospital was Bellin Memorial Hospital, in Green Bay Wisconsin.

	<p>Scenario #2</p> <p>John Gordon, 67 years old, suffered a myocardial infarction, and is being discharged from the hospital to home. He is to return to join the hospital cardiac Rehab program when he is cleared by his Cardiologist.</p> <p>His discharge orders include an order for a Beta Blocker and Coumadin.</p> <p>John already has several medications at home that he took before the hospitalization that was ordered by his PCP including aspirin.</p> <p>John is to make an appointment with his Cardiologist 2 weeks after he is discharged.</p> <p>John and his wife Mary thought they understood the discharge orders, but it was so confusing with everyone coming, talking to them quickly, and with so many papers to sign.</p> <p>At home, they don't remember what was said about medications, and decide they should just resume all the medications John took previously.</p> <p>They think the Cardiologist office is going to set up the follow up appointment, and assumed, as long as they start slowly, John can resume most physical activities.</p> <p>They misplaced the prescription for the Beta Blocker, and honestly, forgot they needed to fill it. They did fill the one for Coumadin.</p> <p>John is readmitted within the week.</p> <p>How many places did Care Coordination and follow up fail?</p> <p>Root Cause issues:</p> <ul style="list-style-type: none"> • Health Literacy • Lack of coordination [Medication reconciliation] • Clearly understood next steps • Validation • Follow up <p>Alternate Scenario/Actions:</p>
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6.	Chronic Disease Management
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	<p>Elsie Stoddard and her husband Joseph both suffer from COPD, Heart Disease, Hypertension, and Diabetes. They are 72 and 74 years old.</p> <p>They have Medicare Coverage</p> <p>“While we should go to the doctor every 6 months for blood work and check ups, we live on limited income now, and really can't see spending all that money for copays and such. Our medications are expensive enough! There is one medication – a purple disc inhaler for our lungs that is considered a BRAND drug...It's so expensive, we no longer use it....</p> <p>And that darn Medicare is so confusing. We keep getting letters about something called mail order drugs, but</p>
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honestly. if it's so much cheaper. are they the real thing? Don't trust anyone anymore. We'll keep going to our local CVS. We know and trust our Pharmacist Dave.

Root Cause Issues:

- Financial situation
- Health Literacy
- Navigation of the 'System'
- Trust

Potential Actions:

NOTE: Consumer Reports May 2013 Article 'Same Generic Drug, many prices. How Retail Drug Costs Compare'

Comparing 5 widely prescribed generic drugs: Actos, Lexapro, Lipitor, Plavix, Singular.
Costco has the lowest retail prices overall and CVS the highest