Background on Primary Patient

Our Team enrolled a patient, GJ, who had a history of congestive heart failure, hypertension, cataracts, and stage IV kidney disease. She had multiple recent hospitalizations due to uncontrolled hypertension and recurring urinary tract infections related to her indwelling catheter. She additionally struggled with the management of her medication, attending appointments, mobility, and health management. She lived in a two-story house, further complicating her everyday movement and activities. She lived with her adult son who acted as the main caregiver. Prior to experiencing issues with mobility, she enjoyed going to church and spending time with other church friends and family. However, she has not been able to participate in the meaningful activities recently due to her health conditions. In the early stages of the program, GJ and her sons, who manage her care, expressed interest in the program and signed all consent forms to formally enroll. However, after a Jefferson hospital admission due to worsening edema, her sons chose to withdraw her from the program for unclear reasons.

Timeline for Primary Patient

Oct. 10th: Team 2 called GJ to establish contact & plan first home visit
Oct. 24th: GJ admitted to Jefferson Hospital due to edema exacerbation
Nov. 12th: GJ discharged, PCP follow-up scheduled for following week
Nov. 14th: Multiple calls to GJ, but unable to reach her directly; GJ’s sons expressed desire to terminate Hotspotting
Nov. 17-30th: GJ has worsening edema, decision to withdraw from program

Four Pillars to Care Transition Interventions

While Student Hotspotting teams’ activities to assist complex patients should be patient-centered and tailored to each patient’s unique needs, evidence-based practice can guide these activities in order to clearly define the scope and ensure maximum impact of Hotspotting activities. Coleman, Parry, Chalmers, and Min (2006) found that there are four key pillars for care transition interventions designed to encourage patients and caregivers to assert more active roles in their health care in order to reduce re-hospitalization rates. These pillars and their potential applications to GJ are detailed below:

- **Assist with medication self-management**
  - Embed medication management in daily routines
  - Educate patient and caregivers

- **Assist with timely follow-up with primary & specialty providers**
  - Coordinate transportation to and from appointments
  - Role play to enhance patient self-advocacy

- **Maintain patient copy of health record to facilitate cross-site treatment**
  - Organize health information which can be brought to all appointments to minimize miscommunication errors

- **Create list of indications of worsening condition & how to respond to them**
  - Make a health journal to log daily symptoms and basic vitals for health management and patient tracking

Aspects of a Strong Interprofessional Team

According to Bannister, Wickenheiser, and Keegan (2014), highly effective healthcare teams share three attributes: purpose, defined roles and skills, and openness. Our team demonstrated many aspects of a strong interprofessional team, but areas for improvement exist within each domain and are explored below:

- **Purpose**
  - Teams must collaboratively agree on their purpose and check in regularly to review progress toward common goals.

- **Roles & Skills**
  - Team members have defined roles, unique skills, and understanding of the roles and skills of their colleagues.
  - Awareness of gaps in team skills or knowledge allow teams to recruit help when needed.

- **Openness**
  - Openness encompasses clear communication, mutual respect, engagement, and shared leadership.

Summary & Lessons Learned

In summary, our team:

- Prepared for the Hotspotting season by assigning roles and coordinating schedules
- Enrolled GJ in the Hotspotting Program and conducted a successful home visit
- Saw GJ’s sons withdraw her from the program
- Contacted four other patients for potential enrollment but were unsuccessful

By participating in the Student Hotspotting Program, students learned that:

- Coordinating the care of a complex patient requires an interprofessional team
- Hotspotting interventions can often be complicated by uncontrollable circumstances
- Building trust is key to working with patients who may be hesitant to engage with the healthcare system
- Successful interprofessional healthcare teams are characterized by specific attributes
- As future healthcare practitioners, we can apply these lessons into our own interprofessional interactions to optimize our treatment plans for complex patients

References

- Icons made by Pixel Perfect & Freepik from www.flaticon.com