Exemplary Model of Care Delivery for Learners

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The Future of Health Care Delivery in Louisiana

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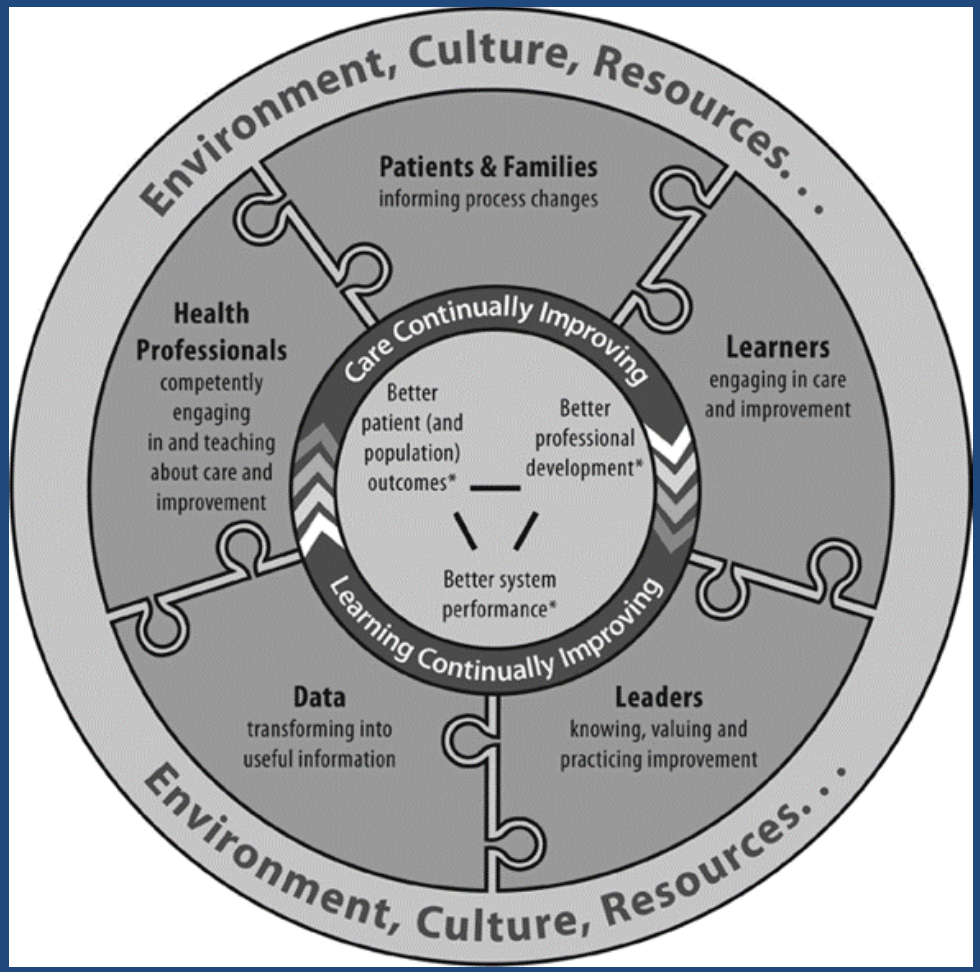
Today's Objectives

- Describe an educational clinical interprofessional program that uses medical home principles to manage uncontrolled diabetics.
- Provide underlying models used to design the program.
- Share outcomes.

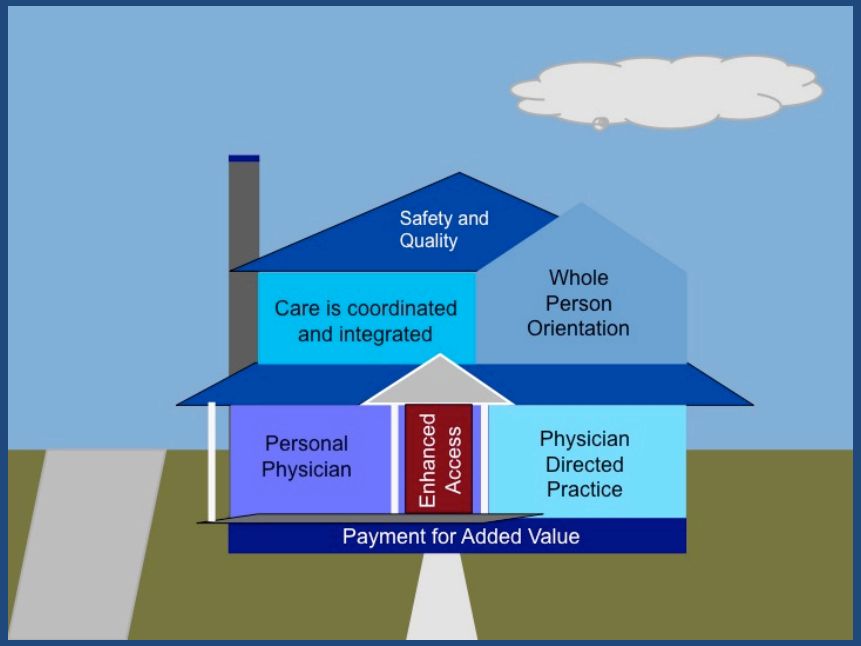
Exemplary Care and Learning Site Model



- **Better Patient/Population Outcomes**
  - Patient Satisfaction
  - Lifestyle Changes
  - Diabetes Quality Indicators
- **Better Professional Development**
  - Medical Home Principles
  - Diabetes Management
  - Patient Self Management
- **Better System Performance**
  - Quality Improvement: Health Literacy

Headrick L et al Academic Medicine 86 (11) Nov 2011

Patient Centered Medical Home



- **Physician-directed practice**
  - Internal Medicine Resident plus Social Worker, Pharmacist, Nursing, Medical, Public health students
- **Enhanced Access**
  - Face-to-face office visits
  - Group visits
  - Frequent Phone Calls
- **Care is coordinated and integrated**
  - Student teams
  - Care management
  - Self management
- **Safety and Quality**
  - Quality Improvement
  - Health Literacy

Program Description

Who

40+ Patients: DM, A1c>9

18-33 Learners: Medical, Nursing, SW, Pharm Students

IM Residents

What

Diabetic Registry

Face to Face/ Group Visits

Discipline-specific Roles

Coordinated Care Plan

Frequent Phone Calls

Didactics/Team Mtgs

When

Academic Semesters Jan-May, Aug-Dec

Weekly Wed AM, Thurs PM

Where

Ambulatory Clinics Internal Medicine Residency, Primary care faculty practice

Why

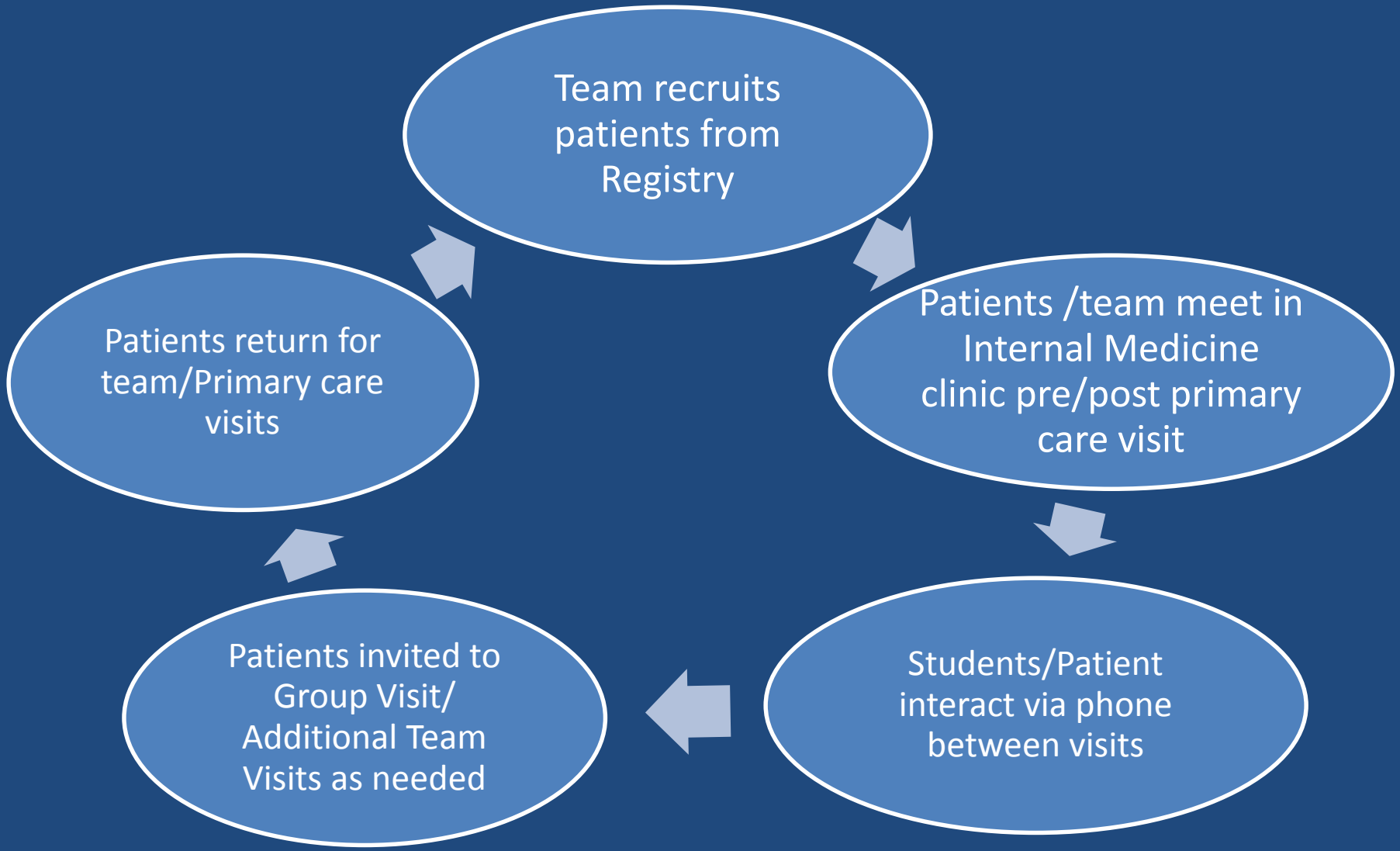
Enhance Learning/ Improve Care

Meet need to provide Patient-Centered chronic care

Meet need to develop Longitudinal Relationships

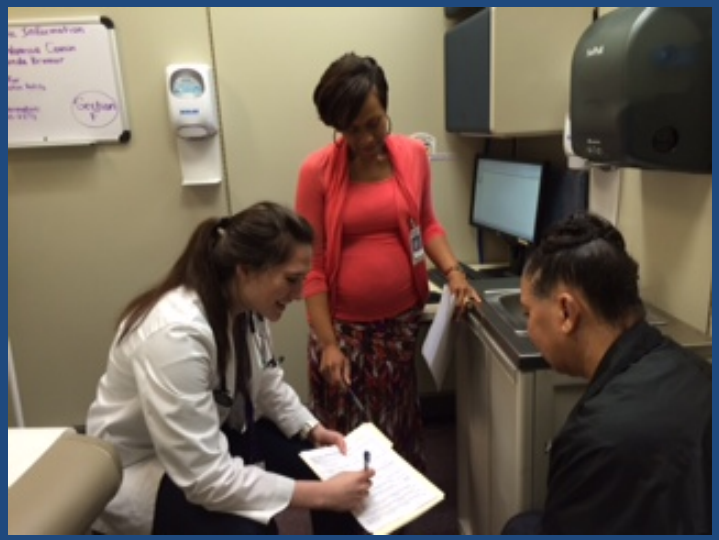
Demonstrate how students can provide value

Clinical Process



Program Details

Team Meeting



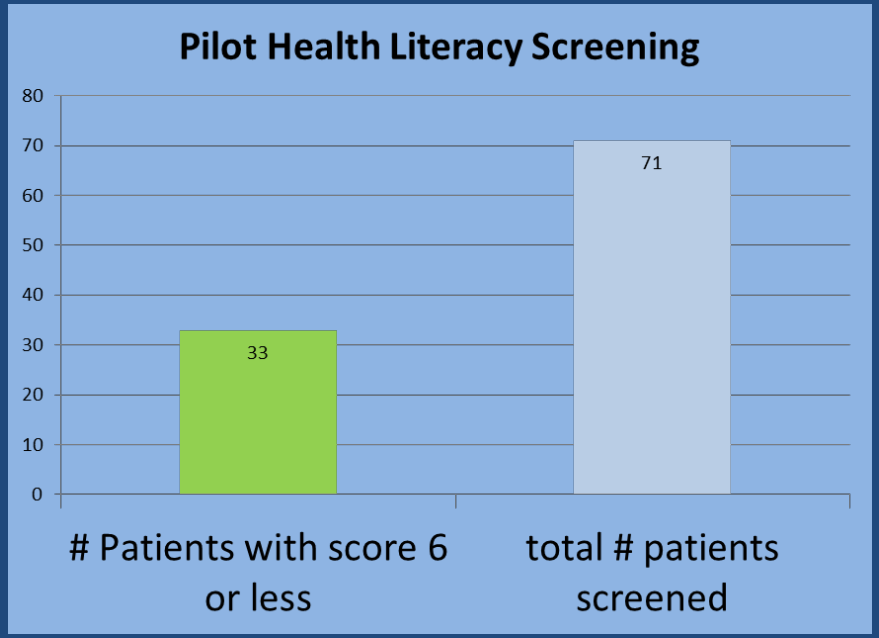
Teach Back Method

- 4 health professional schools at 3 universities
- Elective/Required practicum
- Diabetic patients assigned, 5-6 to each medical /physician assistant student liaison
- Team Meetings:
  - pre visit huddles
  - post visit care plans
  - didactics
  - quality improvement (health literacy)
- Patients receive
  - access
  - screening/exams/prevention
  - education
  - health care coaching

Quality Improvement: Health Literacy

Interventions

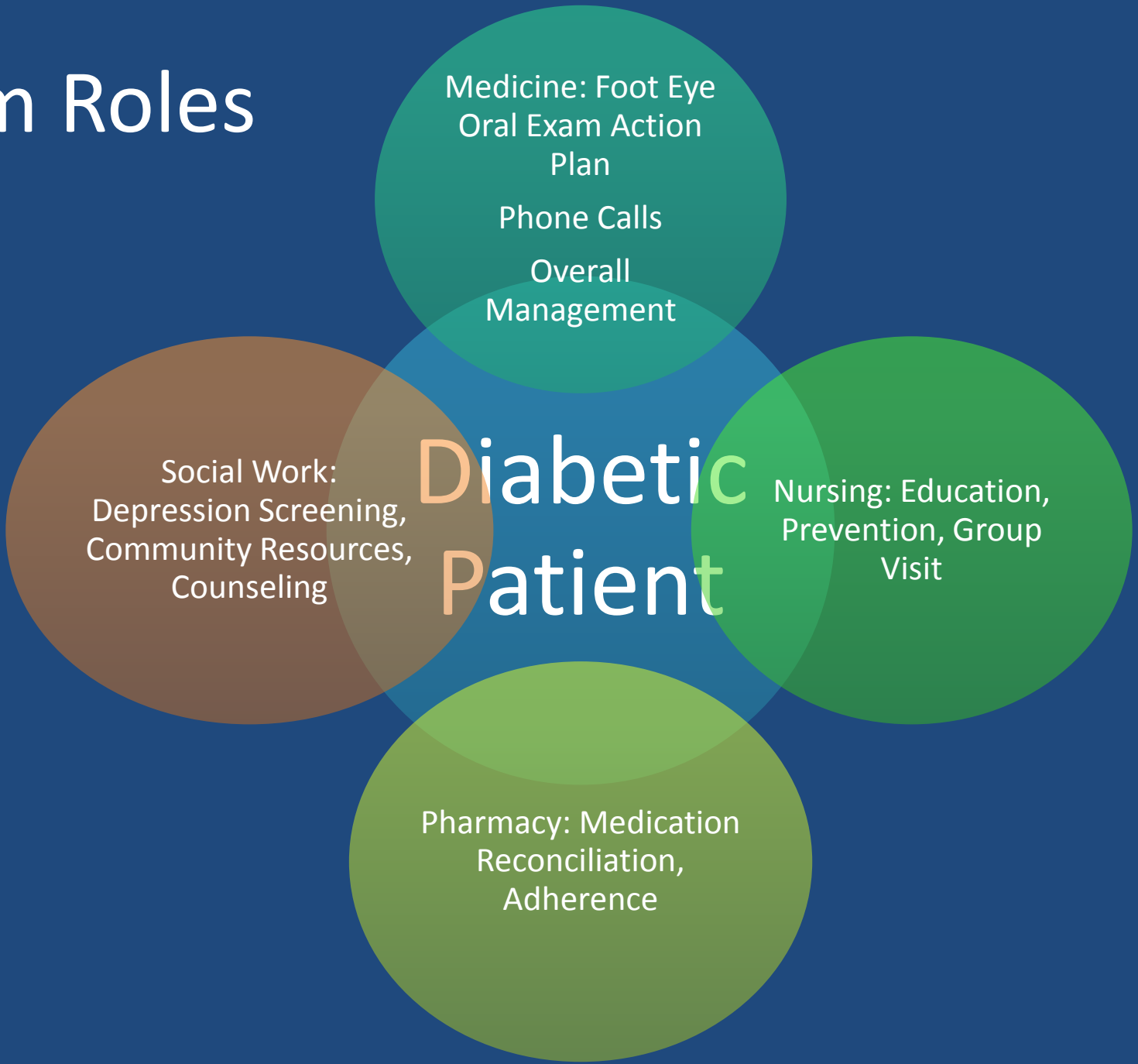
1. Health Literacy screening using REALM R
2. "What questions do you have? Rather than "Do you have any questions?"
3. Group Visits in which patients
   "Dining for diabetics"
   Patient sharing
4. Pill Boxes
5. Feedback re: appropriate dose/ timing for testing of blood sugar and administration of insulin..



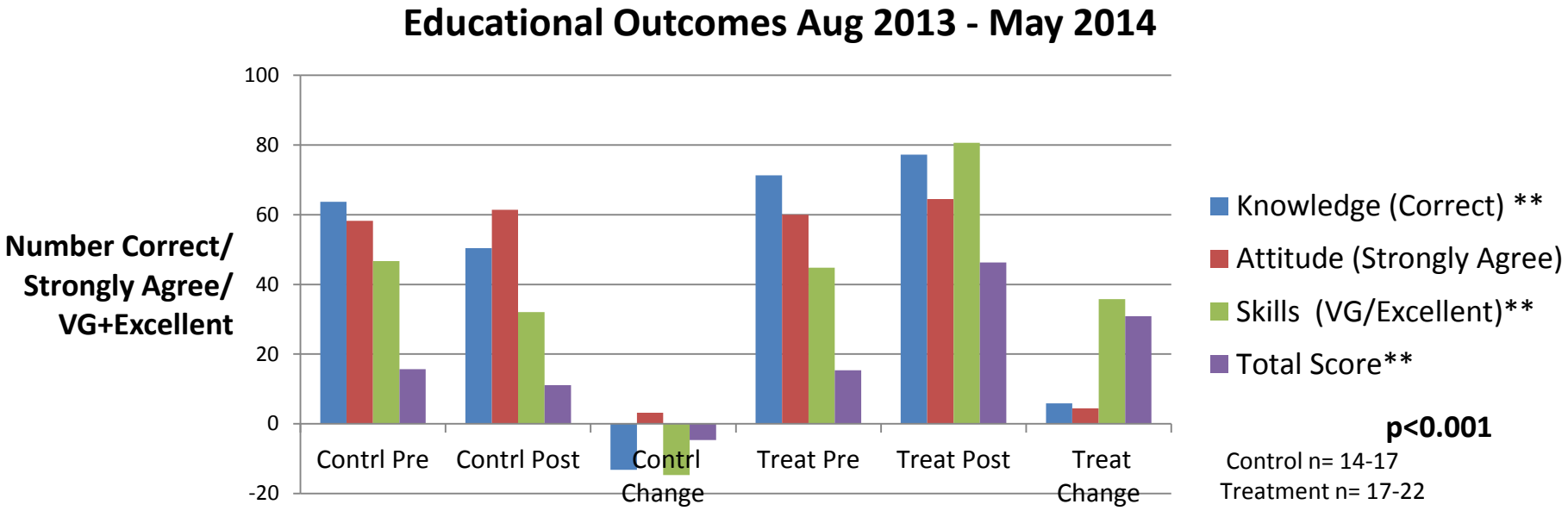
Current QI Focus

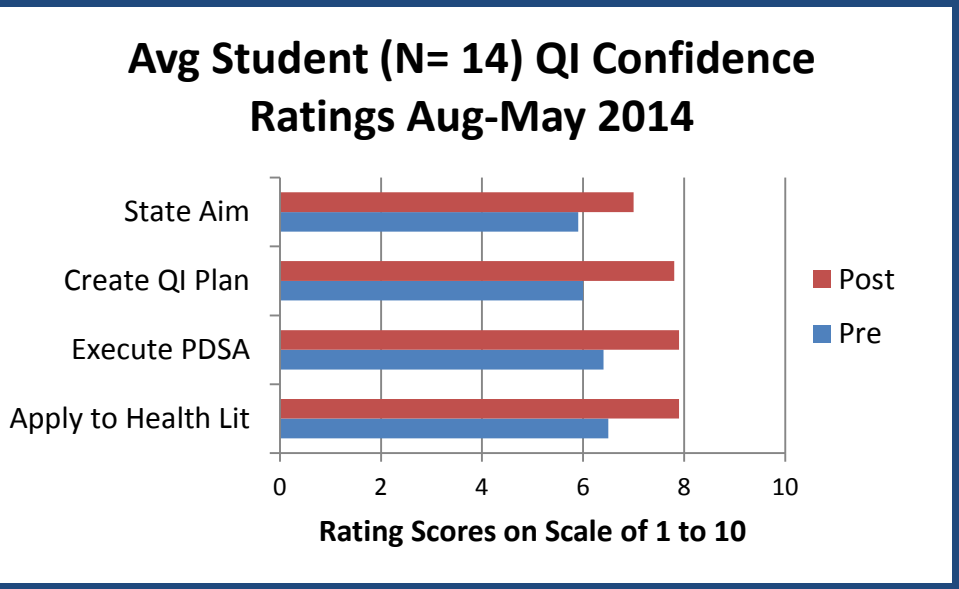
- BP Control
- Smoking
- Cardiovascular Risk Reduction and Statin Prescription

Team Roles


Medicine: Foot Eye Oral Exam Action Plan
Phone Calls
Overall Management
Social Work: Depression Screening, Community Resources, Counseling
Diabetic Patient
Nursing: Education, Prevention, Group Visit
Pharmacy: Medication Reconciliation, Adherence

Educational Outcomes





Student comments:

"The value of specific goals"
"How to reframe questions"
"The excitement of QI when it works"

Patient Outcomes

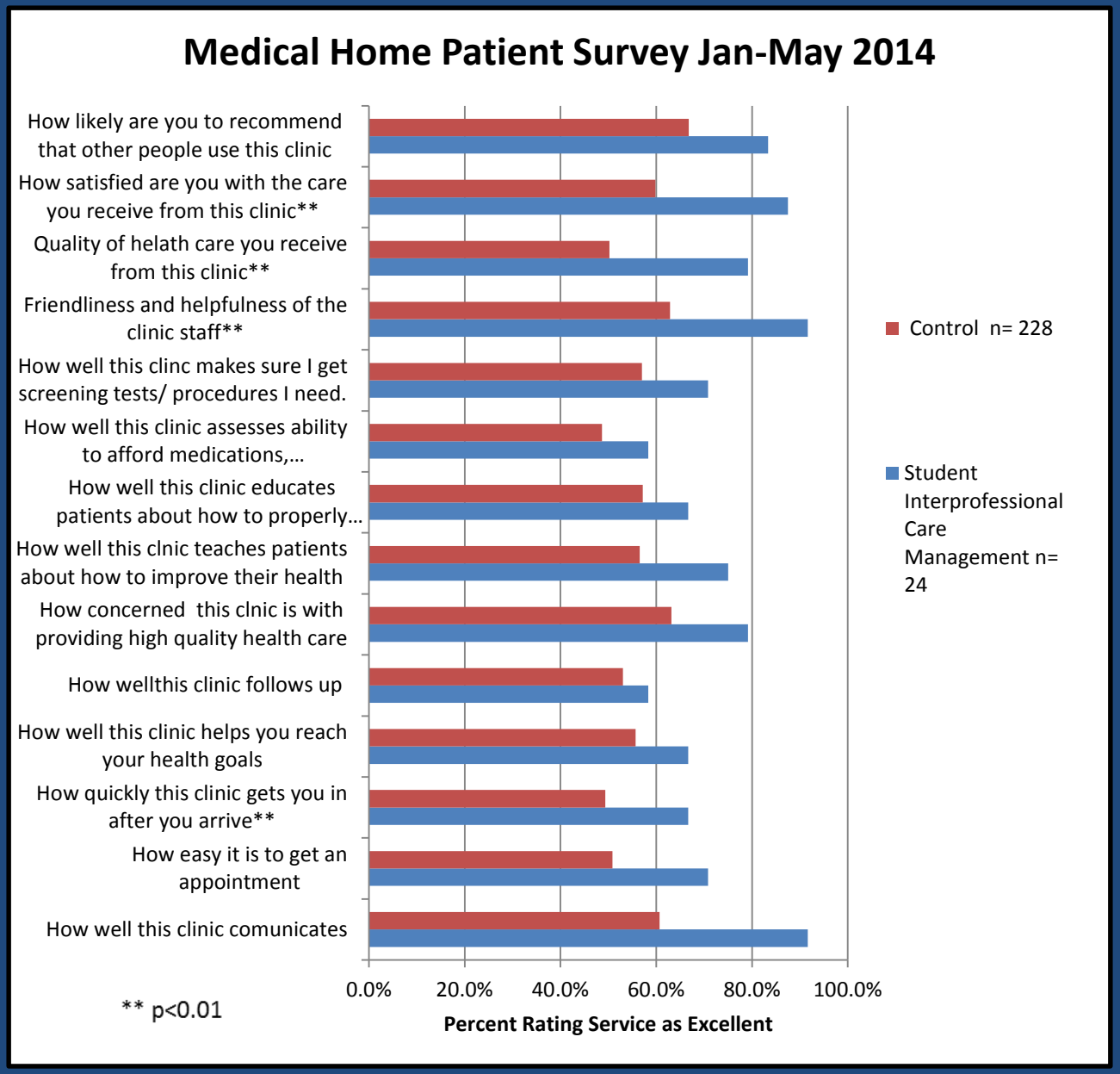
Improved Patient Perceptions of Care

Improved Healthy Behaviors

- "Walking 15 min 2x day"
- "Cut out fruit Juices"
- "No sweeteners or sodas"
- "Substituting water for Coke"

"Stopped eating cookies and candy"

No Significant Change in A1c, BP



Summary

- Learning Enhancement—Knowledge, Teamwork Skills
- Care Improvement—Patient Satisfaction, Behavior Changes
- Successful Introduction of Medical Home Principles—QI, Population Management, Teamwork, Coordinated Care, Access
- Successful Implementation of Student Quality Improvement Projects
- ECLS and PCMH Models Useful for Guidance