DREXEL UNIVERSITY COLLEGE OF MEDICINE
INTRODUCTION TO AMBULATORY CARE COURSE
CHRONIC CARE FOCUS
OVERVIEW OF COURSE DATES:

<table>
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<tr>
<th>EVENT</th>
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<tr>
<td>INTRODUCTORY SESSION</td>
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<tr>
<td>ENTIRE CLASS</td>
<td>THURSDAY, 9/10/15</td>
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<tr>
<td>Introduction to Ambulatory Care Course</td>
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<td>Team-based learning exercise</td>
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<th>LIBERTY BELL SOCIETY DATES</th>
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<td>PATIENT ENCOUNTER</td>
<td>MONDAY, 9/14/15 OR WEDNESDAY, 9/16/15 OR FRIDAY, 9/18/15</td>
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<td>Student will shadow a physician on one of these afternoons.</td>
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<td>Student will meet in small group with either Dr. Evans or Dr. Bakshi.</td>
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<td>PAPER DUE DATE</td>
<td>9AM MONDAY, 11/30/15</td>
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<td>PAPER DUE DATE</td>
<td>9AM MONDAY, 12/7/15</td>
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<td>PAPER DUE DATE</td>
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We will send each of you an e-mail with details of assignment of preceptor, partner, location and date, small group date/time/place etc.
Drexel University College of Medicine
Introduction to Ambulatory Care - Chronic Care Course Syllabus

Contact Information:
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Course Objectives:

1. Appreciate the complexity of chronic disease management, and the burden chronic disease places on our health care system and society.

2. Become familiar with the CDC's six principles of effective chronic care. Use these principles as a foundation to observe and comment on the challenges faced by your own patient.

3. Understand the principles of disease prevention—including the concepts of primary vs secondary prevention, surrogate disease markers, and number needed to treat vs number needed to harm.

4. Learn the factors that contribute to medication adherence vs non-adherence, and the factors that put patients at risk for drug-drug interactions and adverse medication events.

5. Refine your approach to evidence-based medicine, and put that approach into practice when researching your patient report.

6. Appreciate the concepts of "multimorbidity" and the special challenges and approaches necessary when a patient suffers from multiple chronic conditions.

7. Understand the principles and benefits of palliative medicine, and the importance of incorporating these into chronic care management, especially when patients are approaching the end of life.

8. Incorporate patient encounters into a well-written patient report, following the provided rubric.
Course Requirements:

**Introductory Session:** Please prepare by reading this syllabus and answering the embedded questions as you read, preferably with a partner or a group. These answers will not be submitted for grading, but used for discussion, so any method of note taking you choose is ok.

**Patient Encounter:**

1. You and another student will be assigned to a practice where the physician cares for patients with chronic illnesses, and will shadow that physician for one session. During that session your physician will ask a patient with one or more chronic conditions if he or she would give permission for you to and your partner to meet with them once or twice more outside of the practice. Your observations and patient-interview will serve as the material for your written assignment (see instructions for the written assignment in order to formulate your interview).

2. After your office visit session, you and your partner will be required to have at least one more interaction with that patient in their home or in a mutually agreed upon community setting. You may decide to meet on another occasion, for example accompanying the patient to another specialist visit or for CT scans, or at a coffee shop, etc. The idea is for you to understand the experience of a patient living with this chronic illness.

3. You may feel free to interview the physician or any office support staff or supportive community figures that play a role in this patient’s chronic care.

4. Be aware that open-ended interview questions are helpful. E.g. “Tell me about your diabetes and how it effects your life,” “How is your diabetes treated?” “What are some goals you have when it comes to your disease?” This should be an empowering opportunity for your patient. They get the chance to educate YOU about how they understand and deal with their disease.

**Small group session:** In this session you will be expected to present your patient and your findings. Come prepared with a draft, bullet points, or the paper itself. Each student will be allotted 10-15min and we will discuss your findings as a group.

**Written assignment:** In your written assignment, please address the following. The format is not important, though grammar, spelling and neatness are. The paper should be 1000 – 1500 words.

1. 6 domains of the chronic care model: determine if and how these are being applied to your patient; use these principles as the foundation to observe and comment on the difficulties your patient and the provider face with respect to their chronic disease.

2. Medications: review your patient’s medications and determine any possible medication interactions and risks for medication misuse or non-adherence.
3. Palliative medicine: determine how principles of palliative medicine are being incorporated into the care of your patient. If they are not being applied, suggest ways in which they could be.

4. Provide an evidence-based guideline which applies to your patient’s condition and determine how it does or should influence treatment decisions – explain any changes you might make to the plan of care.

5. Discuss the use of surrogate endpoints in the patient’s care. Comment on the patient’s understanding of these markers.

6. Write a description about how you would care for this patient over time if you were his or her doctor, keeping in mind the patient’s personality, strengths, and support from family and friends. How would you organize your practice to maximize the care of this patient?

7. Include your own reflections related to this course material, the assignment, your patient, or your personal experiences.

**Grading:**

Grading is pass/fail. In order to pass, you must complete the following:

| Prepare for the introductory session by reading this syllabus and answering the embedded questions alone or in discussion with fellow students. |
| Complete at least 2 patient encounters. *(including the initial office visit)* |
| Attend small group session, prepared as detailed above. |
| Complete written assignment fulfilling requirements as stated above. |

**Chronic vs. Acute Care**

**Epidemiology**

1. Chronic disease is responsible for 70% of deaths in the US
   a. CV disease and cancer account for almost half of deaths
2. Half of US adults have at least 1 chronic disease
3. A quarter of US adults have at least 2 chronic diseases
4. This phenomenon is largely due to a combination of prevalent, often preventable risk factors, an increase in life expectancy and social and environmental factors that adversely affect health.¹
5. The burden of chronic disease is unequally distributed (e.g. CVD highest among African Americans, obesity highest among low income and less educated, stroke deaths highest in the Southeast)²

**Cost burden**

1. Care for chronic disease accounts for 84% of US Healthcare costs
2. “Waste” accounts for 30% of these costs: this includes fraud, administrative expenses, higher than value prices, and most of all “low value care”³
**What are some ways that care for chronic disease lends itself to wastefulness in healthcare spending?**

**Different expectations**

Inherent qualities of chronic care make it its own unique challenge. Lack of immediate results or physically apparent outcomes require patients have to put a certain amount of trust in the provider. This is different from reducing a fracture, removing an appendix, treating an otitis media, etc. Providers also have to put their faith in treatments, recommendations, guidelines and surrogate markers. The burden of management is often shared between the provider and patient, which requires a change in perspective from physicians as well as patients. To effectively manage chronic disease, we need to dramatically shift our focus from reactive care to proactive care. Some physician and medical practice behaviors that contribute to poor care of chronic disease include rushed providers, failure to consult evidence based guidelines, lack of coordination, lack of active follow up, and inadequate patient training.4

**When we treat patients with chronic disease, how are our goals different from the treatment of acute disease?**

**Recommended Resources:**

1. CDC Website section on chronic care: [http://www.cdc.gov/chronicdisease/](http://www.cdc.gov/chronicdisease/)

**The Chronic Care Model**

The Chronic Care Model is an evidence-based guideline designed to guide the transformation from reactive, acute-style chronic disease care to proactive, team based, high-quality chronic disease care. It was first proposed in the mid-1990’s and has since been updated and validated by multiple studies focusing on multiple different chronic diseases, including diabetes and heart failure.5

6 Components of the Chronic Care Model:

1. **Health system** - organization and support for all facets of the health care system; providing leadership for securing resources and removing barriers to care; includes support from the governing leadership and often reorganization of roles

2. **Self-management support** - facilitating skills-based learning and patient empowerment, may include individual or group sessions with nurses or patient educators or routine telephone follow up; this goes beyond telling patients what to do and includes acknowledging their central role in the management of their disease and utilizing office and community resources to support this effort.

3. **Decision support** - providing guidance for implementing evidence-based care, providing training in EBM for primary care providers (PCP’s) and securing availability of specialist support by phone or email; integrating evidence-based guidelines into daily clinical care via EMR reminders, order sets, feedback, etc.
4. **Delivery system design** – defining roles and distributing tasks among team members; planning the office flow to accommodate proactive care (e.g. Diabetes days, nurse or educator availability timed appropriately with appointments, involving case management when needed) and structuring follow up care.

5. **Clinical information systems** - tracking progress through reporting outcomes to patients and providers, creating and using disease registries, meaningful use of EMR, creating reminder systems; all of these actions can identify patients and providers at risk of falling back into the rhythm of reactive care.

6. **Community resources and policies** - sustaining care by using community-based resources and public health policy; identify and promote community initiatives and organizations that fill gaps between needed services.  

**Recommended Resources:**

1. Improving Chronic Illness Care Website: [http://improvingchroniccare.org/](http://improvingchroniccare.org/)

**Medical Complexity**

The presence of chronic disease creates a level of medical complexity that must be routinely acknowledged, documented and addressed, particularly when acute events take place. The concept of *homeostenosis* is important. It is a change in the body’s ability to adapt to stress. As the body ages or physiologically ages with the accumulation of chronic disease, that ability decreases and the body becomes more susceptible to stress. It reaches its “physiological limit” more easily. We often find it easier to apply this concept to a particular organ or system, but it is equally or more important to apply it to the patient as a whole. Medical complexity affects the way a patient will respond to an illness, a medication, a surgery, a hospitalization, a trauma or even an emotional stress.

Examples of medical complexity altering the course of an acute illness include:

a) A patient with dementia and a UTI: In a young healthy patient, a UTI is likely to be either self-limiting or resolved with a short course of antibiotics with no loss of function, productivity or severe illness. In a patient with dementia, it is common to see delirium, sepsis, severe loss of function and prolonged hospitalization.

b) A patient with diabetes and viral gastroenteritis: A healthy patient with viral gastroenteritis can usually be treated as an outpatient with oral rehydration. A diabetic is more susceptible to severe dehydration and complications such as DKA, HHNK or dangerous hypoglycemia. One day of vomiting can often land a diabetic patient in the ICU.

c) A patient with chronic kidney disease and pneumonia: Pneumonia in a young healthy patient may cause some missed work, but can be
treated as an outpatient with antibiotics. In a patient with chronic kidney disease, their immune function is compromised, making the pneumonia more likely to progress to life threatening severity. Their disease makes choice and dosing of antibiotics more delicate. They are far more likely to require hospitalization, have adverse drug reactions or to become septic.

Consider some more examples of how patients with chronic disease must be viewed through a different lens in the setting of an acute process.

Multimorbidity
The presence of multiple chronic conditions should be viewed as another crucial layer of medical complexity. As a person’s number of chronic diseases increases, their risk for premature death, hospitalization, functional impairment, adverse medication reactions, duplicative tests, and conflicting medical advice increases. Particularly in older adults, physicians may strictly follow a single disease guideline for a patient with multiple conditions, resulting in care that is irrelevant, impractical or even harmful. Care for these patients must be flexible, with communication between providers, close attention to details such as medication interactions and input from the patient and family as well as the healthcare team.

Certain chronic diseases in combination present a more profound complexity than other combinations. Can you think of an example of two chronic diseases that have a particularly synergistic interaction?

Recommended Resources:
1. The department of Health and Human Services has created a strategic framework for the approach to Multimorbidity, which can be viewed here: http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf
2. The American Geriatric Society has presented Guiding Principles, divided into 5 domains, for the Care of older adults with Multiple Chronic Conditions: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/ (listed as “AGS Guiding Principles for the Care of Older Adults with Multimorbidity”)

Medications in Chronic Care:
Medication non-adherence:
According to the WHO, among people with chronic illness, approximately 50% do not take their medications as prescribed. Non-adherence is a complex behavior influenced by socioeconomic factors, disease-related factors, medication-related factors, provider-related factors and health system factors. The term “medication non-compliance,” has come to imply patient passivity. As physicians, we should not place blame on patients when medication regimens are not followed. This is simplistic and unproductive. Instead we share the responsibility of medication management,
appreciate the complexity of medication prescribing and look to research and evidence to incorporate better prescribing habits into our practice.

Adverse Drug Events (ADE):

Medication Related Risk Factors:
The medications most likely to cause an adverse drug reaction leading to hospitalization are anti-coagulants (including aspirin, warfarin, NSAIDs, clopidogrel) followed by anti-diabetic medications (including insulin and oral hypoglycemics) and opiates. Other common offenders are beta-blockers, steroids, and diuretics. Polypharmacy (in the cited study, defined as 5 or more medications) is another strong medication-related risk factor for ADE. Medication errors are common in medication-related hospitalizations, the most common of all being lack of indication for the medication. Know why your patient is on the medications they are on!

Patient-related Risk Factors:
The most common patient-related risk factors for ADE’s are impaired cognition, 4 or more diseases (multimorbidity), dependent living situation, impaired renal function, and medication non-adherence. If your patient falls into one or more of these categories, a careful risk benefit analysis must take place.

Try to come up with a clinical intervention that is already in place or that you might put into place to address the issues of non-adherence and/or adverse drug events.

Recommended Resources:

Endpoints: Surrogate vs. Clinical
Trials are often designed to measure surrogate markers, endpoints or outcomes. These are intermediate markers intended to measure disease, whether it be severity, progress, prognosis, and treatment success or treatment failure. They are distinct from clinical outcomes. Some examples include LDL cholesterol, HgbA1C, FEV1, or even CD4 count. Surrogate outcomes do not affect patients directly and may not be as highly valued by the patient as a clinical outcome such as stroke, MI, opportunistic infection or loss of function from diabetes complications. Surrogate endpoints sometimes prove to be less reliable than previously thought (e.g. HgbA1C is proving to be a racially variable, unreliable indicator of glycemia). However, at times, they are the only methods we have to track disease. When used in accordance with guidelines, they must be explained to patients. Patients and physicians alike must recognize that patients do not experience or die from surrogate endpoints. Whenever possible, evidence we use in
the care of chronic disease and multimorbidity should center around “patient-important outcomes.” We must keep in mind that patient-important outcomes can vary between patients, particularly as patients near the end of life.

Consider an example of a patient choosing one outcome to be more important than another, and the way this may change their chronic disease management.

**Palliative Care:**

WHO Definition of Palliative Care: “Palliative care is an approach that improves the *quality of life* of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”

Palliative care should be integrated into routine practice in all cases of chronic disease. We often think of palliative care as a change in mindset to occur only when traditional medical care has nothing left to offer or is declined by the patient. Guidelines from many organizations now support a model of continuous attention to palliative care from diagnosis until death. This can be in the form of symptom management, advanced end of life planning, or counseling for patients, families and caregivers.

**Recommended Resources:**


**Chronic Disease Prevention:**

Prevention Classification:

- **Primary Prevention (prevention):** an intervention intended to prevent a disease from occurring.
- **Secondary Prevention (detection):** an intervention that attempts to detect a disease early in order to modify the course of the illness.
**Tertiary Prevention** (*mitigation*): an intervention imposed during the course of a disease in order to prevent or delay complications, disability of death from a disease.

*Most medical interventions fall into which of the above categories of preventative medicine?*

The CDC has identified 4 health risk behaviors as the largest contributors to modifiable risk for chronic disease.

1. Lack of exercise
2. Poor Nutrition
3. Excessive alcohol consumption
4. Tobacco use

**Recommended Resources:**

1. CDC Chronic Disease Prevention: [http://www.cdc.gov/chronicdisease/about/prevention.htm](http://www.cdc.gov/chronicdisease/about/prevention.htm)

**High-Quality Evidence:**

POEM’s (Patient Oriented Evidence that Matters):

When assessing an evidence source, usually a peer reviewed journal article, stop and ask yourself the following questions:

1. Is the evidence patient-oriented or disease-oriented?
2. Is the population studied relevant to the patient you are caring for?
3. Is the evidence relevant to your particular clinical question (i.e. does it matter)?

**Are the following examples of good POEM use?**

1. *You are taking care of humans and you refer to an article about the efficacy of a drug on diseased rats.*
2. *You are a pediatrician and an article addresses the most common presentations of influenza in patients older than 65.*
3. *You take care of a patient with diabetes. The most common cause of death in diabetes is MI. Your patient asks how to best avoid MI and you cite an article about the ability of sulfonylureas to reduce Hemoglobin A1C.*

**Guideline Sources:**

1. ChoosingWisely.org: This is a wonderful campaign that compiles recommendations from specialty societies designed to address and prevent wasteful medical care and to promote evidence-based medicine.
2. Specialty Societies: These are examples of the major academic societies that represent their specialty.
   a. Cardiology: American College of Cardiology/American Heart Association
b. Lung Disease: American Thoracic Society  
c. Infectious Disease: Infectious Disease Society of America  
d. You get the idea...  

Think about what specialty you may pursue and determine the corresponding specialty society and how to find their guidelines and recommendations.

3. Government Organizations  
a. USPSTF: http://www.uspreventiveservicestaskforce.org/ evidence-based guidelines for preventative services (e.g. cancer screening)  
b. Centers for Disease Control and Prevention: www.cdc.gov evidence based resource for patients and providers on a host of diseases and public health issues  
c. World Health Organization: http://www.who.int/about/en/ a health resource with a global scope addressing a wide array of diseases and initiatives  

Number needed to treat & Number needed to harm:  
When assessing whether an intervention is in the best interest of your patient, often the best way to answer that question is with NNT/NNH. NNT answers the question: how many people do I have to treat with this intervention in order to create one good outcome? NNH answers the question: how many people do I have to treat with this intervention in order to harm one patient? When applying joint decision making with your patients about things like cancer screening, this is a very helpful tool. Particularly with older patients, a timeframe when presenting NNT data is helpful (referred to as the time horizon benefit). Preventing one cervical cancer death over one year versus preventing one cancer death over 10 years may have a vastly different effect on decision-making. Another pertinent example is tight glycemic control. For tight glycemic control to confer a benefit, the time horizon benefit is likely between 5 and 7 years. When analyzed, tight glycemic control is more likely to do harm (via hypoglycemia) than good in elderly patients with multimorbidity who may have a limited life expectancy for reasons other than glycemic control.

Calculating the NNT requires you to know the absolute risk reduction: NNT = 1/ARR  
Calculating the NNH requires you to know the attributable risk: NNH = 1/AR  
(No, we’re not testing you on this, but USMLE will.)

Recommended Resources:  
1. For review and practice with this, try www.cebm.org  
2. www.thennt.com is a website that does the calculation for you and can be a great resource for you and your patients.

2 “Preventing Chronic Disease: Eliminating the leading preventable causes of Premature Death and Disability in the United States,” A Prevention and Learning Unit prepared by the national Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention http://www.cdc.gov/chronicdisease/pdf/preventing-chronic-disease-508.pdf


