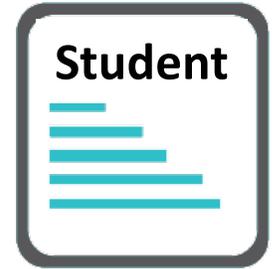


Student Pre-Work

Readmission Reduction Simulation: Interprofessional Home
Visit after Hospital Discharge Simulation

Part of the JHUSON Interprofessional Education and Online Simulation Program



Information for Students to Prepare for Simulation

Objectives

By the end of this simulation, the learner will be able to:

1. Assess the home environment for risk factors that may cause adverse effects and/or re-admission to the hospital for the patient.
2. Identify the indication and potential adverse effects of prescribed medications for patients with diabetes.
3. Develop an awareness of factors that may make it difficult for a patient to adhere to a prescribed therapy.
4. Provide relevant patient/family education and teaching for a patient with diabetes being discharged from the hospital.
5. Collaborate to create a trusting relationship between the patient, family, and interprofessional team.
6. Develop an appreciation for the knowledge and skills various healthcare professionals bring to the team when helping a patient understand and manage a diabetes treatment plan.
7. Discuss the following **core competencies for Interprofessional Collaborative Practice (2016)**

Core Competencies for Interprofessional Collaborative Practice (2016)

A. Values/Ethics sub-competencies

- VE1. Place interests of patients and populations at center of interprofessional health care delivery and population health programs and policies, with the goal of promoting health and health equity across the life span.
- VE3. Embrace the cultural diversity and individual differences that characterize patients, populations, and the health team.
- VE6. Develop a trusting relationship with patients, families and other team members.
- VE9. Act with honesty and integrity in relationships with patients, families, communities, and other team members.
- VE10. Maintain competence in one's own profession appropriate to scope of practice.

B. Roles and Responsibilities sub-competencies

- RR1. Communicate one's roles and responsibilities clearly to patients, families, community members, and other professionals.
- RR2. Recognize one's limitations in skills, knowledge, and abilities.
- RR3. Engage diverse professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific health and healthcare needs of patients and populations.
- RR4. Explain the roles and responsibilities of other providers and how the team works together to provide care, promote health, and prevent disease.
- RR5. Use the full scope of knowledge, skills, and abilities of professionals from health and other fields to provide care that is safe, timely, efficient, effective, and equitable.
- RR6. Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.
- RR9. Use unique and complementary abilities of all members of the team to optimize health and patient care.

C. Interprofessional Communication sub-competencies

- CC2. Communicate information with patients, families, community members, and health team members in a form that is understandable, avoiding discipline-specific terminology when possible.
- CC3. Express one's knowledge and opinions to team members involved in patient care and population health improvement with confidence, clarity and respect, working to ensure common understanding of information, treatment, care decisions, and population health programs and policies
- CC4. Listen actively and encourage ideas and options of other team members.
- CC8. Communicate the importance of teamwork in patient-centered care and population health programs and policies.

D. Teams and Teamwork sub-competencies

- TT3. Engage health and other professionals in shared patient-centered and population-focused problem-solving.
- TT4. Integrate the knowledge and experience of health and other professions to inform health and care decisions, while respecting patient and community values and priorities/preferences for care.
- TT7. Share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care.
- TT8. Reflect on individual and team performance for individual, as well as team, performance improvement.
- TT10. Use available evidence to inform effective teamwork and team-based practices.
- TT11. Perform effectively on teams and in different team roles in a variety of settings.

Prewrite

Please review the following information prior to participating in this simulation:

1. Read brief overview of the patient discussed in the Home Visit after Hospital Discharge.
2. Examine principles of interprofessional care coordination and roles of each member of the team (physician, nurse, pharmacist).
3. Investigate information about Type 2 diabetes and its management (basic principles only of diet, exercise, drugs) PRIOR to the simulation, using text books, class notes, medical dictionaries, online resources, etc.).
4. Use MicroMedex to look up the following medications.

- hydrochlorothiazide
- candesartan
- lisinopril
- metformin
- sitiglipatin
- fluticasone inhaler
- albuterol inhaler

5. Review the IPE competency material found in this module
6. Read the assigned articles:

Required:

Behm, L, Ivanoff, S.D., & Ziden, L. (2013) Preventive home visits and health- experiences among very old people. BioMedCentral Public Health, 13, 378-388. Open access at <http://www.biomedcentral.com/1471-2458/13/378>

Reidt S, Morgan J, et al. (2013). The role of a pharmacist on the home care team: a collaborative model between a college of pharmacy and a visiting nurse agency. Home Healthcare Nurse, 31(2), 80-7; quiz 88-9.

Optional:

Dolovich, L., Nair, K., Sellors, C, et al. (2008) Do patients' expectations influence their use of medications? Canadian Family Physician, 54, 384-393.

Brief overview of patient

Lester Washington, date of birth 05/05/1940, is a male with a history of type 2 diabetes and hypertension was discharged from the hospital one week ago. His admitting diagnosis was uncontrolled diabetes with extreme hyperglycemia (850mg/dl). He now requires several new medications and diet changes. An interprofessional team (nurse, pharmacist and physician) will make a home visit to assess his adherence with the prescribed treatment regimen and his current health status. The simulation begins with an interprofessional team arriving at the home.

His chart upon discharge is as follows:

Overview	Patient name: L. Washington Gender: male/female Diagnosis: Type 2 diabetes Age: 80 Height: 70 inches Weight: 200 lbs Language: English Physician: Karla Mendez Allergies: penicillin	Address: 525 North Wolfe Street Apartment 215E Baltimore, MD 21205
Medical history of patient	Type 2 diabetes x 15 years. Hypertension x 25 years. Smoking 40 pack years history, stopped 22 years ago. Alcohol, occasionally, socially. Overweight with BMI of 28. Admitted to hospital 10 days ago with uncontrolled diabetes and hyperglycemia. HgA1C was 7.6 on admission. Medication regimen adjusted. Glucose levels normalized. Discharged from hospital one week ago. Current medications: metformin (new dose); sitagliptin (new drug); candesartan; hydrochlorothiazide.	
Social history	Married, retired.	
Discharge summary sheet:		
<p><u>Medication Orders</u> metformin 850 mg PO twice/day with breakfast and dinner sitagliptin 25 mg PO/day candesartan 8 mg PO once/day hydrochlorothiazide 12.5 mg PO/day</p> <p><u>Diet Orders</u> Diabetic diet with healthy carbohydrates – see instructions from the dietician</p> <p><u>Activity Order</u> Regular ambulation every hour with walker as possible. Avoid extended “sitting time”</p>		