A question for reflection from the audio coders . . .

We listen to quite a few audio recordings of encounters in which the Veteran has missed the last several appointments. It is not often that the clinician asks the Veteran why they have missed appointments.  When they do, Veterans sometimes give reasons (contextual factors) that can be addressed (e.g. lack of transportation, working the night shift). Should clinicians prioritize asking Veterans why they are missing appointments to see if they might be able to help?

When patients say “no thanks” to the Influenza vaccine…

Many Veterans initially decline the flu vaccine.  Not often do we hear the provider or nurse asking the patient *why*.  When they do ask, we’ve heard reasons from Veterans that could be addressed. Listed below are some of the contextual factors heard and the plan the provider or nurse made:

Factor:          Patient said his sister gets headaches from the vaccine

Plan:             Explained that headaches are not a side effect of the flu vaccine

Factor:          Patient thought that since he had one last year, he didn’t need another one.

Plan:             Explained that the flu vaccine is needed every year.

Factor:          Patient stated that he always gets sick after the shot.

Plan:             Explained that the vaccine does not contain a live virus

Factor:          Patient stated that he isn’t around little children.

Plan:             Explained that anyone can spread the flu, not just children.

Factor:          Patient stated that he didn’t think he should get a shot if he wasn’t experiencing any problems.

Plan:             Explained that the vaccination would prevent problems.

Factor:          Patient states that he never gets sick.

Plan:             Explain that everyone is susceptible to the flu.

Factor:          Patient says that he never gets a cold.

Plan:             Explain the difference between a cold and the flu.

Factor:          Patient doesn’t want to worry about the flu.

Plan:             Calm patient’s fears about the flu and flu vaccine.

Factor:          Patient states he doesn’t need it because he eats plenty of fruits and veggies.

Plan:             Explain to the patient that diet won’t prevent the flu virus.

Factor:          Patient states that he isn’t susceptible to the flu.

Plan:             Explain that no one is immune from viruses.

Factor:          Patient states that a flu vaccine he had 20 years ago put him in the hospital.

Plan:             Explain that the vaccine is different than in the past.

Factor:          Patient states that he believes the vaccine will give him the flu

Plan:             Explain that the vaccine is not a live virus.

Factor:          Patient is afraid of needles.

Plan:             Discuss a plan for de-sensitizing the patient to needles, and see if the nasal spray version is available.

During a visit a patient (a) mentioned he was no longer taking his medication for gout, (b) declined both a flu and pneumonia vaccine, and (c) said that he hadn’t taken his blood pressure medicine that morning when the provider commented that his blood pressure was elevated (on re-take it was normal).  The provider consistently asked the patient to explain why …and learned:  (a) Another clinician had discontinued the colchicine without documenting why, (b) the patient thought he didn’t need vaccines unless he was actually sick, and (c) he’d started taking his meds in the afternoon after he returned home from work, since they make him urinate and he didn’t have easy access to bathroom while on the job.  After some discussion the plan was: (a) the provider would find out why the gout meds were stopped, (b) the patient would think about getting vaccinated at the next visit (after learning that it’s preventive), and (c) they agreed that taking meds in the afternoon is fine.

The provider in this example exhibits excellent, consistent attention to Veteran context with consistent follow through: notice the clue (contextual red flag), ask about it (probe), arrive at a plan that fits the Veteran’s situation (context).

Proactive contextual care . . .

A sudden change in a patient’s life situation should, ideally, prompt their provider to consider how the change might impact their care. We call this pro-active contextualized care planning. Here’s an excellent example:

In a recent encounter, a patient revealed that he recently began living on the streets.  After making sure the patient was working with the VHA homelessness program to secure housing, the provider said to the patient “Does this situation change where you want us to mail your meds?”  The Veteran replied that they should no longer be mailed to his old address. Instead he’d pick them up at the onsite pharmacy.   Quite possibly, this provider helped the patient avoid missing his medications because he anticipated how the changes in the patient’s situation might impact his care.

Missed opportunity to find out *why…*

A Veteran who is taking warfarin mentioned during the visit, without being asked, that he has not been following the recommended instructions to consume leafy vegetables twice a week.  The provider did not ask why, perhaps because the INR was in the desired range. However, we nevertheless code a patient’s comment that they are not following a recommended plan of care as a “contextual red flag” since it suggests they may be facing some sort of challenge that is compromising their care plan. In this case, challenges might include not being ability to afford fresh vegetables, not knowing how to prepare them, and/or not having access to a grocery store.  Because this provider did not probe (i.e. ask why the patient isn’t following the diet), an opportunity was missed to find out what the problem is and whether the VA has services to assist.

Instead of providing a case this week, we decided to share with you a general impression we have after listening to thousands of audio recordings:  The staff at Jesse Brown (clerks at the desk, RNs, nurses taking vitals, attendings, residents, pharmacists, and nurse practitioners) demonstrate passion, empathy, and a sincere drive to provide the best healthcare to our Veterans.  We hear it every day. While our focus has been on whether or not care has been tailored to Veterans’ individual circumstances (contextualized care), we are daily reminded of the wonderful care our Veterans receive.

We’ve observed JBVA folks going out of their way to make sure Veterans understand where they are going and help them at the front desk; we hear providers and staff conscientiously checking in with Veterans, going the extra mile to make sure Veterans’ questions or concerns are addressed; especially we notice how well providers and staff know many of their patients and show genuine interest in their wellbeing and life situations.

We are proud to be working with such passionate and caring professionals.

During a visit, a patient with a history of high cholesterol mentioned (without being asked) that he wasn’t taking his cholesterol medication “the way I am supposed to.”  The provider did not ask the patient why he wasn’t taking his medications as prescribed and instead responded by saying that it is important that he take them as directed.  It’s possible, however, that the patient brought it up because he was facing some sort of barrier or challenge (a “contextual factor”) that could have been addressed. Possible factors include some financial cost related to taking the medication, a misunderstanding about the risk versus benefit, his attitude toward his illness, or any number of possibilities from one or more of the 12 domains of context in the table below.

A patient’s records in CPRS indicated that he had missed 46% (a total of 16) scheduled appointments in the past year (a *contextual red flag*). The provider told the patient that he’d need follow up with the specialist referrals if he wanted to take care of his health, but did not ask him why he had missed so many of them in the first place (failure to *probe* for an underlying *contextual factor*).  It is possible the Veteran is facing challenges that we could help him with. Perhaps, for instance, he doesn’t have transportation and is eligible for transportation services through the VA, or that he could make more appointments if they were coordinated to occur on the same day. Based on his home address, it could also be that he is a candidate for the Veterans Choice program

When we listen to audio recording we distinguish between patient preferences and patient context. Here’s an example: A Veteran declined a flu shot stating, “Nope, I don’t get them.” The provider asked, “Do you mean shots in general?” The patient then stated that he’d accept other shots, just not the flu shot. The provider continued to probe asking, “Do you mind me asking why?” The patient explained that he understood the benefits of the flu shot and knew how it worked. He even stated that he was being irrational, but was just tired of the flu shot. In this case, while the provider did a thorough job probing, there wasn’t a contextual reason for the patient’s refusal (i.e. he could afford it, it didn’t interfere with his life, he had accurate knowledge about how the flue shot, etc.). It was, instead, the patient’s preference to decline the vaccination.

We’re taking a break from our usual case based feedback to share a general observation:

Many of the Veterans who volunteer to audio record their visits tell our staff and volunteers in the waiting room how much they appreciate the care they get at Jesse Brown. Some patients say they are agreeing to record their visits for the simple reason that they would like us to hear what a terrific job their providers and other staff are doing. We just wanted to let you know of the exceptional goodwill and satisfaction many of our patients have towards the VA, providers and staff.

This is example illustrates how picking up on clues that a patient’s care is not on track applies to everyone on the PACT team: A clerk noticed that a patient had been waiting a long time (a contextual red flag), asked if he had already had his vitals taken (contextual probe) and learned that he had not. The clerk then looked in the computer and saw that the nurse had already called the patient. They asked the patient if he had left the waiting area and learned that he briefly had, missing the call (contextual factor). The clerk then ensured that the patient was taken back for vitals and to see his provider after confirming with the provider that they would still see the patient.

This week we thought we’d share with you reasons Veterans give for why they’ve lost control of their diabetes when you’ve asked them.

Sometimes providers don’t ask why. This list gives an overview of the possible reasons which they might be missing by not asking.

The patient:

- lost his glucometer

- is afraid he is going to die of low sugar in his sleep - so he eats a bowl of frosted flakes every night for the sugar

- his wife insists they both have a large meal when they go out to eat

- believes that exercise alone will control sugars so stopped his meds

- says he has a “myriad” of things going on life and can’t handle taking care of diabetes

- can’t afford gas to come into the VA to participate in MOVE (in order to lose weight to control A1C)

- isn’t exercising because his shoes hurt his feet and he can’t afford better shoes

- is eating starchy foods because he cannot afford fresh food

- is confused as to correct dosage of insulin and unsure what an acceptable blood sugar reading is

- is taking a double dose of insulin at night because he routinely forgets to take his insulin in the morning

- ran out of lancets

- says he feels fine and doesn’t think he needs to check his sugar levels

- isn’t taking Metformin as prescribed because he’s afraid it lowers his blood sugar level too fast

- thinks that juice is a low-sugar option

- lives alone and says he needs social support to help him “stay on track”

- is “on the road” often and cannot check his blood sugar readings consistently

- lives alone and isn’t eating consistently

- broke his glucometer

- stated that the labels on the bottles of insulin have a different dosage than the one the provider wanted him to take

- has PTSD and says that his anxiety makes it difficult to eat, especially in social situations so he skips his insulin

- is unsure of what foods are good for a diabetic to eat

- primarily eats at restaurants and finds portion control difficult

- stated that his wife recently lost weight and is no longer considered diabetic, so she is now eating more and pt. wants to eat along with her

- only has expired insulin

- is unable to exercise by walking because his neighborhood is unsafe

- is not using his glucometer because he hates needles

- is confused about food portions and choices

- believes it is healthier to eat one large meal a day

- has been getting “into it” with someone and is too upset to manage his care

- drives a truck for a living and his insulin froze in the truck

- believes that his blood sugar readings are acceptable (they run high)

- has PTSD and says he cannot remember to take his medications

- had an episode of low sugars in the past which frightened him; he adjusted his dosage on his own

- is taking insulin when he was instructed to take his blood sugar reading and vice versa

- says when he’s not working, his eating habits change for the worse

- says he eats more when he is working in order to avoid low sugar readings

- believes if he eats well for breakfast and lunch; he can eat whatever he wants for dinner

- skips meals because he doesn’t feel hungry and doesn’t think he needs to eat

- doesn’t realize he has to eat when he takes insulin

- didn’t realize there was sugar in the cough medicine he is taking

- believes he can eat chocolate if the time of day is right

- recently had a stroke and thinks that people inevitably die quickly after strokes so he doesn't think he has to control diabetes

- states he is so grateful to be alive he doesn't care about controlling diabetes

Our “4C” coding system is designed to track what providers do when there is evidence that a Veteran is facing a life challenge that is complicating their health or health care (e.g. loss of control of diabetes, not refilling meds, etc…)

This week we want to acknowledge those providers who are pro-active in asking patients about any challenges they may be facing, before there are signs of problems.

Most often we hear them ask, “Do you have any issues taking your medications as prescribed?” Sometimes patients respond with concerns, which are then addressed before issues arise.

Why ask “why?”

Research\* has shown that when a patient is struggling with a life challenge affecting their care, such as inability to afford a medication, the provider is more likely to address it if they learned about it by asking in response to a clue (e.g. sudden loss of control of their diabetes) then if the patient just volunteered the information.

That’s why, when we notice a contextual red flag (e.g. frequent missed appointments), we listen for whether the provider asked the patient why. If they did, the underlying reason (e.g. can’t travel by bus due to disability) is more likely to be addressed, even if the patient brought up the problem on their own anyways. The difference is probably due to the provider being more engaged.

\*Schwartz A, Weiner SJ, Binns-Calvey A, et al. BMJ Qual Saf 2016;25:159-163

When a closed-ended question should have been an open-ended question…(when probing for patient context):

A narrow question often leads to a narrow answer -- too narrow to address what the doctor really wanted to know: We heard an example when a patient presented with a hemoglobin A1C > 9. The provider asked the patient if they were having any side effects from their Metformin. The patient said no. They physician replied “okay let’s increase the dosage.” What they didn’t ask was whether the patient was actually taking it, along with other prescribed meds for diabetes, as directed. Perhaps a better question would have been: “Tell me how you’re taking your medications?”

What is this patient trying to their doctor?

During a routine visit, a patient with COPD and persistent respiratory symptoms commented three times that he was “supposed” to be using his maintenance glucocorticoid inhaler daily. The provider did not ask the patient if he was, in fact, using it as prescribed. It’s possible he was hinting he was not because of being hesitant to say so directly. If the provider had asked, they might have discovered a problem that could be addressed, e.g. that the Veteran could not afford the copay on the particular inhaler, or, maybe was leery of using steroids – both reasons we’ve heard given during other encounters when patients are asked. Without following up, the provider missed an opportunity to see if the patient was taking his medications as prescribed and, if not, whether the underlying issue could be addressed.