Instructional Design Project: Team Based Care/Disease Management

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Proposed Assessment

Introduction to Team Based Care and Disease Management to Improve Health Outcomes of a Population of Patients Assigned to the Family Medicine Center

Rationale/Need

- Team based care, Disease Management, and Population Health are relatively new concepts in medicine
- Currently, no known formal process exists to teach these concepts in medical student education
- Proposed population: M3 students on Family Medicine Clerkship

Collaborative Team Members

- Jason Foltz, TQA Fellow
- Susan Schmidt, Director of MSE FM
- Susan Keen, M3 Clerkship Director
- Tammy Mckinney, Clerkship Coordinator

Team Leader Key Contact Info: Jason Foltz, foltzj@ecu.edu, 744-4615

Goals

- Understand the key healthcare tenets driving change within our healthcare system
- Value the role of other healthcare professions within a team to coordinate care
- Define a patient centered medical home and its role in management of a population of patients
- Use health information technology to track high risk patients to manage a disease process

Objectives

- Integrate into a health care team to understand the value of each member of the team
- Access the ECU Physicians Electronic Health Record and run a report on a specific disease metric
- Collaborate with module leaders on a strategy to intervene on 3 patients with a chronic disease
- Implement a plan and act to coordinate care plans on 3 selected patients

Instructional Techniques

- Flipped classroom (online learning modules)
- Lecture
- Demonstration by teacher
- Small Group work

Implementation

- 3 phases of learning:
  1. **Orientation:** lecture block on key components of goals
  2. **Time between orientation and 2 week ambulatory rotation:** independent work with online IHI modules
  3. **2 week local ambulatory experience:** identify 3 high risk patients, coordinate with care team on plan, identify strategy to intervene with patient

Implementation

- Option to intervene on:
  - A health maintenance topic
  - Uncontrolled diabetic
  - Uncontrolled hypertensive
  - Uncontrolled asthmatic
- Intervention ideas:
  - Calling patient and scheduling a follow up during their time on rotation
  - Calling and giving health coaching advice
  - Developing a mass mailing
  - Coordinating care with one of other integrated care team member

Example Dashboard

AMB Physician Dashboard (Diabetes Best Practice Report) [764580] as of Fri 4/17/2015 8:29 AM

? Resize Close

Filters Options Chart Encounter Research Studies Generate Letters HM Modifiers Add to List Send Patients Message Send Bulk Communication Track Pt Outreach

Refresh Selected

PCP	P	N	Age	Last PCP visit	Next PCP Visit	Last HBA1C	Last HBA1C Dt	Last LDL	Last LDL Dt	Last microalbum	Last microalbumin I	Last BP Value	ot exam in last y	e exam in last y	Is on Aspirin?	Is on ACE/ARB	Is on St
Foltz, Jason	S C A	6	51	03/11/2015	05/11/2015	11.6	3/11/15	58	6/10/14	300, 30-300, 150	08/23/2013	149/75	Yes	No	Y	Y	Y
Foltz, Jason	H P Jo	5	57	12/12/2014		10.2	3/31/15	59	9/15/14	<3.0	09/15/2014	128/70	Yes	Yes	Y	Y	Y
Foltz, Jason	A E M	4	67	03/19/2015	05/11/2015	9.8	3/2/15	58	10/23/11			120/80	Yes	Yes	Y	Y	Y
Foltz, Jason	S M A	2	57	04/14/2015		9.1	3/11/15	74	9/9/13			120/75	Yes	No	Y	Y	Y
Foltz, Jason	S F W	7	63	11/21/2014		8.2	11/21/14	85	1/15/14	50 mg/dL, >300 mg/g, 80 mg/L	02/28/2014	142/77	Yes	Yes	Y	Y	Y
Foltz, Jason	S E L	2	69	01/30/2015	05/07/2015	7.9	1/30/15	87	9/20/13	300, <30, 30	09/24/2014	128/72	Yes	Yes	Y	Y	Y
Foltz, Jason	M G L	1	66	03/06/2015	06/12/2015	7.8	3/6/15	87	3/6/15	50, 30-300, 10	03/06/2015	148/80	Yes	Yes	Y	Y	Y
Foltz, Jason	C A	2	75	01/22/2015	04/24/2015	7.7	3/31/15	79	1/23/15	200, 30-300, 150	01/22/2015	143/75	Yes	Yes	Y	Y	Y
Foltz, Jason	P S G	2	56	01/22/2015	05/07/2015	7.7	1/22/15	65	2/14/15	300, 30-300, 80	01/22/2015	143/82	Yes	Yes	Y	Y	Y
Foltz, Jason	W W C	7	58	10/24/2014		7.7	9/5/14	66.6	9/5/14	50 mg/dL, >300 mg/g, 150 mg/L	01/21/2014	114/78	Yes	No	Y	Y	
Foltz, Jason	F W G	2	47	03/20/2015	05/22/2015	7.6	3/6/15	111	12/6/13	200, 30-300, 150	03/06/2015	138/86	Yes	Yes	Y	Y	Y
Foltz, Jason	S D Tl	1	54	03/26/2015	06/25/2015	7.6	3/10/15	66	11/3/14	100, <30, 30	03/26/2015	131/89	Yes	No	Y	Y	Y
Foltz, Jason	Jo R A	5	70	01/05/2015	04/17/2015	7.5	1/5/15	146	4/11/14	100, <30, 30	01/05/2015	169/91	Yes	No	Y	Y	Y
Foltz, Jason	C S Li	4	55	03/12/2015	06/15/2015	7.5	3/12/15	71	6/23/14	300, <30, 30	06/23/2014	162/91	Yes	No	Y	Y	Y
Foltz, Jason	C R A	9	68	04/14/2015		7.5	4/14/15	79	12/16/13	200 mg/dL, <30 mg/g, 30 mg/L	04/17/2014	128/74	Yes	Yes	Y	Y	Y

Assessment

- Log of patients identified with intervention and outcome

Patient	Disease Metric	Intervention	Outcome

- Participation points assigned for IHI module and patient log
- Educational activity assessed by student end of clerkship evaluation

Validity

Area of Validity	Strengths	Weaknesses	Future Evidence to Gain
Content	-Based on the learning objectives, the outcome measurement of the patient logs adequately measures that the student achieved the objectives laid out within the activity - **Students will be required to take a proactive role to identify a patient group of interest and formulate a plan to inflict change.** This will require the student to identify their own learning goals.	-**Students that do not have an interest may simply complete the log without putting forth much effort in attempting to make a change in that specific patient.** -In order to make room in the clerkship curriculum, other content areas may need to be shortened or discontinued	-**Does participation in a hands on learning activity directly related to team-based care and patient orientated outcomes encourage students to look favorably toward the specialty of Family Medicine?**

Relevance

- Aligns with the educational goals for:
  - The Brody School of Medicine
  - Society for Teachers of Family Medicine
  - Clinical Prevention and Population Health Curriculum Framework

Challenges Encountered

- Designing alternative plan for students assigned to non ECU clinics
- Faculty and staff development on use of disease dashboards, population health
- Limitations in ability to start care coordination program within clinic
- Timing to initiate prior to July 2015 new clerkship

Lessons Learned

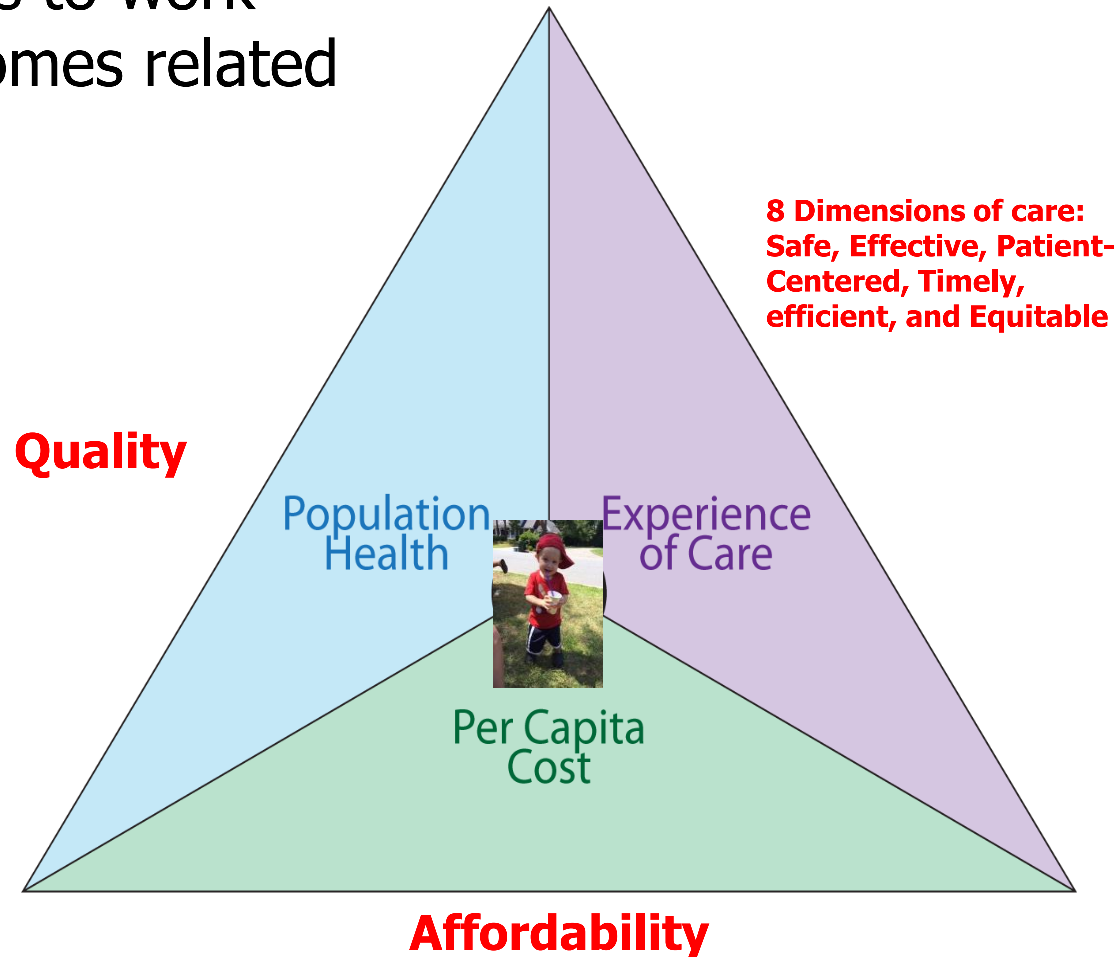
- Value of running details by educational team
  - Allowed for further details to be vetted
- Learned the components required to formulate an educational design project

Next Steps

- Integrate care coordinator within FMC
- Further work with faculty on use of clinical dashboards
- Identify best time to pilot curriculum change within upcoming M3 clerkship

Conclusion

- Teaching tenets of population health helps prepare the next generation of physicians to work toward improving outcomes related to the “triple aim”



Questions?

Acknowledgements

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