Complex Discharge Planning Case Study

Patient ID Number:

<table>
<tr><td>Presenting Problem
No primary MD
No medications, could not afford due co pay
Patient often not home for prearranged home visits</td><td>Diagnosis
Diabetes
Pressure foot ulcer
Neuropathy
Psychosis
Depression</td><td>Mental Status
Alert and Oriented
Makes poor choices</td></tr>
<tr><td>Insurance Medicaid</td><td>Age 47</td><td>SOC date</td></tr>
<tr><td colspan="3">Disabilities:

On SSI, had to pay child support which limited his ability to pay for medications due to co pay</td></tr>
<tr><td colspan="3">Housing; Independent apartment, enriched housing in building complex, grocery store and transportation available</td></tr>
<tr><td colspan="3">Psychosocial support: None</td></tr>
<tr><td colspan="3">High Risk Screening Criteria
Chronic illness, patient not willing to comply with the physician plan of care, patient does not have primary physician in community, last MD refused to continue care due to patients poor follow through.</td></tr>
<tr><td colspan="3">Community agencies presently involved: Certified Home Health Agency</td></tr>
<tr><td colspan="3">What discharge planning has occurred Prior to patient’s discharge home care agency sent a letter to hospital with recommended interventions: Home care agency would ask patient to sign a contract agreeing to follow specific protocol in order to continue with home care services. Hospitalist would sign home care orders until a clinic appointment could be arranged for patient’s medical follow up. Hospital would send patient home with a supply of medications.</td></tr>
</table>

Results: ‘

Hospital followed through with all the recommendations and discharged patient. Patient was admitted to home care. Patient signed home care agreement that he would be available for the prearranged visits. Patient had an appointment with the clinic for medical followup scheduled for July. Patient kept appointments with home care for approximately two weeks. Same patterns started to occur and patient started to refuse nursing visits. Adult and Family Service referral made and client was accepted to their care. Certified Agency discharged patient from home care services, APS to notify home care agency if patient agreeable to readmission.