Project Title: Educating Patients and Care Providers About Familial Hypercholesterolemia using EPIC

Grant ID Number: 24067357

Main Collaborators: Robert Block, MD, MPH; Geof Williams, MD, PhD; Scott McIntosh, PhD; Christiane Wert Rivard, MPH, RD; Jack Chang, M. Sc.

Abstract:
The proposed project aims to address the problem of under-diagnosis and treatment of patients with familial hypercholesterolemia (FH) with a major obstacle being adequate education, motivation and a systematic way of identifying those affected. It will achieve this goal by creating a method in which information about this condition is incorporated into the University of Rochester’s electronic health record (eRecord - an Epic system), in a motivating manner that empowers patients and providers. This will begin with a formative stage consisting of focus groups including patients, providers and both combined, as well as key informant interviews, to partner with them in determining the format of motivational information. This will be followed by building the motivational program to then be incorporated into eRecord. The effects of this integration will then be tested via a trial. The project objectives are: 1) create a motivational program within eRecord designed for patients and their providers using scientific, well-validated, theoretically-based methods; 2) using this program, increase knowledge about FH as well as autonomy and competence motivations for screening and treatment amongst those who appear to be affected by this condition; 3) using this program, improve patient diagnosis by medical providers; 4) enhance practitioner autonomy and competence motivations for managing FH effectively; and 5) detect significant reduction in LDL-cholesterol over 9 months. Dissemination of this program designed to educate and motivate patients and providers can occur in the future given that a very high proportion of medical care institutions in the US use Epic.
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C. Reviewer Comments
The following comments were made by the review panelists:

“Because Pfizer IGLC and the IAS reserve the right to fund projects based on availability of funds and strength and quality of applications, it is very important for you to state the minimum amount of funding you would accept that would enable you to do a smaller or scaled down version of your project. A large number of excellent applications were submitted with requests for funding that greatly exceed the available budget. The panel asks you to provide a minimum amount that if awarded, would at least make your project viable.”

Our comments: Our project team has very carefully considered scaling down this project. The formative/building of the program phase of the project does require the time that we have devoted to it via the budget and proposal. We have minimized the effort required by each team member as much as is feasible and have negotiated with our EHR (eRecord) leadership that no fees will be charged other than for Jack Chang’s time. We have also considered removing some objectives but this would prevent achieving the overarching goals. Thus, IAS-Pfizer will have a very cost-effective project given the time, expertise, and resources involved. If IAS-Pfizer cannot devote all funds required in our submitted budget, our team will consider reducing the total length of the project from 24 to 21 months by truncating the trial by 3 months. This would mean that the trial will last 9 months instead of 12 and we would also reduce the number of LDL cholesterol measurements to 2 instead of 4. This would reduce the total budget by ~$26,000. If IAS-Pfizer is very enthusiastic about sponsoring our proposed project, we are happy to discuss this budget-limiting approach with its representative(s).

“In your full proposal, it is important to include sufficient information to justify your full budget. Please review the attached Full Proposal Guidance document for details.”

Our comments: This information is included in the project protocol and budget.

“Proposals should describe the means of evaluation and how project outcomes will be measured.”

Our comments: The project protocol provides this information.

“Please clearly define the education component of the project. Specifically, the educational design of proposed projects should demonstrate how clinician performance will be supported, beyond the acquisition of knowledge. Please describe any tools that will be used to support the learning and that will help achieve the objectives of the project.”

Our comments: The support of the Greater Rochester Practice-Based Research Network (GR-PBRN) and Primary Care Network (see letters of commitment) indicates that any concerns regarding this study interfering with primary care physician-patient relationships and time have been considered carefully and discussed with the project team. The entire project is designed to support physicians and patients as it allows them to have direct input into the template to be inserted into the EHR. In addition, partnership with the Familial Hypercholesterolemia Foundation takes advantage of the national expertise it has in engaging patients and physicians in order to increase the diagnosis of patients with familial hypercholesterolemia. Thus, the project will form a network to support them along with the ability to communicate directly with Drs. Block and Williams given their physical presence at the University of Rochester.
D. MAIN SECTION OF THE PROPOSAL

**Overall Goal & Objectives:**
The overarching goal is to empower patients and clinicians via an electronic health record (EHR called eRecord) in order to improve the diagnosis and treatment of patients with familial hypercholesterolemia (FH). FH is an autosomal-dominant genetic disease that predisposes to premature cardiovascular disease\(^1\). This project aligns with IAS-Pfizer interests in eliminating a care gap reflected by the known fact that only 10% of patients with FH are diagnosed. This project also aligns very well with goals of the University of Rochester’s Strategic Plan of building health care that’s easier to access, affordable, that delivers better results. This strategy merges well with the major obstacle of deficiencies in regard to FH education, motivation and a systematic way of identifying those affected. Self-Determination Theory (SDT) elements and methods form the theoretical framework (Figure 1). The Department of Public Health Sciences, the academic home for this project, is a vital component of the medical center, and has great expertise in the conduct of projects that focus on improving population health and partnering with clinical departments. The University of Rochester has had eRecord (EHR system; the university’s version of Epic) integrated since March, 2011, with mechanisms of conducting the type of project proposed. Also, since the Biomedical Informatics Group within the University’s Clinical and Translational Science Institute (CTSI) partners with the eRecord team, this leverages technical resources in EHR-based research and dissemination. The goal of dissemination of the method can occur in the future given that a very high proportion of medical care institutions in the US use Epic and by partnering with the Familial Hypercholesterolemia (FH) Foundation. Our project would begin May 1, 2016.

**The objectives include:**
1) Create a motivational program within eRecord designed for patients and their providers using scientific, well-validated, theoretically-based methods

2) Using this program, increase knowledge about FH as well as autonomy and competence motivations for screening and treatment amongst those who appear to be affected by this condition:
   a) Patient knowledge change will be tested using questions from pre- to post-integration of the program into the eRecord system.
   b) Patient motivation, competence, and their changes will be assessed using the component SDT measures from pre- to post-integration of the program into the eRecord system.

3) Using this program, improve patient diagnosis by medical providers

4) Enhance practitioner autonomy and competence motivations for managing FH effectively

5) Detect significant reduction in LDL-cholesterol over 9 months

**Theoretical Basis**
Self-Determination Theory (SDT)\(^2, 3\) is a general theory of human motivation that is fully aligned
with medical professionalism, biomedical ethics, and shared decision making, as it posits that providers and patients become more motivated if the health care system and electronic health record support their autonomy with competence regarding cardiovascular (CVD) risk reduction. We have demonstrated previously that smokers who are more autonomous (feel willing) and feel more competent (able to achieve their goal) stop smoking, use medications more regularly, and lower their LDL cholesterol if their 10-year cardiovascular risk and the potential risk-benefit are presented and discussed with them. In addition, patients with obesity have become more physically active and lost more weight, dental outcomes are improved based on randomized controlled trials. A meta-analysis with over 13,000 subjects and 184 data sets based on SDT measures and physical and mental health outcomes supports the SDT Model for Health Behavior and its Change. We intend to extend these findings by integrating information into our EHR in a manner that increases knowledge, and motivation (autonomy and competence) for patients who meet the criteria for FH along with their primary care physicians and that this will lead to an increase in the diagnosis and treatment of FH by their medical providers reflected as a reduction in LDL-cholesterol.

FIGURE 1

SDT FH Model of the Underlying Motivations for FH Patients’ and Practitioners’ Treating FH

Current Assessment of Need in Target Area
Rochester is in Upstate New York and the University of Rochester is home to the only LDL apheresis program in the state outside of Manhattan while being a preventive cardiology referral center. Since our eRecord EHR contains laboratory data from >200,000 adults, this indicates that there are ~1000 patients with FH who could be identified based on a prevalence of 1/200. We expect that those who meet criteria for FH are being appropriately diagnosed within the University of Rochester’s network of practices at about the same 10% rate as occurs in other medical systems. This gap can be filled for those who participate in the project by our anticipated method of using fasting cholesterol profiles to determine who appears to have FH (see MEDPED criteria below in Objective 1). If the method we will test in our project to identify individuals with FH can be disseminated into 10 other sites that have 2,000,000 patients who have had lab analyses performed, 10,000 potentially could be diagnosed.

Target Audience
The primary audience targeted by this project is patients affected by FH and their primary care physicians within the University of Rochester medical system. We will actively partner with
patients as those affected by a condition are more likely to be beneficially affected by the use of electronic health educational tools than medical providers. A pool of patients, who formally partner with Drs. Block and McIntosh and the FH Foundation within a project sponsored by the Patient-Centered Research Outcomes Institute (PCORI), will be recruited to participate in focus groups and key informant interviews. Other patients that Drs. Block and Williams have formal care relationships with can also participate in this formative EHR Build and Intervention Development Phase. The Greater Rochester Practice-Based Research Network (GR-PBRN) was established in 2007 to bring together primary care clinicians and researchers in a collaborative model designed to improve patient care and outcomes (see letters of support from both the GR-PBRN and Primary Care Network). It includes family medicine, internal medicine, and med/peds practices, representing at least 200,000 adults. Since the majority of these practices use the University of Rochester eRecord EHR, their patients and providers can participate.

**Project Design and Methods:**
This project will include both qualitative and quantitative data creation and analyses. The University of Rochester’s Institutional Review Board (IRB) will review and approve the project prior to recruitment. The early EHR Build and Intervention Development Phase will be when focus groups and key informant interviews will generate qualitative information so as to engage and partner with patients and their physicians while investigating provider willingness and competence with eRecord functionality regarding the proposed program. The next Trial Development and Implementation Phase will be when effects of the integration of program into eRecord will be tested.

**Objective 1: Creating a motivational program within eRecord designed for patients and their providers using scientific, well-validated, theoretically-based methods.**

**Focus Groups & Key Informant Interviews:** To maximize practitioner engagement and improve the EHR build, physicians and a convenience sample of patients with a diagnosis of or sub-clinical presentation of FH, will be purposively sampled to participate in a focus group or key informant interview. Participants (28 physicians – at most as some may participate repeatedly -- and 50 patients) will be contacted to schedule a 30 minute key informant interview and/or to participate in a 60 minute focus group to provide feedback on their knowledge, skills, behaviors, barriers to and facilitators of health communications related to a diagnosis of FH. The focus group and key informant interviews will include key messages from local champions Drs. Block and Williams. Other items that will be discussed during focus groups and key interviews are incenting MDs and other health care providers including competition between health care providers, e.g. who can find the most FH patients in their practice, and clinical quality metrics. The potential integration of a link within the FH Foundation’s website as a source of information for patients and physicians will be discussed. For example, resources on the website include primary care provider tool kits to provide information about screening, diagnosis, and treatment of individuals with FH, patient education materials, and a link to connect with the FH patient portal, the CASCADE Family Registry. The anticipated use of Make Early Diagnosis Prevent Early Death (MEDPED) (the most simplistic for use in an EHR-see Figure 2) thresholds for LDL cholesterol to identify patients with FH will also be discussed. They
will then be asked specifically about their reactions to prototypes of the EHR build. A cornerstone of focus groups and key informant interviews including patients will be repackaging the motivational program, focusing upon their interpretation and understanding of the information, and comments on education sources to which they will be referred. Focus groups will occur where patients or physicians participate and then when both are included. Focus groups discussion and individual interviews will be audio-recorded, with the consent of all participants, for later transcription and analysis. The FH Foundation’s Find FH (FHF) program can help with focus groups by expanding outreach to the FHF advocates to expand reach; focus groups could be conducted via Skype (as we have done in the past).

**FIGURE 2**

<table>
<thead>
<tr>
<th>Most specific</th>
<th>Most sensitive</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDPED 100% prob. FH LDL levels (mg/dl)</td>
<td>MEDPED 80% prob. FH LDL levels (mg/dl)</td>
</tr>
<tr>
<td>&lt;20</td>
<td>240</td>
</tr>
<tr>
<td>20-29</td>
<td>260</td>
</tr>
<tr>
<td>30-39</td>
<td>280</td>
</tr>
<tr>
<td>&gt;40</td>
<td>300</td>
</tr>
</tbody>
</table>

Dr. Block will lead an already scheduled Medicine Grand Rounds at the University of Rochester on June 7, 2016, focused on FH. He will be joined by a patient with FH and the FH Foundation’s Outreach Coordinator. Thoughts from the audience will be considered when moving to the next step. Drs. Block and Williams will make themselves available to provide information and guidance for physicians, upon request.

**Qualitative Data Analysis:** Focus group and key informant interview data will be analyzed using a combination of open coding and thematic analysis to identify the relevant factors associated with health communications related to FH. Thematic analysis allows for the sorting of coded data into common themes, necessary for providing both content and context related to both patient and physician experiences. These methods are consistent with those that have been extensively employed by our team with both physicians and target patient populations.12-17

As the building of motivational/educational content into eRecord will result from data collected, the eRecord building team will work directly and synchronously with our investigators. The program about FH will be integrated into the MyChart patient portal tool in eRecord that provides patients with blood test results, current diagnoses, and a way that they can connect with their care provider(s) securely. The EHR build will be tested using usability testing techniques and iteratively developed until the project team reaches consensus on the program, and practice recommendations. After the build consensus is reached, the intervention will be tested with non-participating physicians to identify final usability issues and generate the final build. The template created in the eRecord EHR should address the established need of improved awareness, diagnosis, and other factors including motivation and competence for managing FH.
Although project leaders plan to use the eRecord MyChart patient portal as the target for integrating the resulting template, they will work hand-in-hand with patients and physicians via partnership to achieve the objectives without directing them. We will determine if our local patients and their providers were fully engaged via focus group/key interview settings and questions asked of them in a trial after integration of the resulting program into eRecord.

**Objective 2: Using this program, increase knowledge about FH as well as motivation and competence for screening and treatment amongst those who appear to be affected by this condition**

a) Patient knowledge change will be tested using questions from pre- to post-integration of the program into the eRecord system.

b) Patient motivation, competence, and their changes will be assessed using the component SDT measures from pre- to post-integration of the program into the eRecord system.

Knowledge, motivation, and competence will be assessed at baseline for patients when they are first exposed to the program about FH via MyChart in eRecord. Assessment of these will be repeated 3, 6, and 9 months later (see Appendix document for examples of questions that can be used, if acceptable to focus group and key informant interview participants). Other questions could be created and added. Motivation for screening and competence of management will be assessed using the Screening Self-Regulation questionnaire (autonomy motivation), Perceived Competence for Screening (competence motivation for screening), the Health Care Climate Questionnaire (HCCQ-need supportiveness), and perceived vitality questionnaire (Vitality), questionnaires already developed by Dr. Williams and colleagues (see Appendix for examples of these questions that have been validated). These mediators and outcomes and their change will form the elements of the SDT Model for Health Behavior for FH Screening (Figure 1). Questions regarding knowledge have been created and validated by the FH Foundation. Data from questions will be analyzed via construct means, range and standard deviations, correlations, t-tests, and multivariate regression. The sample size required to detect such changes in motivation with a two-sided test at the .05 level of significance and 80% power is 50 participants. Assuming a 12-15% dropout, a sample size of 50 patients is needed to detect the differences between intervention and control. Thus, the effect of the information integrated into eRecord will be assessed.

**Objective 3: Using this program, improve patient diagnosis by medical providers**

This objective will assess a critical goal of this project - to have both patients and their physicians carefully consider the issues surrounding a diagnosis and how they optimally communicate about the health implications. This is a primary mechanism with which the project team aims to support both patients and their primary care physicians. As Drs. Block and Williams make themselves available to be consulted officially via a formal referral as clinical lipidologists in the University of Rochester’s preventive cardiology unit and separately in a non-clinical way (given their roles as investigators) given their capacity as project leaders, this is also very supportive. Such consulting availability will be supportive given that primary care doctors do not have clinical lipidology expertise. For example, there are several criteria for an accurate
diagnosis to be made. Physical exam findings and family history can contribute to a diagnosis, and the screening of genetic family members of those diagnosed can be important considerations for clinicians who are not board-certified clinical lipidologists (as are Drs. Block and Williams).

The diagnosis of FH will be assessed at the time that each patient and their primary care physician are first officially provided with the MyChart educational/motivational program during the trial phase of the project. This diagnosis will be determined and then tracked longitudinally in the trial by assessing the specific listing of FH as a formal electronically-entered diagnosis in eRecord for each of these patients. Very importantly, it will also be assessed by asking patients and their providers if a diagnosis has been made, using a survey question, to account for any diagnosis coding inconsistencies in the EHR. This will be assessed at baseline and at 3, 6, and 9 months after participants and their primary care doctors have enrolled in the trial. This approach is designed to provide a supportive environment in which the patient-physician professional/decision-making relationship can be enhanced as mentioned above while not being burdensome. Longitudinally, diagnoses will be analyzed statistically (chi-square and t-test), with outcomes including number of those diagnosed, and whether or not there was a diagnosis.

**Objective 4: Motivate practitioners while enhancing their feelings of competence for managing FH effectively**

Each practitioner’s autonomy and competence motivations will be assessed during focus groups and/or key informant interviews they participate in. Any physicians who participate in the trial will have autonomy and competence motivations assessed for managing FH both before and 3, 6 and 9 months after exposure to the eRecord program. Examples of questions to be asked are in the Appendix and similar to those that apply to Objective 2. Physician motivation for screening will also be assessed at baseline, 3, 6, and 9 months. The survey and key informant interview data will be analyzed using the methods described in Objective 1 and the survey question data will be analyzed via construct means, range and standard deviations, correlations, t-tests, and multivariate regression, as described in Objective 2.

**Objective 5: Detect significant reduction in LDL-cholesterol over 9 months**

We plan to search eRecord for the highest recorded LDL-C for each patient to determine that they may have FH. That LDL-C could have been reduced by a variety of pharmacologic, apheresis, lifestyle factors considering that the ACC/AHA cholesterol guideline recommends high intensity statin for those age ≥21 with an LDL-C ≥190 mg/dL. Thus, it is difficult to estimate the mean LDL-C at baseline when the patient is first exposed to the program. Patient LDL-C levels will be measured at baseline, 3, 6, and 9 months thereafter. We estimate sample-size using feasible differences between the pre- and post-exposure LDL-C from baseline to 9 months taking into account increased awareness of risk with a potential increase in lipid-lowering drug(s) and/or apheresis, lifestyle. In the general population, knowing the effects of statin medication and, the mean and standard deviation of LDL-C at baseline being estimated as 174 mg/dl and 21 mg/dl we assume a 26% reduction in LDL-cholesterol due to medication. A sample size required to detect such a reduction with a two-sided test at the .01 level of
significance and 80% power is 44 participants. Assuming 12-15% dropout, a sample size of 50 patients is needed to detect this percent reduction. A t-test will be used.

**Innovation:** We have not found published articles describing results of any study in which an EHR has been used to directly identify, educate, and motivate individuals with FH after searching PubMed, Google Scholar, and by reviewing articles and references in articles focusing on the diagnosis and management of FH published in *Clinical Lipidology*, the official journal of the *National Lipid Association*. We also did not find any studies registered through Clinicaltrials.gov in which an EHR is being used for this purpose. The FH Foundation has founded a national registry. However, the registry does not integrate patient-level educational information into any EHR systematically. This project builds upon existing work. Dr. Block directs a PCORI-sponsored project where the overarching goal is forming a community of patients with FH and those with expertise in its appropriate diagnosis and treatment. Dr. Williams serves as a consultant for this project, is Dr. Block’s clinical preventive cardiology colleague, and a health psychologist. Dr. McIntosh is a formal co-director of the PCORI project and also a health psychologist. Christiane Rivard is Director of FIND FH for the FH Foundation, a formal PCORI-project partner, which is a national leader in the diagnosis and treatment of individuals with FH. Dr. Block is Principal Investigator for an ongoing research project sponsored by Kaneka Corporation in which the supportive nature of an LDL apheresis program is being investigated using the Self-Determination Theory as a theoretical framework. Combining the expertise of these team members with eRecord/CTSI resources is an innovative approach.

The program that is developed during this project will become publically available at no cost.

**Evaluation Design**
That only about 10% of patients with FH are diagnosed nationally is the gap this project will focus on. To overcome this gap, patients and physicians have their unique issues they need to consider in the path of making a correct diagnosis and then optimizing management. We do not yet know how FH information provided via an EHR affects this path, but we hypothesize that when developed by a partnership with patients and providers it will have a substantial beneficial effect (at least 10%, depending on the outcome). Elements of the Self-Determination Theory have been shown to predict improved health outcomes and, thus, form the theoretical framework for this project as they are within the path of human illnesses. Optimizing them is another gap this project focuses on. Survey questions that use this framework will be asked of patients and their primary care doctors during the trial to determine effects their participation had on their autonomous motivation, perceived competence, and knowledge. Given that these data will be collected after the program is integrated into eRecord, effects should be due to their interactions with it. Data collected during focus groups and key informant interviews will also be analyzed with a focus on closing the existing gaps for these issues.

We will publish resulting data in a peer-reviewed journal (targeting the *Journal of Clinical Lipidology*) and an abstract or oral podium presentation at a national scientific meeting (targeting the National Lipid Association). Dissemination of the resulting program will occur via connections the University of Rochester has with the national CTSI network, its formal
connections with other Upstate New York medical centers that use Epic via the UNYTE Translational Research Network https://www.urmc.rochester.edu/ctsi/unyte/ in which Dr. Block has a formal leadership role, and via our eRecord leadership’s connections directly with Epic Systems Company whose EHR holds 54% of US EHR medical records. We will also leverage the FH Foundation’s thought-leaders network to disseminate any program.

**Project Timeline and Deliverables.** This project’s timeline (Table 1) will apply for this study that will last for 24 months. Three main deliverables guide this project: the Interventions are developed and built using formative data; the trial is developed and implemented; and the information from the trial is analyzed, interpreted, and disseminated.

**Deliverable 1: EHR Build and Intervention Development.** While the project team members have ideas about the EHR intervention program (a MyChart template, decision-aids), the details need to be discussed and then tested with patients and physicians. Thus, the qualitative phase will begin immediately with concept and prototype discussion to refine and finalize the electronic interventions by month 10 of the project. Those involved in this discussion will be team leaders, the eRecord building team, patient and physician participants in focus groups and key informant interviews. Because the trial begins with a baseline prototype phase (no intervention via the program yet) that consists solely of assessment deployment, the builders will have until month 11 to finalize and integrate the program into the eRecord system. Dr. Block will oversee this process to ensure that appropriate scientific and inclusive methods are taken and that team meeting agendas have a focus on achieving this deliverable’s timeline.

**Deliverable 2: Trial Developed and Implemented.** The next focus of the project is the trial. Physicians will be recruited for this study (starting month 11). All patients within each of their practices meeting eligibility criteria within the 3 month window of recruitment will be approached electronically to obtain consent to participate. MyChart (the patient interface with eRecord and their physician) will be deployed with the autonomy, competence, health care climate, and vitality assessments (instruments to consented participants repeated at three month intervals throughout the project). The actual trial is expected to last for 12 months within the project period, with two months in the first quarter for additional planning and administrative procedures. Dr. Block will oversee the project manager to ensure that recruitment is successful and that team meeting agendas have a focus on achieving this deliverable’s timeline.

**Deliverable 3: Trial Evaluated and Disseminated.** Final analysis with manuscript generation and conference abstract submission (dissemination) will occur during the last 2 months. However, the project team will be conducting statistical analyses throughout the Deliverable 1 phase by transcribing audio recordings of focus groups and key informant interviews, coding the resulting information, discussing these results during team meetings, and to adapt communication during subsequent focus groups and key informant interviews. We will also be conducting evaluation activities from the start of the project period through: 1) the ongoing qualitative formative and process evaluation, 2) ongoing data and enrollment management and data quality reviews, and 3) anticipatory statistical analysis and analytic plan development.
## Table 1: Timeline

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<tr>
<th>Deliverable 1: EHR Build and Intervention Development</th>
<th>Month of Project</th>
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<td>IRB approval</td>
<td>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24</td>
</tr>
<tr>
<td>Meeting of all team members (monthly)</td>
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<tr>
<td>Deliverable 2: Trial Developed and Implemented</td>
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</tr>
<tr>
<td>Trial begins and ends</td>
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<tr>
<td>Patients of physicians recruited</td>
<td></td>
</tr>
<tr>
<td>Physicians recruited</td>
<td></td>
</tr>
<tr>
<td>Patient LDL cholesterol levels measured every 3 months</td>
<td></td>
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<tr>
<td>Deliverable 3: Trial Evaluated and Disseminated</td>
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</tr>
<tr>
<td>Qualitative and quantitative process evaluation</td>
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<tr>
<td>Data management and quality control</td>
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<td>Data analyses</td>
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<td>Conference presentation</td>
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<tr>
<td>Preparation of manuscripts</td>
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</table>
E. References (no page limit)


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