Case Study:

The following patient was identified as a result of the population health management project.

The project involved performing a note search for patients who were moderately frail with long term conditions. The aim was to visit these patients and devise a care plan based on " what matters most to the patient" irrespective to what their actual long term condition needs were.

The patient below demonstrates how as result of the initial project visit, we were able to engage with the patient by focusing what mattered to them in order to manage their health condition. With regards to SS this was heart failure.

By discussing the management strategies to management his HF symptoms and adjustment of medications his goal to play golf was achieved and will continue because he has a management plan alerting his to escalate any deterioration in symptoms.

Had we not be involved with the project and the patient hadn't been identified, I doubt SS would have been re reviewed or had contacted the GP, his symptoms would have deteriorated and he probably would have been admitted into hospital. SS initially didn't want to engage in his health management, it wasn't until we built health management strategies which would enable him to play golf that he did!

Frailty score 2017 = EFI 0.33 (2017)
Score at OPTUM visit = 6 moderate frailty
Post Community ANP visit = 4 vulnerable

SS 91 yrs old

PMHX: polymyalgia, IHD, benign prostatic hyperplasia, biventricular failure

12/18 Cardiology OPA x 1 clinic – discharged

Only GP contact was INR since registration until 2018

12/06/2019: GP contact – re SOB ankle oedema. Switched to DOAG from warfarin (CXR and bloods)

13/06/2019: CXR: consolidation – no further action from GP, no further contact to GP by patient

17/06/2019: Com ANP visit (OPTUM) – increased furosemide (double dose), weight monitoring SOS advice re SOB etc

Lives with wife in house, independent in aspects of life, was playing golf, walking well,
Easter = woke very SOB "didn't want to make a fuss and thought it would go away". Since then PND
Struggling SOB, "slowed down, stopped going out so much, struggling".
Very vague about cardiac history.

What matters most to the patient "I want to play golf again"

25/06/2019: phone call – "I feel worse, can't breath"

27/06/2019: phone call – “nothing is working, I can’t sleep or walk”
Changed to bumetanide 2mg OD

28/06/2019: GP consultation (wife requested an appointment) confirmed bumetanide and added PPI

01/07/2019: states “I feel so much better, breathing is back to normal, am sleeping at night”
Ongoing SOS advice given re escalation.

This case study could be classed as “pretty normal” because the actions of the ANP were within her expected role. However, the difference is that OPTUM enabled the patient to be identified and had this intervention not taken place the patient probably would have resulted in a hospital admission.