

Primary Care Provider

You will participate in a care planning meeting for Mr. Jim Thomas. You are to assume the role of the **primary care provider (Physician or Nurse Practitioner)**. Your job is to represent that person and make sure your concerns and services are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

The Primary Care Provider diagnoses and manages common and chronic illnesses, performs physical exams, orders and interprets diagnostic tests, provides health counseling and education and prescribes medications.

Your participation in the care plan meeting should include the following:

- After the Community Health Navigator opens the meeting, ask Mr. Thomas what he understands about his illness to assess his level of knowledge and understanding
- Share the results of your physical assessment and lab work – his blood sugar level is over 200, A1C is not good, but kidney function is normal
- Emphasize the importance of ongoing diabetes care
- Offer information about the possible complications of untreated diabetes such as skin and eye problems, high blood pressure, kidney disease, heart disease and stroke
- Be sympathetic but firm about the possible consequences of his illness
- Explain that you consulted with a pharmacist in regard to Mr. Thomas' medications
- Express concern about his wife's condition and offer a home visit from a fellow provider.

Community Health Navigator

You will participate in a care planning meeting for Mr. Jim Thomas. You are to assume the role of the **community health navigator**. Your job is to represent that person and make sure your concerns and services are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

The community health navigator serves as the link between the primary care team and the community based team. You assist the older adult in managing their chronic disease and advocate for the patient's health, psychosocial, spiritual and cultural needs. You have knowledge of community resources, make referrals and coordinate services. You can help the older adult with health insurance issues and public assistance.

Your role in the care planning meeting includes the following:

- You open the meeting which you have organized. Ask the team and family members to introduce themselves.
- The primary care provider will then review the patient's medical condition
- You report that you made a visit to the Thomas' home and you are concerned about home safety, transportation issues (the family has one car and their granddaughter usually drives them everywhere, and pressures placed on Mr. and Mrs. Thomas related to caring for their great grandson
- You also express concern about their health insurance (Medicare only – no supplements) and suggest they make application for Medicaid and also food stamps
- You are concerned about their eating habits and suggest a local farmer's market that accepts food stamps
- You encourage the group to come up with solutions
- You make sure every team member participates during the session
- At the end of the meeting, you summarize the plan going forward

Mr. Thomas

You will participate in a care planning meeting for Mr. Jim Thomas. You are to assume the role of the **Mr. Thomas**. Your job is to represent him and make sure his concerns are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

In your role as Mr. Thomas, you:

- are obviously overwhelmed by your health problems but grateful that your tooth is no longer hurting as it was
- have difficulty understanding why your diabetes has “come back” and why you must check your blood sugars (you hate needles)
- are concerned about your wife who cannot attend the meeting because of her functional limitations (obese, severe arthritis, recent hip surgery)
- make excuses for and baby your granddaughter whom you raised after her parents died rather than expecting her to assist in the home
- share that you are often exhausted from watching your grandson while his mother is at work or away on weekends
- state you don't have the money to buy fresh fruits and vegetables and prefer to eat beans and cornbread and processed foods (bologna, hotdogs, etc.)
- are hesitant to commit to ongoing care and making the necessary changes in your life
- but you are open to solutions offered by the team members as you want to remain as independent as possible at home and continue caring for your wife, granddaughter and great grandson

Christy (patient's granddaughter)

You will participate in a care planning meeting for Mr. Jim Thomas. You are to assume the role of **Christy**. Your job is to represent her and make sure her concerns are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

As Christy, you:

- attend the meeting reluctantly.
- state that you work nights and as a nurse's aide you don't make much and have a hard time providing for yourself and your son
- state that you can't afford childcare and can only get by if your parents watch your son, Brandon
- say that you need to spend time with your boyfriend when you are off and he doesn't like having Brandon around
- complain of being tired and stressed
- reluctantly agree to help cook dinner for the family before you go to work and help pay for groceries

Home Health Representative/Liaison

You will participate in a care planning meeting for Mr. Jim Thomas. You are to assume the role of the **home health representative/liaison**. Your job is to represent that person and make sure the concerns and services of the home health agency are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

Home health representatives promote the services of their agency. They often reach out to physicians and nurse practitioners to encourage referrals to their agency and explain the services available. Home health nurses are RNs or NPs who visit patients in their homes. They provide education and skilled nursing support for a designated period of time. Home health services are covered by Medicare when a skilled nursing need is present. Home health agencies also offer physical therapy and other ancillary services.

As the representative of the home health agency, you:

- explain that your agency has a home health nurse/diabetic educator who can visit the Thomas' home and help Mr. Thomas understand and manage his disease. This nurse could teach him to monitor his blood sugar and diet.
- state that the home health nurse would also involve both Mrs. Thomas and Christy in such teaching so they can be supportive and helpful in the patient's care.
- suggest that in-home physical therapy may be available for Mrs. Thomas if ordered by the orthopedic surgeon who did her hip replacement.
- also share that the agency's social worker might be able to help with financial concerns.

Dental Hygienist from Dental Clinic

You will participate in a care planning meeting for Mr. Jim Thomas. You are to assume the role of the **dental hygienist for the dental clinic** where Mr. Thomas is receiving care. Your job is to represent that person and make sure your concerns and services are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

Dental hygienists examine patient's teeth and gums for signs of oral diseases or abnormalities. They work alongside dentists and other dental professionals in a team to provide full oral health care.

During the care planning session, you:

- explain that Dr. Hill asked you to attend the meeting to represent the concerns about Mr. Thomas' oral care.
- review Mr. Thomas' recent visit to the dentist and the gum abscess.
- stress the need for ongoing dental care.
- try to get a commitment from Mr. Thomas to make his next scheduled appointment.

Case Manager/Social Worker from Local Area Agency on Aging

You will participate in a care planning meeting for Mr. Jim Thomas. You are to assume the role of the **case manager/social worker from the local Area Agency on Aging** who is working with the community health navigator and Mr. Thomas. Your job is to represent that person and make sure your concerns and services are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

As a case manager/social worker for the Area Agency on Aging, you assess and assist persons 60 years or older with functional disabilities who are at risk of becoming institutionalized. The goal of the services offered is to maintain elderly residents in their homes by providing needed assistance and case management. Services include: assessment and case management; homemaking (assistance with tasks such as light cooking, cleaning and laundry); personal care (assistance with activities of daily living); escort services for persons going to their doctor, dentist or other healthcare services; respite for caregivers, and home delivered meals.

As the case manager, you participate in the care planning session by:

- giving an overview of the services of your agency as described above.
- specifically suggesting that the Thomas family sign up for frozen meal delivery which will assure that they receive one nutritious meal each day and light homemaking services.
- explaining that your services are available on a sliding scale basis and that the Thomases would be eligible for some free services based on their age and income.
- suggesting that Mr. Thomas be assigned a peer mentor – someone who has successfully dealt with their diabetes and can offer support, information and encouragement. This can be done through the local community Organizer.

Pharmacist in the Community

You will participate in a care planning meeting for Mr. Jim Thomas. You are to assume the role of the **community pharmacist** where Mr. Thomas is receiving care. Your job is to represent that person and make sure your concerns and services are considered and included in the plan of care going forward. The care plan should be patient-centered and outcome driven.

Jim Thomas has been getting his medications at your pharmacy for years. Jim took oral diabetes medications and then stopped a few years back. You thought perhaps his doctor told him that he didn't need them anymore. But, one day, you talked to him about his tooth pain and in the course of conversation, he mentioned that he didn't want to pay for expensive medication for his tooth and that he'd stopped buying his diabetes medication years back because it was too expensive.

You looked back at his file and discovered that he had no prescription coverage. When you asked Mr. Thomas about it, he said he thought with Medicare his prescriptions were covered and he was surprised that they were not. Mr. Thomas didn't realize that he has to sign up for Medicare D for prescription coverage.

As the pharmacist, you participate in the care planning session by:

- Explaining to his physician and the entire care team that Mr. Thomas hadn't filled his prescriptions because he had not signed up for Medicare D.
- Help identify a stake holder to help Mr. Thomas go online and sign up (daughter, social work professional, or even the pharmacy if they provide that service)
- Help offer prescription assistance programs or \$4 formulary alternatives to get him started on affordable diabetes medications until his Medicare D insurance starts.
- Make sure the stake holders have in place a means of helping Mr. Thomas address open enrollment which comes around every October.