

# ***Introduction To Health Care I***

**Syllabus**

**Fall 2003**



Department of Family Medicine

Georgetown University

School of Medicine

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## Contact Numbers

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## IHC Team Leaders 2003-2004

Dr. Kim Bullock	Ms. Mary Beth Levin	Dr. David Rabin
Dr. Donna Cameron	Dr. Matthew Levy	Dr. Asha Subramanian
Dr. Pat Evans	Dr. James Marsh	Dr. Jay Siwek
Dr. April Everett	Dr. Harry Marshall	Dr. Steve Schwartz
Dr. John Gimpel	Dr. David Meyers	Dr. Jeff Weinfeld
Dr. Nilana Gunasakeran	Dr. Kenneth Moon	Dr. Caroline Wellbery
Dr. Seiji Hayashi	Dr. Gerren Perry	Dr. Joy Williams
Dr. Linda Keyser	Dr. Rebecca Poage	Dr. Alan Zuckerman

# Introduction to Health Care I

## Fall 2003

### Course Schema

Date	Topic	Presenter(s)	IHC Teams	Reading*
<b>Friday Aug 29</b>	<b>9:00 AM</b> <b>Introduction</b> <i>Course Overview</i>	John R. Gimpel, DO, MEd Director of Predoctoral Education Assistant Professor, Family Medicine Course Director, IHC GUSOM		Ch 1          Ch 6, 7, 17
	<b>10:00 AM</b> <b>Organization of Health Care in The United States:</b> <i>Squaring the Old Values, American Culture, and The New Economy</i>	Dr. Gimpel		
<b>Friday Sep 5**</b>	<b>9:00 AM</b> <b>Introduction to Health Care in Washington, DC, and Orientation to the Community Health Informatics Project (CHIP)</b>  <b>9:30 AM</b> <b>Overview of Health Statistics</b>	Jeff Weinfeld, MD Assistant Professor, Family Medicine Associate Course Director, IHC GUSOM   Leonard Chiazze, ScD Director, Occupational Studies & Professor, Department of Family Medicine GUSOM		Handout

	<p><b>10:00 AM</b> <b>Introduction to Service-Learning</b></p> <p><b>10:10 AM</b> <b>Community-Oriented Primary Care: <i>Practicing What We Preach</i></b></p>	<p>Donna Cameron, PhD Director, Service-Learning Program Assistant Professor, Family Medicine Associate Course Director, IHC GUSOM</p> <p>A. Seiji Hayashi, MD, MPH Director, Community Projects Assistant Professor, Family Medicine GUSOM</p>		
<b>Friday Sep 12**</b>	<p><b>9:00 AM</b> <b>Health Status of the US Population: <i>Who Cares About Prevention?</i></b></p>	<p>Douglas Kamerow, MD, MPH Assistant Surgeon General, USPHS, (Ret.) Chief Scientist RTI International Clinical Professor, Family Medicine GUSOM</p>		Ch 11
	<p><b>10:00 AM</b></p>	<p><b>All IHC Teams- First Meeting</b></p>	<p><b>Case A Community-Oriented Primary Care</b></p>	Ch 3
<b>Friday Sep 19</b> (2 hr session)	<p><b>9:00 - 11:00 AM</b> <b>Medical Economics: <i>Paying for Health Care</i></b></p>	<p>John R. Gimpel, DO, MEd</p>		Ch 2, 4, 8

<b>Friday Sept 26**</b>	<b>9:00 AM</b> <b>Introduction to Managed Care and Managing Care</b>	James Welsh, MD, MBA Director, Student Primary Care Clinic Assistant Vice President for Student Health Services, Georgetown University Assistant Professor, Family Medicine GUSOM		Ch 5, 7, 8, 9
	<b>10:00 AM</b>	<b>All IHC Teams- Second Meeting</b>	<b>Case B Health Insurance</b>	
<b>Friday Oct 10</b>	<b>9:00 AM</b> <b>The Federal Government's Role in Health Care: <i>Focus on Medicare</i></b>	Louis B. Jacques, MD Medical Officer Program Integrity Group Office of Financial Management Centers for Medicare & Medicaid Services		Ch 2
	<b>10:00 AM</b> <b>Access to Health Care: <i>The Ecology of Health Care in the US</i></b>	Robert L. Phillips, Jr. MD, MSPH Assistant Director, The Robert Graham Center: Policy Studies in Family Practice & Primary Care Assistant Professor, Family Medicine GUSOM		Ch 3
<b>Friday Oct 17**</b>	<b>9:00 AM</b> <b>Focus on Quality: <i>Curing Health Care</i></b>	Steve Schwartz, MD Clerkship Director Assistant Professor, Family Medicine GUSOM		Ch 12
	<b>10:00 AM</b>	<b>All IHC Teams- Third Meeting</b>	<b>Case C Government -Financed Health Care</b>	
<b>Friday Oct 24 **</b>	<b>9:00 - 11:00AM (2-Hours)</b>	<b>All IHC Teams- CHIP Presentations</b>		

Friday Oct 31	9:00 AM <b>Comparative National Health Systems</b>	F. Edwin Froelich, MD, JD Private Law Practice Carroll & Froelich, PLLC Assistant Professor, Family Medicine GUSOM		Ch 14
	10:00 AM <b>Health Care Reform Proposals</b>	Judith Feder, PhD Dean of Public Policy and Professor Georgetown Public Policy Institute Georgetown University		Ch 15 JAMA 2003 article
Friday Nov 7	9:00 AM <b>The Future of Health Care in the United States: A Panel Discussion</b>  Jay Siwek, MD Moderator Professor & Chair Department of Family Medicine Editor, <i>American Family Physician</i>	Distinguished Panelists have been invited, including: Richard H. Carmona, MD Surgeon General of the United States		Ch 14, 15
	10:20 AM <b>Course Review</b>	Dr. Gimpel		
Friday Nov 21	9:00 - 11:00 AM <b>WRITTEN EXAMINATION</b>	<i>Happy Thanksgiving!</i>		

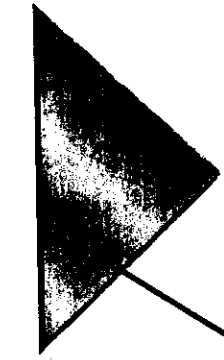
All lectures are held in LA-6 Preclinical Science Bldg. The first lecture runs from 9:00 to 9:50 AM, unless otherwise noted. This is either followed by a second lecture presentation or by a meeting of the IHC Teams. The Team Meeting (or the second lecture) runs from 10:00 to 10:50 AM, unless otherwise noted.

\*All readings are from the course text: Bodenheimer TS, Grumbach K. *Understanding Health Policy: A Clinical Approach. Third Edition*. New York: Appleton & Lange, 2002, or from selected medical journals (e.g. *JAMA*, *AFP*), which will be posted on Blackboard. IHC Team rosters and room assignments will be posted on Blackboard (<https://campus.georgetown.edu>) during the first week of class.

\*\*IHC Teams meet from 10:00 - 10:50 AM on these dates, except for October 24, when it is 9:00 to 10:50 AM.

No class meetings on October 3 or November 14.

**Access**



**Quality**

**Cost**

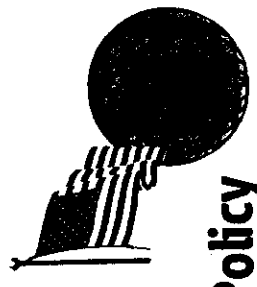
**Containment**

**PPB**

**RTHC**

**Ethics**

**IHC II**



**HC Policy**

**Future**



**Organization**

**HC Workforce**

**IHC**

**I**

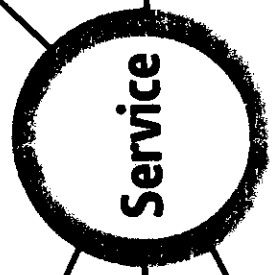
**Fall, 2003**



**SL**

**COPC**

**CHIP**



**PREVENTION**



# Introduction to Healthcare I

## Course Description and Overview

The Introduction to Health Care I (IHC I) course is the first semester of a year long required course for first year medical students at Georgetown University School of Medicine. It serves as an orientation program for a student's entire career in medicine, outlining a systematic way of organizing perspectives on health care. IHC I provides an overview of the current and proposed strategies for the organization, financing, and delivery of health care in the United States and in selected other countries. The course aims to complement concurrent and future coursework in helping to bridge the more familiar individual patient-physician clinical encounter with the often-complex world of health policy and medical economics. At the very core of the course components is the importance of the development of altruism and concern for the individual patient as well as foundation for a concern for the health of the population as a whole.

The course is not intended to make you into an epidemiologist, a public health officer, or a managed care health executive, though you should be able to converse with one early on in the year. A student's eventual practice of medicine is unavoidably influenced by public concerns, whether expressed directly by patients or indirectly through elected officials, legislation, or public funding. In contrast to many medical school courses, IHC deals with many issues about which students and faculty members may already have strong feelings because of prior experiences, political affiliations, and the like. The course is not intended to change a student's opinions, but merely to help the student to be an informed participant in this process.

## IHC I Format

The educational activities for IHC I are highly experiential, and, as such, attendance and participation is critical for all students to meeting the educational objectives of the course. Lecture presentations occur most Friday mornings for one or two hours. IHC Team Meetings follow selected lecture presentations.

IHC Teams will pair 8-9 students with a Faculty Team Leader, and the groups will work collaboratively on clinical cases and other learning activities designed to augment the course concepts introduced in the lecture presentations and the required readings. Campus-Based IHC Teams meet on campus, and Service-Based Teams meet on campus or at their community site. All IHC Teams emphasize teamwork and collaborative learning attributes; Campus-Based and Service-Based Teams just differ in the learning activities that they are involved in. "Rules for Participants" for IHC Teams and Cases A-C are included in the syllabus. Students may have the opportunity to earn "extra credit points" for the course based on points earned by other members of their IHC Team, fostering cooperative learning.

### **Campus-Based IHC Teams**

Traditional small group setting that pair 8-9 students with one Faculty Team Leader. The group meets on campus four times in IHC I, and stays together for IHC II. Learning activities included case-based learning, role-play, problem-solving exercises, and extensive discussion as well as the Community Health Informatics Project (CHIP) oral presentations.

### **Service-Based IHC Teams**

Georgetown introduced a Service-Learning Track in IHC in 1996, allowing students to work in community settings, emphasizing learning through community service. This portion of IHC has been reorganized, such that students on Service-Based IHC Teams have the opportunity to actively participate in thoughtfully organized service experiences that meet actual community needs. The service experience enhances coursework, by extending student learning beyond the classroom into the community and by providing for guided reflection. We have been continuing to increase the number of community partners and sites, with the goal of providing a service component to all IHC Teams by 2007. In IHC I, the teams will meet predominantly on campus and work with the same clinical discussion cases as the Campus-Based Teams, as well as the CHIP. The majority of the off-campus service will be performed in IHC II in the Spring semester. All students will be further introduced to Service-Learning and to Service-Based Teams by Director Dr. Donna Cameron on Friday, September 5.

### **Community Health Informatics Project (CHIP)**

This project is required of all students, and is presented to student peers and IHC Team Faculty Leaders on October 17. Students will research key health indicators in the District of Columbia and compare and contrast these attributes and problems with those in a distinct county (urban, suburban, or rural) or District Ward. Criteria for this project, resources, as well as scoring rubrics are posted on **Blackboard**, and will be reviewed by Project Director Dr. Jeff Weinfeld on September 5.

### **Readings**

The required text is Bodenheimer TS, Grumbach K. *Understanding Health Policy: A Clinical Approach*. Third Edition. New York: Appleton & Lange, 2002.

Recommended readings include any additional articles distributed by course faculty (and posted on **Blackboard**) as well as the following book, Lown B. *The Lost Art of Healing: Practicing Compassion In Medicine*. New York: Ballantine Books, 1999.

The Bodenheimer text is a complement to, NOT A SUBSTITUTE FOR, the material from the lecture presentations. All students are responsible for the content of the lectures and assigned readings for the written examination. Students should consult **Blackboard** on a weekly basis for updated reading assignments.

Content from the IHC Teams per se is NOT included in the written examination, but skills and attitudes acquired in these activities may indeed be helpful to you in the examination.

## Goals and Objectives

The Introduction to Healthcare I course (IHC I) was designed as guided by Georgetown University's Jesuit tradition of *cura personalis*, of caring for the whole person, in that Georgetown University School of Medicine will educate, in an integrated way, knowledgeable, skillful, ethical, and compassionate physicians and biomedical scientists dedicated to the care of others and the health needs of our society. (*Executive Faculty*, January 2002)

Georgetown University School of Medicine's Committee on Medical Education (January 2002) provides overall General and Intermediate Objectives for its four-year curriculum. These particular goals and objectives function as a broad blueprint for Georgetown's curriculum. In particular, the following (with minor adaptations) are presented here to show only IHC I's connection to the overall mission and curricular objectives of the School of Medicine. Some of these components are dealt with in detail in IHC I, and others are simply introduced in IHC I and then further elaborated on in IHC II or other courses and clerkships in the four-year curriculum. (<http://data.georgetown.edu/schmed/ead/gu/index.cfm>)

## Overall GT Curricular Goals Relevant to IHC I

Specific GT curricular goals related to IHC I are as follows:

1. for students to develop a declarative **knowledge** of the following issues in contemporary health care:
  - a. current and proposed strategies for the organization, financing, and delivery of health care in the United States and selected other nations
  - b. socioeconomic and cultural dimensions of human health and illness
  - c. population-based concepts and community-oriented primary care (COPC)
2. for students to give evidence of clinical competency by demonstrating the following **skills**:
  - a. the ability to retrieve, manage and utilize information from electronic sources in addressing both individual and public health care problems
  - b. the ability to communicate, orally and in writing, with colleagues
  - c. sensitivity to patient diversity and values
  - d. critical thinking, problem solving, and reasoning skills
  - e. cooperative work with peers as well as creativity and acceptance of differences as promoted by cooperative learning strategies
3. for students to demonstrate the following **attitudes and values**:
  - a. altruism through a commitment to service, especially service to the disadvantaged
  - b. an understanding of the ethical dimensions of the patient-physician relationship and of the ethical dilemmas encountered in health care, at the bedside as well as in the formulation of policy
  - c. an understanding of the obligations-to patients, the profession, and society-inherent to the practice of medicine
  - d. an appreciation and respect for the roles of other health care professionals and ability to collaborate with them effectively in caring for patients

## **Specific Course Objectives- IHC I**

The IHC I course will utilize varied educational methodologies and instructional activities to assist the students in meeting course goals. Each learner-centered objective is cross-referenced to the particular **assessment methods** utilized in the course (detailed below and lettered with an "A" and the relevant number).

At the completion of IHC I, students will be able to:

1. Provide an overview of the healthcare system in the United States, including the organization of healthcare and the graduate medical education system.  
(A-1, A-3, A-4, A-5)
2. Describe the health status of the US population and concepts in prevention, as well as to define community-oriented primary care (COPC).  
(A-2, A-3, A-4)
3. Discuss healthcare in the District of Columbia and access to care issues.  
(A-2, A-3, A-4)
4. Recognize the complex environment in which we all work, including being able to describe the makeup of the healthcare workforce, the roles of other health care professionals, as well as alternatives for practice.  
(A-1, A-3, A-3, A-4, A-5)
5. Describe the methods of payment for healthcare, to physicians as well as to hospitals and health systems.  
(A-1, A-3, A-4, A-5)
6. Summarize issues related to managed care, including capitation as well as quality indicators and improvement strategies.  
(A-1, A-3, A-3, A-4)
7. Describe the role of the federal government in healthcare, including the Medicare program.  
(A-1, A-3, A-4)
8. Demonstrate knowledge of international healthcare issues, and be able to compare and contrast health care systems in selected countries.  
(A-3, A-4)
9. Debate the issues regarding the future of US healthcare, including proposals for reform.  
(A-3, A-4, A-5)
10. Recognize relevant ethical issues in medical practice, including the professional obligations of physicians, and the current threats to these obligations posed by conflicts

of interest inherent in various financial and organizational arrangements for the practice of medicine.

(A-3, A-4)

11. Exhibit the ability to retrieve, manage, and utilize information from electronic sources in addressing public health care issues.  
(A-2)
12. Define the following population health terms and health-status indicators and apply them to the analysis of the health of a community: birth rate, death rate, incidence, prevalence, causes of death, disparity, and poverty rate. (A-2, A-4)
13. Summarize in the form of an effective oral presentation the analysis of a Community Health Informatics Project (CHIP).  
(A-2)
14. Evaluate and reflect on the professional and teamwork skills necessary to work collaboratively with peers in a group setting, including respect for differing opinions and active listening.  
(A-3)
15. Exemplify the further development of altruism through a commitment to service, especially service to the disadvantaged. (See also Service-Learning objectives for Service-Based IHC Teams )  
(A-2, A-3)

### **Student Assessment Criteria**

The learning of each student will be assessed by the following means, with the respective component weighing towards the final grade as shown:

A-1: Self-Assessment Questionnaires	10%
A-2: Community Health Informatics Project Oral Presentation (includes peer input)	15%
A-3: IHC Teams (Campus-Based or Service-Based) Faculty/Peer Evaluation	20%
<b>Note: 5 pts (5%) reduction for each session absence</b>	
A-4: Written Examination	55%
A-5: Discretionary Assignments	(Extra Credit)
<hr/>	
<b>FINAL GRADE</b>	<b>100%</b>

## IHC I- Assessment Component Overview

IHC I is designed with the following outcomes-based assessment methods. Each assessment method (e.g., A-1 to A-5) is linked above to the specific learning objectives for the course.

### A-1: Self-Assessment Questionnaires (SAQs)

These self-graded evaluations (a form of formative assessment) are given in class to assess knowledge, attitudes, and progress in the course. The format will be selected response test items (true-false, matching, multiple-choice, or short answer completion). Full credit is given for participation and between three and five of these will be administered throughout the semester, with the sum total of points representing 10% of the students' final grade.

Please note that there is a five minute window for completing the SAQs: Don't sweat it--students who miss a SAQ due to arriving late, leaving early, going away, or falling into a deep sleep will only be able to make up for these points by discretionary assignments (extra credit)- not by asking to have the SAQ at another time- **NO EXCEPTIONS**.

Also note- *it is considered a violation of professional conduct to collect an extra SAQ form for a peer, sign another's name, or any other sort of irregular behavior, and will be dealt with accordingly.* Simply complete your form, turn it in quickly, and reflect on your own progress.

### A-2: Community Health Informatics Project (CHIP)

The oral presentation (A-2) given in the IHC Teams will be evaluated using defined scoring criteria by the Team Faculty Leader and by the other students in the group. This portion counts for 15% of the final grade. Scoring rubrics for the oral presentation will be posted on **Blackboard**.

### A-3: IHC Teams (Campus-Based or Service-Based)

Students will be assessed in each of the course activities in either the Campus-Based or the Service-Based Teams. Faculty Team Leaders will utilize the IHC Professionalism and Teamwork scale (IHC PAT) to evaluate each student for the semester. Collaborative learning attributes, emphasizing teamwork, are highly valued in this component (see also Discretionary assignments-above). Student peers in the group will evaluate each other, utilizing the same IHC PAT scale, as well as his or herself, utilizing the same tool. Faculty Team Leaders are also asked to provide mid-semester **formative feedback** (after the second team meeting) to each student (either by brief meetings after the team meets, email, or telephone). The final scoring for the IHC Team component will be determined by the Faculty Team Leader and the Course Director and comprises 20% of the final grade for the semester.

*There will be a mandatory 5 pt (5%) reduction in the final grade for each session absence.*

### A-4: Written Examination

The written final examination will consist of selected response test items (true-false, matching, multiple-choice, or short-answer completion) as well as restricted response essay items (short essays). Content from any of the lecture presentation material or assigned readings from the course may be included. Additionally, attitudes and skills (but not content) from IHC Teams, Community Health Informatics Projects, and Discretionary Assignments may prove helpful to students for the written examination.

**Students requiring non-standard testing conditions due to a documented disability should contact the Course Director by October 1, 2003, and provide documentation from the Dean's office.**

Note: Please bring two #2 pencils for the written final exam for completion of the multiple-choice portion; pen or pencil are acceptable for the short-answer completion and short essay portions of the exam.

**A-5: Discretionary Assignments (Extra Credit)**

Adult learning is often best facilitated when students are self-motivated by choice and have the opportunity to immediately apply what they have learned. These "extra credit" assignments are designed to foster a student's individual learning style, and allow the student to pursue an area of interest related to the course. Each can earn a student up to two extra points for the course. IHC Team members may all be eligible for certain points earned by other members of their team, fostering cooperative learning. All discretionary assignment opportunities and their deadlines for completion will be announced during the lecture presentations and also posted on **Blackboard**.

## Final Grade

A student's final grade for the course will be principally determined by criterion-referenced measures. That is, a student's grade is not so much affected by the performance of a student's peers, but by a student's own progress in meeting the learning objectives detailed above. The course director will determine all final grades and reserves the right to adjust and equate component scores as needed. Final grades of Honors, High Pass, Pass, or Fail will be determined based on a student's total points in course components as follows:

93 and above	Honors
87-92	High Pass
76-86	Pass
70-75	Marginal Pass
Below 70	Fail

Unsuccessful attempts to pass the course will require individual remediation.

## Course Evaluation

Students are **required** to complete a course evaluation for course components and faculty members at the conclusion of the course. This evaluation is coordinated by the Office of Evaluation and Assessment, and students will be notified by email with directions for completing this on-line survey.

## IHC I Teams- Rules for Participants (\*\*See also IHC PAT for scoring criteria/expectations)

1. Participants should be alert, attentive, honest, and willing to share with others.
2. Participants should concentrate on active listening, recognizing the importance of contributions from everyone.
3. Questions and contributions are not only acceptable, but are **essential**.
4. The atmosphere should be one of mutual respect, inquiry, and personal awareness. Nonjudgmental acceptance of others is the rule.
5. Silence is acceptable and can be productive at times.
6. Participants should try to engage **each other**, not only speaking to the Faculty Leader.
7. Participants should assume **responsibility** for the learning that takes place within the group.
8. Ambiguity can be present, and participants should be able to say, "I don't know."



Student Name \_\_\_\_\_

Team Leader's Name \_\_\_\_\_

## IHC Professionalism and Teamwork Scale

<b>Total Score</b> _____ /20	<b>Hindered Learning of Others</b> <u>0 Points</u>	<b>1 Point</b>	<b>Acceptable</b> <u>2 Points</u>	<b>3 Points</b>	<b>Consistently Excellent Contribution to the Team</b> <u>4 Points</u>
<p><b><u>Excellence &amp; Scholarship:</u></b> Commitment to attaining and sharing knowledge, preparation, and lifelong learning</p>	<p><input type="checkbox"/> Consistently unprepared for sessions</p> <p><input type="checkbox"/> Misinformed, not seemingly committed to excellence or lifelong learning</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Well prepared for sessions</li> <li>• Provides knowledge and well-supported information to help group's progress</li> <li>• Effective and creative with problem-solving</li> <li>• Committed to excellence and lifelong learning</li> </ul>
<p><b><u>Altruism, Honor, and Integrity:</u></b> Commitment to service to others, to the learning and development of the team, and to the truth</p>	<p><input type="checkbox"/> Lacks personal commitment to medicine and to service of others</p> <p><input type="checkbox"/> Exhibits self-aggrandizement</p> <p><input type="checkbox"/> More concerned with being well thought of</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Promotes common good of team above self</li> <li>• Demonstrates supportive behavior, forthright and truthful</li> <li>• Facilitates others' receiving credit and praise and their learning</li> <li>• Avoids destructive competitiveness</li> </ul>
<p><b><u>Caring, Compassion, Respect and Acceptance of Differences:</u></b> Commitment to acceptance of individual and diverse opinions and differences, as well as respect for others and empathy</p>	<p><input type="checkbox"/> Seemingly intolerant of or insensitive to differing opinions or cultural, ethnic, or individual differences</p> <p><input type="checkbox"/> Distracting sidebars/disrupting group</p> <p><input type="checkbox"/> Emotionally distant, guarded, or seemingly uncaring</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Nonjudgmental, always accepting of individual differences</li> <li>• Respectful of faculty and peers</li> <li>• Works well in team</li> <li>• Exhibits empathy well</li> </ul>
<p><b><u>Responsibility, Accountability, and Leadership:</u></b> Commitment to accomplishing the work of the team, behavior that befits a professional, and building and maintaining a culture that facilitates professionalism</p>	<p><input type="checkbox"/> Defensive or fails to respond to feedback</p> <p><input type="checkbox"/> Consistently late for sessions</p> <p><input type="checkbox"/> Arrogant</p> <p><input type="checkbox"/> Lacks initiative or leadership qualities</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Takes responsibility for appropriate share of team work, as well as for own learning and that of other team members</li> <li>• Responsive to feedback and offers feedback</li> <li>• Asks for help when needed</li> <li>• Provides leadership</li> </ul>
<p><b><u>Communication:</u></b> Effective oral communication including listening skills</p>	<p><input type="checkbox"/> Unable to communicate clearly</p> <p><input type="checkbox"/> Dominates/Not listening to others</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Communicates well orally</li> <li>• Demonstrates attentive listening</li> <li>• Exhibits empathy well</li> </ul>

**COMMENTS:**

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Rater's Name \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Case A**  
**Community-Oriented Primary Care (COPC)**

Mrs. B. is a 35 year-old female who comes to the community health clinic complaining of cough for 3 months. She had come to the clinic 2 months ago with a similar complaint and was given "some pills" to take. She reported that she only took 3 of the pills because "they did not help" and they upset her stomach. She does not know that her diagnosis was or what the name of the pills was that she was given. She was also given pills for her blood pressure and she reports that she needs some more of them as she ran out two days ago. She has no other symptoms and she reports that no one in her family is sick at this time.

She does not smoke, although her husband does. She does not drink alcohol or use any recreational drugs. She does not exercise. She eats a small amount for breakfast and a big dinner at night.

Mrs. B works as a cleaning lady for a family who lives in the suburbs. She is married, and lives with her husband, a 3 year-old daughter, a 7 year-old son and 3 other adults. She has lived in the United States for about 3 ½ years after emigrating from Central America. She speaks little English, and has brought her son today to interpret. He was not able to come with her last time. Mrs. B reads only little in her native language and does not read in English. She earns \$600 monthly at her job and has no medical insurance. She traveled by bus to the clinic this evening. This is the clinic nearest to Mrs. B's home. They live in a two-bedroom apartment. There are no pets. Mrs. B reports that she takes "shots" from her native country to prevent pregnancy.

There is a family history of Diabetes.

Vital Signs at this visit as taken by the clinic nurse are: Weight 185 lbs, Height 5' 4", BP (Right arm) 168/108. The nurse notes that the patient appears depressed and tired.

Mrs. B is examined by a new volunteer clinic physician. He has not seen Mrs. B before.

**Plan of Care this visit:**

**PPD (skin test for tuberculosis) placed. Patient to return in 2 days for test to be read.**

**Patient given referral for a chest x-ray at the nearest hospital. (Hospital is 3 buses away and only does routine studies from 9-5 on weekdays).**

**A new medicine for hypertension is given. (The medicine she was previously given is now not available at the clinic.) Patient is to return in 1 month for a BP recheck.**

**Appropriate labs were drawn and results are pending.**

**She is given an appointment for nutrition/exercise counseling in 3 weeks. (Nutritionist available one day weekly.)**

**Patient advised to make an appointment for a complete physical examination, including gyn exam and pap smear test.**

**Mrs. B returns to the clinic 6 weeks later with the complaint of continued coughing. Her employer was concerned that she might have something contagious. She did not return for the PPD reading or BP recheck as scheduled. She did go to the hospital for the chest x-ray, but left without having the test as the wait was too long. She ran out of her blood pressure medication again. BP is 180/110.**

**A community clinic volunteer has agreed to go with Mrs. B for the chest x-ray. A new PPD is placed, and a new medication given for her blood pressure since the clinic does not currently have the previous two medicines.**

**The chest x-ray is negative. The PPD is read as 15mm in size (a positive test). The Department of Health is notified, and Mrs. B is told to go to the Chest Clinic for smear and culture. The patient's daughter is found also to be PPD positive as well as one of the other adults sharing the apartment. The husband has not yet been tested. Mrs. B's employer and the other members of her family have tested negative.**

**Discussion Questions:**

- 1. Identify 3 major health problems this patient and her family were encountering. Consider health problems in a community-oriented framework. Think about her individual health problems and**

health risks as well as those of her family and community. You may want to generate three problem lists: one for the patient, one for the family, and one for the community.

2. What barriers were presented in this case that impeded her access to optimal health care?
3. Identify the individual members of the health care team involved thus far in Mrs. B's care, and describe their roles. What might each team member have done to address the barriers she faces? What additional team members could have been utilized to facilitate optimal health care for Mrs. B, her family, and the community?
4. Discuss some possible solutions to the dilemmas Mrs. B. encountered.

This case was adapted from *The DC AHEC Curriculum*.

## CASE B

### Health Insurance

You are a college student at a large state university that recommends that students have health insurance coverage, but does not require it. You are not eligible to be covered by your parents' health plan, and therefore are currently uninsured. The cost of acquiring a school-based plan for students seemed prohibitive, considering your already mounting student indebtedness.

You get severe bouts of abdominal pains and cramping as the first semester approaches final exams, and seek medical care at the student health center. They give you some recommendations, and tell you to go to the hospital emergency room if the pain gets a lot worse during the weekend, when they are closed. You decide that you need to get your own health insurance now, and to discuss the options with some of your friends at the medical school.

#### Discussion Questions:

1. Discuss your own medical coverage and how it works for you. Is this an individual private insurer, an employment-based group private insurer, or government financed plan? Is it an HMO or a type of Fee-for-Service plan. How are the physicians reimbursed for services provided? (You may want to consult the directory or handbook for your health insurer. Bring this information along with your "insurance card" to the IHC Team meeting). You may want to call your parents, family members, roommates, etc to ask them questions about their health coverage.
2. Who pays the health insurance premiums? How much does it cost? Do you pay part of the premium?
3. When you need health care, how does it work? Are co-payments involved? Deductibles? Is coverage for preventive care provided?
4. When you need health care, are you required to see your primary care physician first? Do you need referrals to see a specialist?
5. Are prescription medications covered? Generic brands only?
6. How does it work if you are hospitalized?

- 7. What is NOT covered under your plan?**
- 8. If you left your job or position, what would happen to the coverage?**

## Case C

### Government-Financed Health Care

Madeline is a 75 year-old woman who is hospitalized for a stroke complicated by a deep vein thrombosis of the leg and a pulmonary embolus. She is critically ill for a number of weeks in the ICU, and winds up spending 70 days in the acute care hospital. She is cared for by her family physician and numerous specialist consultants during her hospitalization. She improves somewhat, and is then transferred to the skilled nursing facility (SNF) for rehabilitation. She remains in the SNF for 30 days, is still severely disabled and unable to go home. She is sent to a nursing home for custodial care, where she stays for 3 months. Surprisingly, she improves and is able to be discharged to her home where she receives skilled physical therapy services from a home care agency, and also has a homemaker come in for 4 hours a day to buy food, cook, and clean the house. She is discharged on four prescription medications, two of which there are no generic brands available.

Madeline has Medicare Part A and B without a Medigap policy or Medicaid.

#### Discussion Questions:

1. What does Madeline pay and what does Medicare pay?
  - a. Acute hospital?
  - b. SNF?
  - c. Nursing home?
  - d. Home physical therapy
  - e. Home health aide?
  - f. Primary care physician?
  - g. Consultant physicians?
  - h. Prescriptions while in the hospital?
  - i. Prescriptions after discharge?
  
2. If Madeline were to require a wheelchair to use at home, as well as an adjustable bed, would Medicare pay for these?
3. Her family physician schedules a follow-up visit in her office. Would this be covered? How about a home visit ("house-call")?

- 4. If Madeline had chosen (and paid the premiums for) a Medigap policy, would her out-of-pocket expenses have been different? How about if she was enrolled in a "Medicare HMO"?**
- 5. If time allows, discuss personal experiences that you have had regarding elderly family members and their health care.**

**This case was adapted from Bodenheimer, *Understanding Health Policy*.**