Helping a Dual Eligible Veteran navigate between VA and non-VA care….

A patient who has a longstanding doctor he sees outside the VA stated that he had stopped taking a medication ordered by his non-VA provider.  He was interested in getting the medication at the VA but could not recall the name. The physician asked the patient what the medication was for and why he’d stopped taking it.   The patient replied “I don’t know what it’s for but I stopped taking it because it’s expensive.” The physician counselled the patient to check his list of medications and discuss with his non-VA provider what the medication is for. The physician stated, “If you understand why the doctor thinks you should take it, you might be able to get generic options.  It could also be covered by Medicare, and if you come back we might be able to provide it to you through the VA.”

A provider noticed that an elderly patient in the outpatient clinic had been losing weight over several visits.  Rather than assuming the problem was biomedical, the clinician started with an open-ended question: “Why do you think you are losing weight?” When the patient didn’t respond, the provider asked, “How many meals a day do you eat?”  The patient answered, “not three meals a day.”  The provider continued, asking “Are you having trouble paying for food?”  The patient revealed that he used to receive help from Meals on Wheels, but because he had moved he was no longer receiving assistance.  The provider then called the social worker on the phone to re-establish Meals on Wheels, and also to determine if the patient qualified for homecare assistance.

This encounter is a nice example of picking up on a contextual red flag, probing until the full story comes out, and then acting on behalf of the Veteran to solve the problem. From the list below, we’d say the clinician addressed the patients “skills and abilities” deficit by helping him reconnect to needed services.

We often hear providers go to substantial lengths to make sure Veterans get what they need:

On one recent audio recording we heard a patient with diabetes say that he was about to run out of insulin and syringes.  The provider asked the patient if he had ordered the supplies (he had).  The provider then looked in CPRS to see if the order had been placed in the system.  The record indicated that the medication had been mailed more than a week earlier and should have arrived.  The provider verified the patient’s address. The provider then called the pharmacy to see why the patient hadn’t received the supplies.  The provider was informed on the phone that while the online record showed the order had been mailed more than a week ago, it actually had only been sent out a few days previous.  The provider then confirmed that the patient had enough supplies for the next few days and checked with the patient to see if he could come into the pharmacy if for some reason the supplies didn’t arrive before he ran out of medication.

This is an example of contextualizing care: recognizing a red flag (the patient hadn’t received his medications), identifying the problem (the medications were mailed late) and making sure the problem got resolved (confirming they were on their way and that the patient had access if they didn’t arrive on time).

A Veteran’s previously stable INR went up (contextual red flag). When the physician asked what was going on (contextual probe), the patient revealed that when the weather was bad they had trouble getting to the grocery store and were not consistently eating fresh foods, including leafy green vegetables (contextual factor). After discussing various options they looked up ways to maintain a stable vitamin K intake by looking for foods that can be stored in the home that the Veteran likes. Dried basil, prunes, soybean oil and hard cheeses are all sources. Charts and tables on-line list the amounts. The provider also scheduled a follow-up appointment for the patient with a nutritionist to explore other dietary options. This interaction illustrated a provider and patient working collaboratively to arrive at a contextualized plan of care.

Resourceful solution to a unique situation...

During a recent pharmacist appointment, the patient mentioned that he was going to be sleeping in his car in the VA parking lot that night. The pharmacist asked the patient why. The patient explained that he had another appointment at the VA the next day, but lived quite a distance away and it was going to be easier to sleep in his car instead of driving back and forth. The pharmacist contacted the other provider and was able to move the patient’s appointment to that same day so he would not have to sleep in his car. This was a unique situation and the pharmacist thought “out of the box” to address it.