

**Learning Cases for
Systems Based Practice
In Outpatient Continuity Care Clinics
Using Concepts of
Advanced Clinic Access
as a Teaching Tool**

Developed by:

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Office of Academic Affiliations
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Case 1: 'Max Packing' at Clinical Visits

A 57-year-old man presents to your clinic for a new patient visit for low back pain. This symptom has been present for two weeks and was precipitated by lifting a heavy object. He has not been to a primary physician for at least 5 years. His past medical history is significant only for chronic dermatitis, which he is seen in the Dermatology clinic and is under excellent control. In his review of symptoms, he denies any symptoms not related to his complaint and is focused on the issue of his low back pain. His physical examination is unremarkable, except for minor left lumbar paraspinal tenderness. In review of his records from the Dermatology Clinic, his last 3 blood pressures taken over the past 6 months have all been greater than 145/95.

Goals:

- Appropriate use and understanding of "Max Packing" during provider visits as it related to quality and cost effective care.
- Understanding the role of Clinical Practice Guidelines in "real time" patient care.
- Facilitate the understanding of individual decisions on the system wide provision of health care.

What are your goals for this visit?

After you decided on the appropriate actions, how do you decide on the appropriate follow up and with whom?

Case 2: Understanding Team dynamics in Health Care

Mr. Johnson is a 71-year-old male, who is an established patient in the resident clinic of Dr. Moore. He is having increased shortness of breath with exercise. He followed the clinic protocol 4 days ago and called to discuss his problems with the nurse. Miss Smith called Dr. Moore for recommendations and returned them to Mr. Johnson.

Yesterday, Mr. Johnson still was not better and thus called for an 8:00 a.m. appointment. On arriving at the clinic, he found Dr. Moore was delayed on ward rounds. He was given the option of waiting for Dr. Moore, seeing the physician's assistant, Mr. Brown, or waiting for the attending physician, Dr. Dunn, or another resident to have free time to see him.

Mr. Johnson decided to wait for Dr. Moore, but the patient scheduled at 8:30 a.m. was seen by the physician assistant and his needs met. Dr. Moore appeared at 9:00 a.m., examined Mr. Johnson, ordered lab work and a chest x-ray and called him the results after lunch

Goals:

- Understand the importance in setting expectations for patients and staff
- Explore the options for patient interaction to meet demand
- Review the use of other professionals in meeting patient needs
- Understand advanced clinic access as a component of VA systems practice (ACGME)

What were the difficulties that occurred in the episode of care regarding

The Patient?

The Resident?

The Program?

What steps can be taken to decrease future occurrences of this type of interaction?

Case 3A: System Redesign: Optimizing Patient and Provider Interactions

It is your first visit with Mr. M. He is a 62-year-old with Diabetes Mellitus for many years. He is coming to your practice because his current MD has retired. Previously, he had been with an MD in a solo practice. He tells you that his Doctor instructed him to “Go to the Emergency Room,” if he had problems during times when he did not have a regular scheduled appointment. He has never done self-glucose monitoring. He explains that he manages his blood sugar by “how he feels”.

Goals:

- Understanding how synchronizing patient and provider can impact on the health care system and patient quality outcomes
- Understand the role the provider plays in acting as a patient advocate within the health care system

*How would you orient **this patient** to your clinic practice?*

*How do you currently orient your patients **in general** to your clinic practice?*

Case 3B:

Mr. Z is an 82-year-old with coronary artery disease, hypertension, and diabetes mellitus. He receives all of his care at your VA-affiliated clinic. The patient lives 60 miles from his place of care. He does not like to travel after dark, because he doesn't feel he drives well enough to avoid accidents. He has excellent blood pressure control at 130/60. He is compliant with his meds. His Hgb A_{1c} has been consistently in the 6.5 range. Dr. L is his medical provider. The day of Mr. Z's clinic appointment. Dr. L leaves his ward rotation at the affiliate hospital late. He arrives at clinic ½-hour late and has a full schedule. Dr. L arrives at clinic ½-hour late on a regular basis. Mr. Z waits patiently until about 4 pm, when he starts to worry about hitting rush hour and its getting dark outside. He decides to leave without being seen.

What are the issues that this case illustrates in regards to patient satisfaction and what would the consequences of this behavior be in the “real world” outside the VA, where the patient has a choice of providers?

How could understanding other principles of Advanced Clinic Access be used to offer other allied processes or alternatives to serve this patient's needs? Give examples.

Case 4A: Planning for Contingencies

Dr X. is a 3rd year resident. He has chosen to take an International Medicine Rotation. From February through early March, he will be in Brazil. When he returns from Brazil, he immediately leaves for a Critical Care Elective at an out of state hospital. He realizes that he will not be in his outpatient clinic practice for 2-3 months. On his last clinic day in January, he sees Mrs. Z. Mrs. Z is a 61-year-old with diabetes, hypertension, and hyperlipidemia. On that visit, her blood pressure is 160 /110. Her LDL cholesterol is 150. A quick diet history reveals that she has little knowledge of a diabetic diet. Her Hgb A_{1C} is 8.5.

Goals:

- Developing an understanding of unique nature of each provider within a health delivery system with respect to demonstrating the constraints that patients can encounter in attempting to access care services
- Understand the allocation of scarce health care resources within a system designed to provide uncompromised quality of care by the most appropriate provider

How can Dr. X manage this patient while he is gone for 3 months?

Case 4B:

Dr. X is in the exact same clinical situation. He is no longer going to Brazil or to his outside elective.

Would the patient's management be different in this case?

What is(are) the limiting factor(s) in his providing for Mrs. Z's care?

Case 5: Understanding and Molding Demand for Provider Services and the use of Physician Extenders

Mr. R, 57-year-old male, presents to your primary care clinic for follow-up for his chronic medical conditions. He has no current complaints and his review of systems is normal. All of the appropriate preventive screening has been completed for the next year. Currently, he has congestive heart failure (NYHA Class II) after an MI three years ago. He has hypercholesterolemia and hypertension that have both been well controlled. He no longer smokes.

Goals:

- Elucidate the relationship between the physician-driven demand for return visits and the impact physician behavior has on quality and access
- Understanding how evidence based medicine can guide the return visit interval selection and lead to appropriate utilization of physician visits

Laboratory Studies:

Na 142 K 4.5 Cl 110 CO2 25
BUN 18 Cr 1.1 Glu 102
Cholesterol, Total 167
LDL 91 HDL 46 Trig 150

Medications:

Lisinopril 20mg PO daily
Metoprolol SA 100mg PO daily
Simvastatin 20mg PO daily
EC-ASA 325mg PO daily

Vitals: 98.4°F, 105/74 pulse 62, height 6'0", weight 184 lbs

Physical Examination reveals normal lung examination, no jugular venous distension at 45 degrees, a regular rate and rhythm with an S4 but no murmurs and normal PMI. Abdominal examination is unremarkable, and no edema is seen in the lower extremities. Pulses are palpable and 2+ throughout. Prostate examination is normal and no focal neurologic deficits are seen.

Given this patients medical conditions, what would be the appropriate time for his next visit and consider with whom this visit should occur (MD, RN, Pharm D, etc...)?

What are the consequences to the health care system of both underutilization and over utilization of clinic visits?

Case 6: Understanding and Molding Demand through Clinic Practice Guidelines and the Electronic Medical Record Systems

Mr. K, a 59-year-old Vietnam-era African American veteran with a 20% service-connected disability for hearing loss, presents to your clinic for a new patient visit. He has been followed by a private physician for the last 15 years, but has recently lost his health insurance and is now seeking care in the VA. He has been treated by his private physician for hypertension, diabetes, and "heart disease" and has been told that his BP and lipids are "fine", but his "sugar is high."

His medications include hydrochlorothiazide, simvastatin, and lisinopril. He is also on insulin twice a day. His social history reveals that he has been smoking ½-pack per day since military service.

Mr. K's review of systems reveals no physical complaints but he mentions that since 9/11 he has been having more difficulty sleeping and describes recurrence of nightmares he experienced when he first returned from Vietnam.

On physical exam, the patient's BMI is 25. His BP is 165/92 and he has slightly decreased sensation in his feet bilaterally, but his exam is otherwise unremarkable. Lab results from 6 months ago, performed by his private physician show a fasting glucose of 160, a total cholesterol of 206 and an LDL of 120. His urinalysis is normal.

Goals:

- Assess whether current treatment for existing diagnoses is adequate using clinical practice guidelines; if time permits, include discussion of relationship between era of service and DM (Agent Orange).
- Identify primary, secondary and tertiary prevention needs for patient's sex and age, including discussion of how to approach screening for prostate cancer, and need for colorectal cancer screening.
- Using clinical practice guidelines, develop follow-up treatment plan including what types of providers (e.g., podiatry, eye care, etc.) he needs to see and how to address recurrence of possible PTSD symptoms.

What are your goals for this visit?

What systems are in place within CPRS to aid in providing the highest quality care as demonstrated by the best evidence available?

Are there other services and types of care that would benefit this patient today and how does the availability of these services directly impact on this patient's quality of care?

Case 7: Managing Demand through Optimal Patient Involvement

Mr. C, 64-year-old man, comes in for routine F/U. He had an MI four years ago and has had some intermittent exacerbations of his congestive heart failure (CHF). His last EF (ejection fraction) was 49%. When he has had CHF exacerbations, he has tended to wait until he is unable to breathe. Then, he comes in to the ER and often gets admitted to the hospital. His last admission was two months ago. He also has diabetes mellitus Type II and HTN. He states that he took his BP at the drugstore and it was 165/92. Mr. C denies any CP, SOB, change in the bowel or bladder habits. He is still smoking and eats out a lot. On exam, his BP is 134/80, pulse of 68. Weight is 202lbs. The rest of the exam is unremarkable, except for some mild non-pitting pedal edema bilaterally.

Labs: electrolytes are normal, and his Hgb A_{1C} is 6.4, total cholesterol 180, LDL 92.

Meds:

furosemide 40mg BID
lisinopril 40 mg QD
glyburide 10mg BID
metoprolol SA 50mg QD
ASA 81mg QD
simvastatin 20mg QD.

Goals:

- Appropriate use and understanding of “Optimizing Patient Involvement,” as it relates to quality of care and effective use of future visits.
- Become more comfortable with patient education, as it relates to patients understanding of when to call for appointments.
- Help patients and their families to become more involved in their own healthcare.

Briefly discuss the control of his various medical problems.

In what ways can you as the physician intervene and what aspects should the patient become more involved in or change?

When would you want to have him return?

References:

- Advanced Clinic Access: Prepared for VHA by the Institute for Healthcare Improvement
- Murray M, Berwick DM. Advanced Access: Reducing Waiting and Delays in Primary Care. JAMA 2003; 289:1035-1040
- Berry LL, Seiders K, Wilder SS. Innovations in Access to Care: A Patient-Centered Approach. Ann Intern Med. 2003;568-574.
- Institute for Healthcare Improvement web site on the Idealized Design of Clinical Office Practice: <http://www.ihp.org/idealized/idcop/background.asp>
- Clinical Practice Guideline for Congestive Heart Failure, http://www.oqp.med.va.gov/cpg/CHF/CHF_Base.html
- Advisory Council To Improve Outcomes Nationwide in Heart Failure (ACTION-HF). Consensus Recommendations for Management of Heart Failure. Am J Card 1999 83(2A) 1A-38A.
- Bodenheimer T, Lorig K, Holman H, Grumbach K. Patient self-management of chronic disease in primary care. JAMA. 2002 Nov 20;288(19):2469-75.
- Grumbach K, Bodenheimer T. Can health care teams improve primary care practice? JAMA. 2004 Mar 10;291(10):1246-51.
- Murray M, Bodenheimer T, Rittenhouse D, Grumbach K. Improving timely access to primary care: case studies of the advanced access model. JAMA. 2003 Feb 26;289(8):1042-6.
- Casalino L, Gillies RR, Shortell SM, Schmittiel JA, Bodenheimer T, Robinson JC, Rundall T, Oswald N, Schauffler H, Wang MC. External incentives, information technology, and organized processes to improve health care quality for patients with chronic diseases. JAMA. 2003 Jan 22-29;289(4):434-41.
- Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. JAMA. 2002 Oct 9;288(14):1775-9.
- Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: the chronic care model, Part 2. JAMA. 2002 Oct 16;288(15):1909-14.