

University of Michigan

Collaborative Interprofessional Team Education Program (CITE) Funded by Partnerships for Quality Education

I. Executive Summary

The University of Michigan Health System and its managed care organization, M-CARE, have embarked on a comprehensive three year initiative in which health professions trainees work as an interprofessional team to identify, intervene and manage high risk patients within a finite set of managed care resources. This program builds on a unique, existing strong collaboration in interdisciplinary education between the University of Michigan Medical School, School of Nursing, School of Social Work, and College of Pharmacy.

A. Interprofessional Clinical Team Intervention

The clinical team intervention targets complex elderly patients who have two or more of three target health conditions: diabetes, hypertension or polypharmacy. Patients who meet selection criteria will be scheduled for a comprehensive assessment to be conducted by the interprofessional team trainees along with their faculty preceptors. Following completion of the comprehensive assessment, a written interdisciplinary care plan (ICP) will be drafted with specific actions, responsible team members for each action, and target dates for subsequent review. Follow up visits with lead trainees will be scheduled, and progress towards meeting stated goals will be documented as part of the program evaluation process. Six month updates of the ICP developed in the initial assessment will be sent via secure e-mail to each trainee to review.

B. Summary of Education Intervention

Trainees from all four disciplines participate in a weekly four hour seminar in which they will meet with faculty for a structured, didactic experience in interprofessional team care of complex geriatric managed care patients. The sessions will include review of specific patients seen by the trainees, analysis of administrative and utilization data provided by M-CARE, and educational sessions on managed care, interdisciplinary geriatric assessment, care planning and dementia. These didactic sessions will be coupled with hands on clinical experience seeing patients in the weekly 4 hour clinic session described above.

C.

Learners	# in Yr. 1	Hrs./wk.	# of Wks./yr.
Social Work	10	8	4
Nursing	10	8	4
Pharmacy	20	8	4
Medicine	10	8	4

II. Comprehensive Team Care Model

A. How is this clinic different from the care currently provided?

- The patient and family will be working with a team of a physician, nurse practitioner, social worker and pharmacist. The patient will get comprehensive assessment and management of their complex health issues; physical health, mental health, social and economic status, functional and environmental status will be reviewed.
- The team will be accessible to the patient. Input from the patient and family and communication with the team are highly valued.
- Goal-Oriented Patient Care: The patient will know what specific health issues will be worked on and the progress being made towards the goals.
- Time limited program: The patient will be discharged back to their Primary Care Physician once the goals are achieved.

B. Patient and Family Perspective

1. Patient receives a letter from the Primary Care Physician explaining their interest in referring the patient for team evaluation and management.
2. Patient receives a phone call from the team's social worker to schedule the appointment and explain the evaluation process. The patient is asked to bring in all medications and OTCs. They are encouraged to bring a family member to the visit. An appointment is scheduled on a Wednesday afternoon.
3. During the Initial Visit
 - Staff nurse checks in the patient and takes vital signs.
 - Patient and family are met by Pharmacist/ Pharmacy students and review use of medications/ OTCs/ herbs, etc. (15 min.)
 - Social worker/ SW student will discuss the patient's social support network/ financial resource/ psychological state with the patient and family members. (20 min)
 - With patient permission, Social worker/SW student will assess caregiver stress and elicit family perspective without patient present.
 - Nurse practitioner assesses functional status, self-care abilities and knowledge. (20 min.)
 - Physician goes over medical history and provides physical exam. (45 min.)
 - Group discussion by the above mentioned professionals while patient dresses and patient/family move to conference room.
 - Team meeting with patient and family:
 - Discuss the findings of comprehensive assessment.
 - Patient and family are encouraged to actively participate in the formation of care plans. (e.g. more in-depth testing, treatments, in-home services, referrals, etc.)
 - Return visit date will be given.
 - Identify clinical contact persons for the patient and family.
 - Written communication (findings, plans of the care, contact persons, return visits) are provided to patient and family : A hand written memo will be given at this meeting, and a formal dictated letter will be mailed to the patient and/or family later.
4. Post visit follow-up phone calls by a designated team member.
5. Discipline specific follow-ups will be provided in home and/or in clinic as needed.

6. Return Visits: · Reminder phone call by secretarial staff · Patient and family re-assessed by appropriate members of the interdisciplinary team.

- Update care plan
- Evaluate/ set discharge goals with patient and family.

7. Discharge Discharge patient to care of Primary Care Physician when the initial or revised goals are met.

C. The Training Program from the Student and Faculty Perspective.

An interdisciplinary group of faculty and trainees will participate. Faculty members will include grant participants from the Schools of Social Work, Pharmacy, Nursing, and Medicine. The trainees will include students enrolled in the School of Social Work M.S.W program, the School of Nursing Nurse Practitioner M.S., the School of Pharmacy Doctor of Pharmacy program and the Internal Medicine residency program.

The CITE/PQE sponsored interdisciplinary training will include both educational seminar sessions and clinical experiences with an interdisciplinary team practice. As summarized in attachment 1, seminar sessions and case discussions will be scheduled on Wednesday mornings with a one month rotation of topics that corresponds to the monthly rotation of medical residents and pharmacy students. Faculty and trainees from all four disciplines will participate in clinical team practice on Wednesday afternoons. On the other days of the week, each trainee will be involved in activities that enhance or complement their geriatric training, but are not part of interventions planned specifically for this grant. The total length and timing of our trainees rotations vary by discipline, as outlined on Attachment 2. Wednesdays will be scheduled so that all trainees participate in the intervention activities every Wednesday for a month. Faculty will teach the Wednesday morning didactic and small group sessions in interdisciplinary teams. A monthly schedule of seminar topics with faculty disciplines involved in facilitating each session is attached. The first session will begin with case discussion to illustrate the importance and relevance of team care for high risk complex elders. Active learning strategies that use trainees' input will be used in all didactic sessions. The late morning session is devoted to rounds on patients the interdisciplinary team is following and will be supervised by a faculty member who is a member of the interdisciplinary practice team. The target population for this program will be complex elderly patients who have two or more of three target health conditions: diabetes, hypertension, or polypharmacy. Such patients are high utilizers of health services who may benefit from a team intervention. As summarized in Attachment 3 a three step process will be used by a faculty subcommittee for the PQE grant according to the attached protocol to identify M-CARE Senior Plan patients who meet criteria for the team intervention.

D. Interdisciplinary Team Intervention from the Team Member Perspective.

Patients will be selected by the process outlined in Attachment 3 and scheduled for a comprehensive team evaluation in the model clinic. As described in section II B., each trainee will carry out an evaluation focused on their discipline under the supervision of a faculty preceptor from their discipline. Results of each discipline assessment will be recorded on the ICP document to enhance communication. The goals of this comprehensive assessment include:

1. Update of the patient's health data base
2. Comprehensive review of target conditions

3. Identification of other comorbidities

4. Identification of barriers to optimal treatment

Prior to completion of the comprehensive patient assessment visit, the trainees and faculty will meet together briefly to formulate an initial plan of action and present the team's recommendations to the patient and family in written form. The team discussion is lead by a facilitator that is rotated among disciplines each week. At the end of the clinic session, the trainees and faculty will meet together to establish long term goals for each new patient and complete the interdisciplinary care plan (ICP) document with specific actions, responsible team members for each action, and target dates for subsequent review. Reflection on the team process and filling out the ICP questionnaire will occur in the last five minutes of this meeting. One of the trainees will be selected to be responsible for completing the ICP and leading the presentation and discussion of the patient during the rounds component of the following Wednesday's educational session. Over the course of their rotation, each trainee will be expected to take the lead for the ICP plan for at least one patient. The assigned trainee will take the initial draft ICP from the team meeting at the end of clinic, revise it following the discussion at the subsequent rounds discussion, and then circulate it for sign off by the trainees and faculty from each discipline. Whenever possible a follow up clinic visit will be scheduled within two to four weeks so that the trainee with lead responsibility will be able to participate in the follow up. At that visit progress on the care plan will be reviewed with patient and family, appropriate modifications will be made, and further follow up identified. The progress of patients seen in follow up will also be reviewed at the subsequent weeks Wednesday rounds session. Automatic review and feedback to trainees involved in the original care plan will occur at six months or at discharge from comprehensive team management, whichever occurs earlier. Trainees who were involved in the original care plan will be encouraged to participate in this discussion. Progress towards meeting the goals will be documented as part of the program evaluation process. In the event that the original trainees are unable to participate in the six month review, the outcome of that review will be communicated to them via secure e-mail. Each trainee will be asked to review these follow up care plans and complete a follow up questionnaire as part of the evaluation process.

Each of the trainees will spend considerable time on geriatrics related activities in addition to participation in the model team care clinic, as described in attachment 1. Each trainee will participate in the clinic's regular patient care activities which involve collaborative practice with variable involvement of different disciplines and no formal development of an interdisciplinary care plan. Thus trainees will have an opportunity to directly contrast these two different approaches and have direct experience with the strengths and weaknesses of each.

Attachment 1

Faculty and Trainee

Seminar Content and Activities - Wednesday AM

	Session 1	Session 2	Session 3	Session 4
Hour 1 Content	Introduction Team Attitudes (M&N)	Dementia with Case Management (M&S)	CGA with Case Management (M&P)	Managed Care Quality Care (M&N) Resources Utilization (M,N&S)
Hour 2 Content	Team Work (M&N)			
Hour 3 Exercises	Constructed Cases	Constructed Cases	Constructed Cases (M&P)	Consolidation Eval & Future (M,N)
Hour 4 Patients	Care Planning (M)	Care Planning (S)	Care Planning (P)	Care Planning (N)

(N) Note: All trainees are involved in each session. Faculty involvement is indicated by discipline.
M = medicine
S = social work N= nursing P = pharmacy

Faculty & Trainee Clinic Activities- Wednesday PM

	Session 1	Session 2	Session 3	Session 4
Hours 1-5	Patients & Care Planning			

Attachment 2

Pharm D trainees weekly schedule during one month rotation

Monday	AM	Geriatric Clinic
Monday	PM	Library/Project time

Tuesday	AM	Geriatric Clinic
Tuesday	PM	Journal Club or Geriatric Conf, patient discussions with preceptor
Wednesday	AM	PQE Seminar, case discussion, rounds
Wednesday	PM	PQE Interdisciplinary Clinical Care
Thursday	AM	Cognitive Disorders Clinic
Thursday	PM	Patient discussions with preceptor
Friday	AM	Classes at College of Pharmacy
Friday	PM	Classes at College of Pharmacy

Medical Resident Geriatrics Ambulatory Care Rotation (1 month)

Ambulatory Morning Report with the CMR precedes clinic assignments from 0730 to 0830 on Tuesday, Thursday and Friday at a TBA location. Morning clinic sessions otherwise begin at 0800 and afternoon sessions begin at 1300. All clinic sessions except two are located in the Geriatrics Center, located on the first floor of the Cancer Center and Geriatrics Center Building.

Monday	AM	Geriatric Center Cognitive Disorders Clinic
Monday	PM	Teaching Learning Seminars@ 2915 TMC with Dr. Williams
Tuesday	AM	Geriatric Center Movement Disorders Clinic
Tuesday	PM	Geriatric Medicine
Wednesday	AM	PQE Seminar, case discussion, rounds
Wednesday	PM	PQE Interdisciplinary Clinical Care
Thursday	AM	Geriatrics Neurology Cognitive Disorders Clinic
Thursday	PM	East Ann Arbor Breast Care Clinic
Friday	AM	Geriatric Medicine
Friday	PM	Geriatric Center Arthritis Clinic

Social Work Trainees Rotation

(2 days per week for 2 semesters)

Wednesday activities for one month as listed for medicine and pharmacy trainees.

Their other activities while assigned at Turner Clinic include:

1. one half day of intake social work
2. Care management cases- Home assessment for care management, monitoring care management patients
3. Counseling of patients or families
4. Nursing home enrichment programs--provide 6 week 1-hour structured activities to nursing home residents who have mental health diagnosis.
5. Organize and conduct a group such as Caring for Aging Relatives workshop at the clinic and a group for residents in a senior apartment complex for psycho-educational purposes.

6. Classes at the School of Social Work

Nurse Practitioner Trainees Rotation

(2 days per week for one semester)

Wednesday activities for one month as listed for medicine and pharmacy trainees.

The additional day of clinical is spent doing patient visits with preceptor supervision. They attend an advanced practice seminar with faculty 2 hours per week as part of their clinical course, and may or may not be enrolled in additional courses.

Attachment 3

Patient Selection Process:

Step 1. Completion of chart review checklist by student or clerical staff

Step 2. Review of checklist by the Clinical Criteria Subcommittee with allocation to one of three categories:

Yes, refer for team care evaluation

Inclusion Criteria: Problems with two or more of the three target conditions(diabetes, hypertension, or polypharmacy). Definition of problem for inclusion:

o Polypharmacy: > five medications (item d under medications on the checklist).

o Hypertension: two of three values listed out of the range of acceptable control (>140/85 or 130/85 if diabetic).

o Diabetes: last glycosylated hemoglobin value >1% over the upper limit of normal (for a total GHb a value >9.0% or for hemoglobin A1C a value > 7.4%).

Exclusion criteria: Nursing home resident.

a) No, not a candidate for team care.

Criterion: Less than two active problems per above definitions.

b) May be a candidate for team evaluation, but needs further evaluation

Criterion: Problem with one of the three target conditions plus any one of the following:

Mini-mental status exam score <27. GDS score \geq 5. Number of hospitalizations/ER visits >3 over past two years. - The total number of medications (item d on the checklist) is >10.

Step 3. For patients in the may be category, one member of the committee will carry out a chart review and make a recommendation to the committee regarding inclusion or exclusion.