**Diabetes Care Delivery: From Patient to Panel**

**Student Guide**

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| **LEARNING OBJECTIVES** |
| 1. Evaluate how different payment models can impact the organization of patient care.  2. Compare team structures and team members who provide care in chronic disease management.  3. Explain how health belief models can influence patient acceptance of recommended care.  4. Define and apply health literacy and numeracy to patient cases.  5. Compare and contrast methods to improve process versus outcome measures in chronic disease management.  6. Evaluate the use of quality improvement techniques applied to diabetes care. |

**Day One, Part One: Panel Management  
*Spend ~50 minutes on this content***

*You will receive a separate document containing Dr. Cordero’s Quarterly Quality Report.*

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| **A1. Caring for Populations** |
| Dr. Maria Cordero is a primary care physician practicing with Primary Care Group. She cares for 1800 patients, and has approximately 640 patients with diabetes in her panel. Attached, you will find the first page of her quarterly diabetes panel report. This shows how well her panel as a whole is doing meeting certain criteria associated with diabetes care. These metrics are based on 2014 Healthcare Effectiveness Data and Information Set (HEDIS) criteria.  In your groups, first identify which measures are consistent with *process measures* and which are most consistent with *outcome measures.* Then, discuss which measures Dr. Cordero seems to be achieving most easily and which are more challenging. Why do you think that is the case?  Why do you think Dr. Cordero receives these reports? Can you come up with pros and cons to this type of system? Also, discuss with your facilitator how easy or difficult it is for them to get process or outcome metrics related to the care of the patients they take care of. Reflect back to your HQPS site visit goal regarding the barriers to receiving and responding to clinical quality data and discuss as a small group. |

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| **A2. Caring for Populations** |
| Once a month, Dr. Cordero’s practice group has a meeting to discuss upcoming changes to the practice environment led by Dr. Karen Welsh, the medical director of the practice. Dr. Welsh presents the overall practice’s metrics regarding diabetes care and notes that they are well below the national average. She notes that the healthcare system you are part of is considering being part of a pilot project that includes changes in both the team structure and the way that your group receives payment from insurance companies.  Your group has always been paid based on “fee for service” and now she is proposing that you work with an insurance company to pilot a “shared savings model” that is considered typical for new “accountable care organizations.” A colleague suggests that this sounds similar to prior efforts to implement “pay for performance” models of care and doesn’t like the idea.  First, discuss what team changes might help improve care for your patients with diabetes. Then, share what you know about the payment models above. Your facilitator will give a brief presentation on the different models so you have a better understanding of this data. |

**Day One, Part Two: Patient Chronic Disease Management  
*Spend ~50 minutes on this content***

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| **B1. Beginning of case** |
| Kathryn Jones is a 41 year old woman who returns for a follow up visit to discuss her Type 2 Diabetes. At her last visit 3 months ago, you discussed her poor diabetes control. At that time, given her hemoglobin A1c of 11, you had recommended that she begin insulin glargine. She declined and wanted to continue on her metformin and glipizide while making additional changes to her diet and physical activity.  Past Medical History:  Hypertension  Diabetes  Hyperlipidemia  Abnormal Pap smear (HGSIL) March 2014  Medications:  Metformin 1000 mg twice daily  Glipizide Extended Release 10 mg daily  Lisinopril 20 mg daily  Atorvastatin 40 mg daily  Allergies:  No known drug allergies  Social History:  Lives with her 2 children ages 15 and 17 years. She graduated high school and works as a cashier at the local grocery store. No tobacco. Drinks 1 glass of wine per month.  Family History:  Mother with Type 2 diabetes, deceased age 66.  Physical Exam:  Temp 98.6 F, HR 72, RR 10, BP 132/78, Weight 120 lbs, Height 4 feet 9 inches  Gen: comfortable appearing  CV: regular rhythm, normal S1, S2, no m/r/g  Lungs: clear to auscultation bilaterally  Abd: soft, non-tender, non-distended, normoactive bowel sounds  Ext: sensation to monofilament intact in lower extremities bilaterally, +2 dorsalis pedis pulses bilaterally, skin without breakdown or callous formation. |

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| **B2.** |
| **On review of her health record, you note that she has had A1cs >10 for the last 18 months. She has returned for visits every 3 months for follow up during this time.** |

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| **B3.** |
| In further conversation, the patient reveals that insulin made her mother really sick and she worries that it will do the same to her. Soon after her mother started insulin, her kidney failure worsened, she started hemodialysis, and she died within 2 years of starting dialysis from a blood stream infection. |

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| **B4.** |
| After extensive discussion, she agrees to try insulin therapy. You stop her glipizide, continue her metformin 1000 twice daily and initiate insulin glargine 10 units nightly. You advise her to check her fasting blood sugar daily with a target of 70-130 mg/dL. You recommend she increase her insulin by 2 units every 3 days until her fasting blood sugars are in the target range.  Upon returning 12 weeks later, she states, “My blood sugars are great!” You review her blood sugar log, which she proudly displays. Her fasting blood sugars range from 170-200 fasting. She states she is taking insulin, just as you had recommended, 10 units nightly. Furthermore, she stopped both her glipizide and metformin when she started her insulin. |

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| **B5.** |
| After realizing that the patient requires more support with diabetes education and management, you look into potential resources available to this patient. Your social worker mentions that the practice has just started a peer coaching initiative. There are also classes run by community health educators that the patient can attend. She reports that there are 2 available options, peer coaching for diabetes and community health workers for diabetes. You have heard a little bit about each one, but need to decide which you would choose for Ms. Jones. |

**Learning Issues and Reference List**

1) Summarize the scientific limitations to the intermediate biological outcomes that have been used to assess the quality of care (i.e. blood pressure <140/90 mmHg at the last visit in the measurement period or A1c <8.0).

*--Pogach L1, Engelgau M, Aron D. Measuring progress toward achieving hemoglobin A1c goals in diabetes care: pass/fail or partial credit. JAMA. 2007 Feb 7;297(5):520-3.*

*--Kerr EA1, Lucatorto MA, Holleman R, Hogan MM, Klamerus ML, Hofer TP; Monitoring performance for blood pressure management among patients with diabetes mellitus: too much of a good thing? VA Diabetes Quality Enhancement Research Initiative (QUERI) Workgroup on Clinical Action Measures. Arch Intern Med. 2012 Jun 25;172(12):938-45.*

2) Compare which quality improvement strategies have been shown to be effective for improving processes of care (i.e. A1c testing, eye exams, vaccinations, or nephropathy screening) to those that are effective in improving biological outcomes for chronic conditions (i.e. A1c level and blood pressure control). \**Students should be selective in their use of the following references to answer these questions and do not need to read each paper in its entirety*

*--Scott I. What are the most effective strategies for improving quality and safety of health care? Intern Med J. 2009;39:389-400.*

*--Tric*[*co AC*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Tricco%20AC%5BAuthor%5D&cauthor=true&cauthor_uid=22683130)*,* [*Ivers NM*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Ivers%20NM%5BAuthor%5D&cauthor=true&cauthor_uid=22683130)*,* [*Grimshaw JM*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Grimshaw%20JM%5BAuthor%5D&cauthor=true&cauthor_uid=22683130)*,* [*Moher D*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Moher%20D%5BAuthor%5D&cauthor=true&cauthor_uid=22683130)*,* [*Turner L*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Turner%20L%5BAuthor%5D&cauthor=true&cauthor_uid=22683130)*,* [*Galipeau J*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Galipeau%20J%5BAuthor%5D&cauthor=true&cauthor_uid=22683130)*,* [*Halperin I*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Halperin%20I%5BAuthor%5D&cauthor=true&cauthor_uid=22683130)*,* [*Vachon B*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Vachon%20B%5BAuthor%5D&cauthor=true&cauthor_uid=22683130)*,* [*Ramsay T*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Ramsay%20T%5BAuthor%5D&cauthor=true&cauthor_uid=22683130)*,* [*Manns B*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Manns%20B%5BAuthor%5D&cauthor=true&cauthor_uid=22683130)*,* [*Tonelli M*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Tonelli%20M%5BAuthor%5D&cauthor=true&cauthor_uid=22683130)*,* [*Shojania K*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Shojania%20K%5BAuthor%5D&cauthor=true&cauthor_uid=22683130)*. Effectiveness of quality improvement strategies on the management of diabetes: a systematic review and meta-analysis. Lancet. 2012 Jun 16; 379(9833)2252-61.*

*--Bright TJ1, Wong A, Dhurjati R, Bristow E, Bastian L, Coeytaux RR, Samsa G, Hasselblad V, Williams JW, Musty MD, Wing L, Kendrick AS, Sanders GD, Lobach D. Effect of clinical decision-support systems: a systematic review. Ann Intern Med. 2012 Jul 3;157(1):29-43. doi: 10.7326/0003-4819-157-1-201207030-00450.*

*--Audit and feedback: effects on professional practice and healthcare outcomes. Cochrane Database Syst Rev. 2012 Jun 13;6:CD000259. doi: 10.1002/14651858.CD000259.*

3) Describe the potential undesirable consequences of providing doctors financial incentives for the A1c results they achieve or of public reporting of those results.

*--Casalino L1, Alexander GC, Jin L, Konetzka RT. General internists' views on pay-for-performance and public reporting of quality scores: a national survey. Health Aff. 2007 Mar-Apr;26(2):492-9.*

*--Wharam JF, Paasche-Orlow MK, Farber NJ, Sinsky C, Rucker L, Rask KJ, Figaro MK, Braddock C 3rd, Barry MJ, Sulmasy DP. High quality care and ethical pay-for-performance: a Society of General Internal Medicine policy analysis. J Gen Intern Med. 2009 Jul;24(7):854-9. doi: 10.1007/s11606-009-0947-3. Epub 2009 Mar 18.*

*--* [*Hibbard JH*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Hibbard%20JH%5BAuthor%5D&cauthor=true&cauthor_uid=25962744)*,* [*Greene J*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Greene%20J%5BAuthor%5D&cauthor=true&cauthor_uid=25962744)*,* [*Sacks R*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Sacks%20R%5BAuthor%5D&cauthor=true&cauthor_uid=25962744)*,* [*Overton V*](http://www.ncbi.nlm.nih.gov/pubmed/?term=Overton%20V%5BAuthor%5D&cauthor=true&cauthor_uid=25962744)*. Does Compensating Primary Care Providers to Produce Higher Quality Make Them More or Less Patient Centric?* [*Med Care Res Rev.*](http://www.ncbi.nlm.nih.gov/pubmed/25962744) *2015 Aug;72(4):481-95.*

4) Outline at least one example of how team structure can be designed to improve patient chronic disease management.

-*Bodenheimer, T. Transforming Practice. NEJM 359 (20): 2086-2089  
-Green BB, et al JAMA 2008; JAMA Internal Medicine 2013*

5) Define the concept of pay for performance. Then, evaluate its effectiveness in improving patient care thus far.

*--Rosenthal MB, Dudley RA. Pay-for Performance: Will the Latest Payment Trend Improve Care. JAMA 2007; 297:740-743.*

*--Houle SK1, McAlister FA, Jackevicius CA, Chuck AW, Tsuyuki RT. Does performance-based remuneration for individual health care practitioners affect patient care?: a systematic review*. *Ann Intern Med. 2012 Dec 18;157(12):889-99.*

6) Compare how incentives to adopt team models for diabetes care differ between fee-for-service payment models and accountable care organization models.

-*Hong, CS, Abrams, MK, Ferris, TG. Toward Increased Adoption of Complex Care Management. NEJM 371 (6) 491-493)*

7) Explore the reasons a provider may not prescribe a medication, even when clinically indicated. Define the term “Clinical Inertia.” and reasons behind it.

*--Phillips LS, Branch WT, Cook CB, Doyle JP, El-Kebbi IM, Gallina DL, Miller CD, Ziemer DC, Barnes CS. Clinical inertia. Ann Intern Med. 2001 Nov 6;135(9):825-34.*

*--Khunti K, Wolden ML, Thorsted BL, Andersen M, Davies MJ. Clinical inertia in people with type 2 diabetes: a retrospective cohort study of more than 80,000 people. Diabetes Care. 2013;36:3411-3417.*

8) Describe a few reasons, beyond cost-related concerns, that a patient might decline insulin therapy. Include examples of health beliefs that may contribute to a patient’s reluctance to start insulin therapy.

*--Brod, M. Kongsø JH, Lessard S, Christensen TL.* [*Psychological insulin resistance: patient beliefs and implications for diabetes management.*](http://www.ncbi.nlm.nih.gov.ezproxy.galter.northwestern.edu/pubmed/19039679) *Qual Life Res. 2009 Feb;18(1):23-32.*

*-- Polonsky WH, Jackson RA: What’s so tough about taking insulin? Addressing the problem of psychological insulin resistance in type 2 diabetes. Clinical Diabetes 22:147-150,2004.*

9) Define health literacy and health numeracy. Explain how low health literacy might affect a patient’s ability to manage their diabetes. Describe how low health numeracy may affect a patient’s ability to titrate insulin therapy in this example.

*--Dean Schillinger, MD; Kevin Grumbach, MD; John Piette, PhD; Frances Wang, MS; Dennis Osmond, PhD; Carolyn Daher, MPH; Jorge Palacios, MA; Gabriela Diaz Sullivan, MD; Andrew B. Bindman, MD* ***Association of Health Literacy With Diabetes Outcomes Author Affiliations:*** *University of California, San Francisco, Primary Care Research Center, San Francisco General Hospital (Drs Schillinger, Osmond, Sullivan, and Bindman, Mss Wang and Daher, and Mr Palacios); University of California, San Francisco, Department of Family and Community Medicine (Dr Grumbach); and Center for Practice Management and Outcomes Research, VA Ann Arbor Health Care System, and the University of Michigan School of Medicine, Ann Arbor (Dr Piette). Ms Daher is now with the Johns Hopkins School of Public Health, Baltimore, MJAMA. 2002;288(4):475-482. doi:10.1001/jama.288.4.475.*

*--Kerri Cavanaugh, MD, MHS; Mary Margaret Huizinga, MD, MPH; Kenneth A. Wallston, PhD; Tebeb Gebretsadik, MPH; Ayumi Shintani, PhD, MPH; Dianne Davis, RD, CDE; Rebecca Pratt Gregory, RD, CDE; Lynn Fuchs, PhD; Robb Malone, PharmD, CDE; Andrea Cherrington, MD, MPH; Michael Pignone, MD, MPH; Darren A. DeWalt, MD, MPH; Tom A. Elasy, MD, MPH; and Russell L. Rothman, MD, MPP* ***Association of Numeracy and Diabetes Control*** *Ann Intern Med. 2008;148(10):737-746. doi:10.7326/0003-4819-148-10-200805200-00006*

10) Define “community health workers” and “peer coaches”. Explain how these types of care providers can be incorporated into clinical practice. Provide examples from the literature regarding glycemic control data in your discussion

*--Dale JR, Williams SM, and Bowyer V. What is the effect of peer support on diabetes outcomes in adults? A systematic review. Diabet Med. 2012;29(11):1361-77.*

*--Thom DH et al. Impact of Peer Health Coaching on Glyce- mic Control in Low-Income Patients With Diabetes: A Randomized Controlled Trial. Ann Fam Med 2013;11:137-144. doi:10.1370/afm.1443.*

*--Palmas W, March D, Darakjy S et al. Community Health Worker Interventions to Improve Glycemic Control in People with Diabetes: A Systematic Review and Meta-Analysis. J Gen Intern Med. 2015;30(7):1004-12.*

**Group Paper Assignment: Last Step (45 minutes)**

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| **C1.** |
| **There are three parts to this exercise: one systems case and two patient cases. Each case is followed by questions that you should address in your paper. You may choose to split your group into three parts to accomplish the writing of the paper most efficiently, however, all members of your group are responsible for the final product and for the knowledge gained from writing all three portions. Comparing and contrasting your approach to the two patient cases is highly recommended. You should also link the decisions made in the System Case with your solutions in the Patient Cases, since both patients are cared for in Dr. Cordero’s medical practice. Use what you learned from each other in the Learning Issue discussions to complete this paper. Be thorough and thoughtful in your write-ups, illustrating your understanding of the key concepts in the overall Learning Objectives.**  **Submission Instructions:** Please compile all three parts (one systems case, 2 patient cases) into one report with your group number and team member names. Please type this and submit it by email by 10 pm on Friday, December 8, 2016 to Ciara Noel *(*[*ciara.noel@northwestern.edu*](mailto:ciara.noel@northwestern.edu)*).*  **System Case:**  After the initial practice meeting (on day 1), Dr. Cordero’s group decides that they will become part of the pilot group for Major Insurance Company in their new Shared Savings Model plan. While the group has been doing well on most important metrics, Dr. Walsh, the practice director, notes that the physician group as a whole is performing below the necessary benchmarks for Major Insurance Company in two areas: adequate glycemic control for diabetic patients (only 55% of the patients in the practice have a Hemoglobin A1c <8.0). The group also is not meeting the metric for percentage of patients either on an ACEI or with a microalbumin check in the past year.  *You are now part of the strategic planning committee for the practice. Provide a plan for how the practice will go about improving diabetes care quality in both of these measures, noting which measure is a process measure and which is an intermediate outcome measure. Explain why your group has chosen the approach for each measure. Indicate how the changes in practice financing will impact your ability to carry out your plan.*  **Patient Case: Michael Warner**  Michael Warner is a 52 y/o man who comes in for follow-up diabetes visit. You last saw him almost one year ago, in January 2014. At that time, his hemoglobin A1c was 9.7; you recommended adjustments to his insulin regimen and that he come back in 8 weeks for a follow-up visit to adjust his insulin. However, he works for Union Pacific in rail management, which requires frequent last minute travel. He cancelled the 8-week visit and forgot to reschedule the visit. You note that his blood pressure is at goal on Lisinopril 20mg daily and his last LDL cholesterol was 85 while taking Atorvastatin. A point-of-care hemoglobin A1c obtained by the nurse at the beginning of today’s visit reveals a hemoglobin A1c of 10.1.  **Patient Case: Sally Rafa**  Sally Rafa is a 59 year old woman who was recently seen in the office for a diabetes follow-up visit. Since being diagnosed with diabetes two years ago, she has made several lifestyle changes including exercising regularly and eating out less. She also takes metformin every day for her diabetes and her A1C has come down from 8.5 to 7.2. She does not take any other medications. Her last office blood pressure was 135/80 which is pretty close to the blood pressures results she has obtained when she checks her blood pressure at the drug store once or twice a month. She has had a foot exam and seen the eye doctor within the past year. Her last test to screen for microalbuminuria was almost two years ago. Despite her best efforts to eat a diet that is low in fat, her LDL cholesterol has not improved much and was 134 on last check a few months ago. She has told you several times that she really does not like taking pills and prefers to use natural treatments. You recommended starting a statin at her last visit but she declined because she has heard from many of her friends that the cholesterol lowering medications are very dangerous. She feels confident that with stricter dietary monitoring, she can get her cholesterol down.  *For each patient, list the factors that serve as barriers to adherence. What improvement techniques and/or team structure changes are needed to overcome these barriers for each patient? Include all changes you feel are appropriate without including changes that would not likely impact this patient. Include 3-4 sentences of “patient instructions” for each patient that explains your plan, taking care to consider health literacy in your instructions (aim for 8th grade level).* |

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| Course | **Endocrine** |  | Date |  |
| Unit | **DOC [BOM, TL, HEA, HQPS]** |  | Evaluator Name |  |
| Assessment | **Group Paper** |  | **Name** |  |

**Continuous Learning and Quality Improvement**

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| **SATBC-1**  **Describe healthcare finance and delivery in various healthcare systems, and demonstrate the ability to effectively call on system resources to provide care that is of optimal value.**  *For this small group exercise, students will compare fee-for-service and ACO models and how this impacts the structure of chronic care.* | | | | | | | | | |
| 1   | 2   | 3   | 4   | | 5   | 6   | 7   | 8   | 9   |
|  |  | |  | | | |  | |  |
| Critical deficiencies in comparing ACO and fee-for-service care; fails to apply payment model to patient care. | Defines ACO and fee-for-service payment models but application to patient care structures has critical deficiencies. | | | Clearly defines ACO and fee-for-service payment models. Provides a superficial but correct application to patient care. | | | Clearly defines ACO and fee-for-service payment models and provides detailed analysis of application to patient care. | | N/A |

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| **CLQI-4**  **Demonstrate quality improvement knowledge and skill.**  *Students are told to consider how to implement changes to the clinic to improve both process and outcome measures using appropriate methods.* | | | | | | | | |
| 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | |
|  |  | |  | | |  | |  |
| Students misidentify process and outcome measures. | Students identify process and outcome measures correctly, but apply incorrect concepts for quality improvement. | | Students correctly identify process and outcome measures. Discussion of quality improvement concepts is correct but superficial. | | | Students correctly identify process and outcome measures. Discussion of quality improvement concepts is detailed and correct and displays thorough understanding of key concepts. | | N/A |

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| **CES-2**  **Assess challenges to providing high quality health care for members of vulnerable groups and articulate the role of physicians in working to eliminate barriers.**  *For this small group exercise, students will assess patient cases and apply concepts of health literacy/numeracy and health belief model* | | | | | | | | |
| 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | |
|  |  | |  | | |  | |  |
| Students do not apply concepts of health belief model or numeracy/literacy. | Students mention health belief model or health literacy/numeracy in their analysis, but only superficially. | | Students adequately consider how health belief model or health literacy/numeracy impacts diabetes care. | | | Students discuss how health belief model and health literacy/numeracy impact diabetes care in a detailed and thoughtful manner that demonstrates full understanding of concepts. | | N/A |

Group Grading Rubric:

The following rubric was provided to your group facilitator to assess your group’s teamwork.

When completing this form, consider the following:

What does a good group that is working together look like?  
- All members are engaged  
- Team members readily volunteer for learning issues  
- Team members prepare their LIs in detail and use methods to share the information clearly in the 5-7 minutes allotted/group member.

-Team members use appropriate resources to complete the LIs**, including the references provided by the care authors.**

Please select the box that best describes the characteristics of the entire group that you are facilitating. If the group displays some characteristics from two boxes, choose the middle column.

See next page for the detailed rubric.

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| Learning Activity | **DOC Groups** |  | Date |  |
| Module | **Head and Neck**  **Endocrine**  **Hematology/Oncology** |  | Evaluator Name |  |
| Assessment | **Faculty Assessment of Group Teamwork** |  | Student Name |  |

When completing this form, consider the following:

What does a good group that is working together look like?  
- All members are engaged  
- Team members readily volunteer for learning issues (Lis)  
- Team members prepare their LIs in detail and use methods to share the information clearly in the 5-7 minutes allotted/group member.

-Team members use appropriate resources to complete the LIs**, including the references provided by the care authors.**

**System Awareness and Team-Based Care**

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| **SATBC-2** Demonstrate a clear understanding of healthcare team goals, primary roles of team members, and **work effectively to help the team achieve its goals.**  *For this exercise, a group working together will demonstrate “team orientation”—working together to help each other learn the material. They will provide each other feedback to each other if needed to keep the group on track. They demonstrate engagement and interest in the efforts of all members of the group.* | | | | |
| 1   | 2 3    | 4 5 6   | 7   |  |
|  |  |  |  |  |
| * The group requires significant facilitator involvement to engage in the discussion. * Group members make few contributions to the discussion. * Group members display indifference during other students’ presentations, (i.e. checking emails or having frequent sidebars) | * The group sometimes engages in independent discussion of the case, but often requires the facilitator to bring up key points. * A few student contribute to the discussion in meaningful ways * Some group members are attentive during LI presentations, but others appear indifferent | * The group maintains discussion for the most part, occasionally requiring redirection from the facilitator. * Almost all students contribute equally to the discussion * Most students display active listening skills during LI presentations. | * Nearly all try to meaningfully contribute to the group effort. * Students ask each other questions, invite less participatory members of the group to share their thoughts. * All members are engaged during LI presentations, ask questions of each other. | N/A |

**Professional Behavior and Moral Reasoning**

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| **PBMR-5 Behave with accountability and dependability.**  ***Accountability to each other and to each others’ learning*** | | | | |
| 1   | 2 3    | 4 5 6   | 7   |  |
|  |  |  |  |  |
| * Several group members are late * More than 1-2 members are poorly prepared with their LIs * Many members are disengaged in the learning process. | * Some group members are late * 1-2 students are unprepared for LI presentations | * Almost all group members are prepared and on time. * Almost all LI presentations are well prepared | * All group members are on time for both sessions. * All group members are well prepared for LI presentations | N/A |

**Continuous Learning and Quality Improvement**

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| **CLQI-3b Use information technology obtain information needed for effective self-learning and peer education.**  ***Group skill : Learning Issue Preparation – Information Literacy*** | | | | |
| 1   | 2 3    | 4 5 6   | 7   |  |
|  |  |  |  |  |
| * More than 1 group member used inappropriate information technology to develop LI presentation (used Wikipedia or non-medical websites). * More than one group member did not cite sources. | * Group members used the sources recommended by the facilitators, but clearly skimmed and did not understand issues. * Occasionally cited sources without prompting | * Most group members used the sources recommended by the facilitators, they may miss 1 or 2 important points * Cited sources consistently. | * All group members used all the sources recommended by facilitators and highlighted critical points for colleagues | **N/A** |

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| **Positive Observations:** |
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| **Suggestions for Improvement:** |
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