

Preventing Disease and Complications: Education Through Team-Based Practice

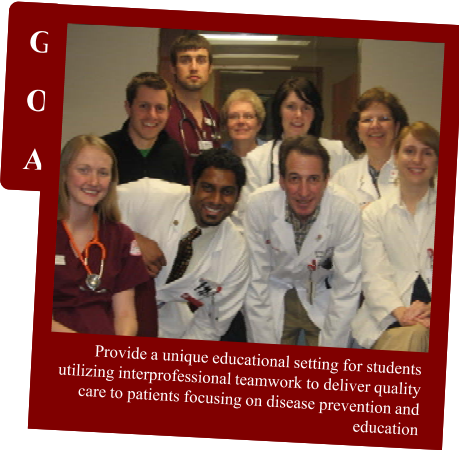
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BACKGROUND

The Bedlam Longitudinal (Bedlam-L) Clinic is a clinic program to aide in the follow-up of care for uninsured patients with chronic illness.

- One in five Oklahomans lack health care insurance. ¹
- In 2006, 16% of Oklahoman's lived in poverty. ²
- The Bedlam-L clinic also strives to meet the national call to increase collaboration among health care professionals, increase team-based and patient-centered care, while seeking quality improvement in patient care and improved outcomes. ³

¹ The Henry J. Kaiser Family Foundation. Oklahoma: Health insurance coverage of the total population, states (2005-2006), U.S., 2006. Available at <http://www.statehealthfacts.org>. Accessed February 15, 2008.
² U.S. Census Bureau, 2006 American Community Survey. Available at: <http://factfinder.census.gov>. Accessed February 15, 2008.
³ Institute of Medicine (U.S.). Committee on Quality of Health Care in America. Crossing the quality chasm: A new health system for the 21st century. Washington, D.C.: National Academy Press; 2001.



Provide a unique educational setting for students utilizing interprofessional teamwork to deliver quality care to patients focusing on disease prevention and education

CLINIC DESIGN

- Meets one afternoon per week
- Students are involved in the clinic during the last two years of their training.
- Provide Interprofessional Team Approach with Continuity of Providers
- Provides a training ground for students to learn about health care service delivery for uninsured patients with complex chronic medical conditions, particularly diabetes and cardiovascular disease
- Designed by students and faculty from the colleges of nursing and medicine, along with the administrative teams from Bedlam Alliance and OU Family Medicine.
- Quarterly retreats held with representatives of all participant group members

METHODS

1. Patient Education:

- Personal Health Binders: Self-monitoring forms, disease specific educational materials, most recent medication/problem list, recipes, contact information for clinic aid in self-management
- Training Materials: More interactive instruction with hands-on activities and training materials for new diabetics

2. Student Education:

- Patient Protocols: Students learn best practices for disease screening, prevention, risk reduction, and complication prevention through creation and implementation of patient protocols
- Reflective Blogging site under development for student reflections of clinical practice and interprofessional education.

3. Intervention Protocols:

- Intervention Protocols: Diabetes Protocol completed; Hypertention and Hyperlipidemia forthcoming
- Electronic Medical Records (EMR) are integral in the team approach

4. Protocol Activation:

- Teams perform proactively through strategies such as pre-clinic planning sessions (round-up) and post-clinic sessions (round-down) to coordinate care. The program focuses on high levels of contact between the patient, team and health care system, whether face-to-face, at home, by phone or mail.
- Seven navigational teams meet twice a month and provide care to 10-12 patients per session

THE NAVIGATIONAL TEAM CONCEPT

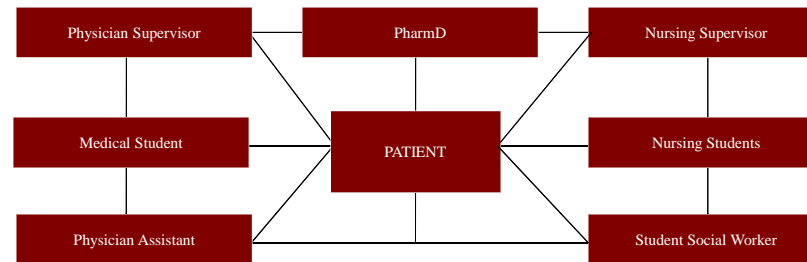
- Students learn best practices
- Patients learn about their diseases including diet, medications, exercise, complications and self-management
- Through obtained data entry, a disease registry will be a tool for protocol application
- Barriers are identified and protocols are activated to optimize patient condition and prevent end-organ damage
- Students practice "at the top of their license" and appreciate the strengths and efficiencies of systems-based practice.

RESULTS

- ✓ 181 patients made 431 clinic visits during the first year of clinic services
- ✓ Four scholarly projects were spawned
- ✓ Two clinic awards received
- ✓ Dramatic growth after one year; Pharmacy students begin July 2008
- ✓ Pilot 'Diabetic Day' to provide overall screening and prevention teaching for diabetic patients
- ✓ IRB approval for patient and educational studies underway
- ✓ Interprofessional Education Study (IPE): Longitudinal study in progress looking at attitudes of different professions working together



NAVIGATIONAL TEAM MODEL



FUTURE PLANS

- ✓ Creation of a Disease Registry to use as a tool for protocol application.
- ✓ Incorporate an annual "Diabetic Day" to promote recommended screening measures for diabetic complications including foot and eye exams, psychosocial assessments and education.
- ✓ Formalize our proposed set of common competencies for students involved in the clinic.

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