IMPLEMENTING AND EVALUATING TEAM-BASED COMPLEXITY CARE

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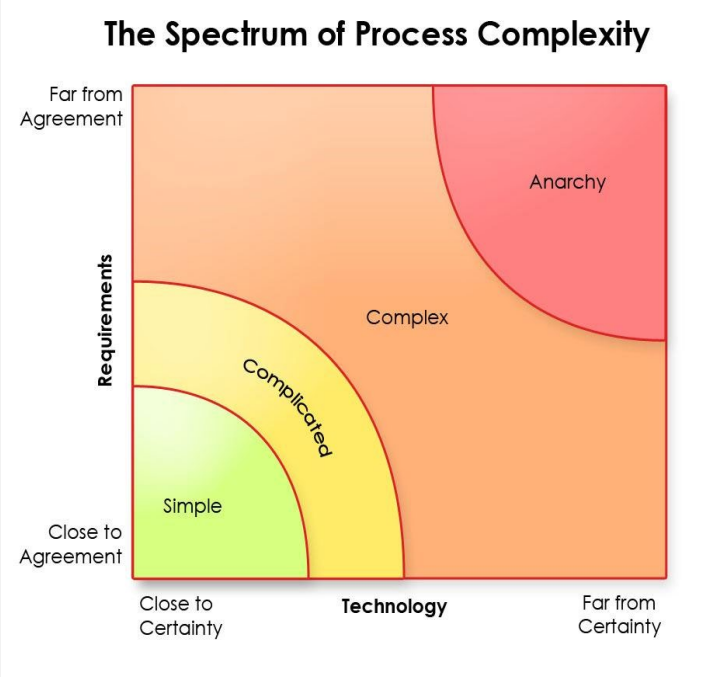
GOALS AND OBJECTIVES

1. WHAT: Learn about a definitions of complexity
2. WHO: Identify the team members . Identification of complex patient care.
3. HOW: Team-based structure, case review, and follow-up care.
4. QUALITY IMPROVEMENT: Evaluation of outcomes and team processes

WHAT IS COMPLEXITY CARE?

- Lacking a consistent consensus: "What makes patient care complex?"
- Limitations of complex care based on patient's multiple chronic conditions (e.g. Dartmouth model)
- Biases of provider's GUT feelings: (e.g. heart-sink patients)
- Complexity recognizes key challenges such as social or non-medical issues not easily amenable to current healthcare interventions (Risk Assessment Tools).



A COMPLEX ADAPTIVE SYSTEM: THE CYCLE OF COMPLEXITY*

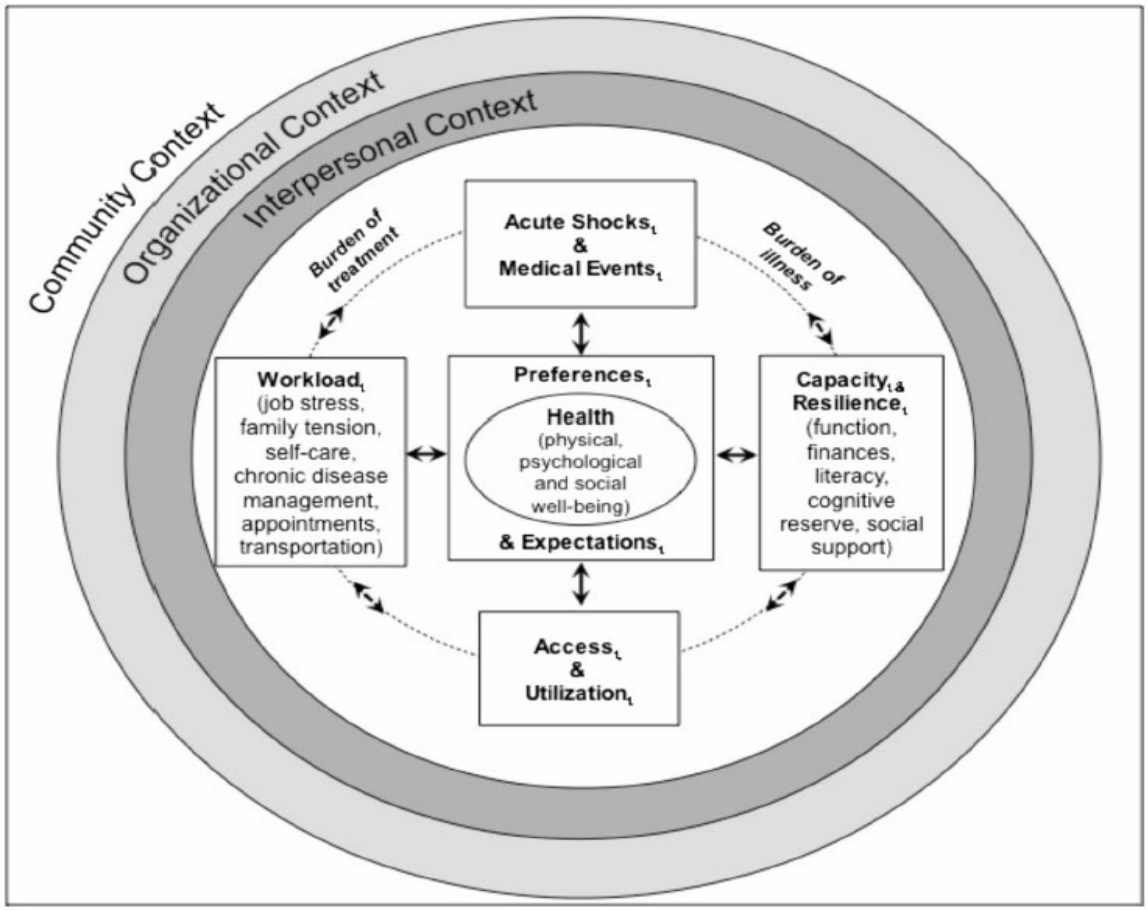


Figure 3 The Cycle of Complexity

WHAT IS COMPLEXITY CARE?

- Multiple methods of assessing complexity: standardized risk assessment, EMR based algorithms, PCP identification[1]
- 2 Recent RCTs evaluating programs to better serve complex patients:
  - Camden Coalition: 800 hospitalized patients in "hotspotting" care-transition program vs usual care did not decrease hospital readmission in 180 days after discharge[2]
  - CareMore: 253 high-need, high-cost Medicaid patients in a complex care management program vs usual care decreased total medical expenditure, inpatient bed days, inpatient admissions and specialist visits over 12 months[3]

Table 1. **Identifying Patient Complexity***

Complexity Domain	Definition
Medical decision making	The cognitive effort required to evaluate and understand the clinical processes and make the appropriate therapeutic decisions
Coordination of care	The work involved in overseeing and coordinating elements of care involving other providers, and the responsibility for making sure that the medical system is working for the patient
Patient's personal characteristics	The individual behaviors of the patient that increase the challenge of providing effective care (such as suboptimal adherence to medications or scheduled appointments)
Patient's diagnosed mental health issues	Psychiatric disorders distinct from the patient's characteristics that increase the complexity of care (including substance abuse)
Patient's socioeconomic circumstance	Influences outside of the medical sphere that increase the complexity of managing the patient (such as patient home or work responsibilities that interfere with self-management or patient inability to afford prescribed medications)

WHY ARE WE DOING THIS?

- Patients with complex needs require a multi-disciplinary, multi-pronged approach to meet their needs
- Care Conferences allow for coordination between team members to identify patients' needs and gaps in the system to meet their needs. It creates opportunities to strategize on how to meet those needs.
- Case Conferences should decrease the overall workload, not increase it
- Part of an overarching attention to optimizing practice management
- It is the right thing to do!

GOALS OF OUR COMPLEXITY CARE CONFERENCES

1. Identify patients with complex healthcare needs based on medical and social determinants of health
2. Implement a team structure to review, plan, and allocate team resources from complex patient care
3. Improve resident understanding of Complexity Care and Population Health and efficacy in implementing best practices
4. Evaluate resident learning, patient follow up, and healthcare teamwork

THE TEAM

- Family Medicine Residents and Attending Physicians
- County Care Care Managers
- County Care Nurse Managers
- Behavioral Health Consultants
- Health Educators and Health Promotion Team

WHO: PATIENT PANELS -EMR VARIABLES

Medical Complexity	System Fragmentation	Patient Engagement	Social Determinants
Number of Chronic Illness: DM, COPD, CAD, CHR, PVD, CRD, HTN, Obesity, HIV High risk Medications	Number of Referrals to Specialists ED visits Continuity of Care with PCP (e.g language parity) Insurance Type	Behavioral Health Substance Use Show rates Self-Management Goals	Housing, Health Justice Neighborhood, family safety Food security Transportation Financial security

THE PROCESS

- Complexity Desktop: Provider flagged patients
- CountyCare Standardized Health Risk Assessment
- ED utilization panel
- Merge

- Didactic on Panel Management and Population Health (30 minutes)
- Role Assignment: Scribe, Time-keeper, Facilitator
- Review of Patients: Biopsychosocial (50 minutes)
- Teamwork Feedback (10 minutes)

- Person-centered care plans
- Provider-staff assigned follow-up items

HOW: TEAM COLLABORATION COMMUNICATION

WHO

- RN Care Manager:
- Care Manager:
- BH Care Manager
- Behavioral Health Consultants (BHC)
- Family Medicine Resident Physicians
- PCPs

HOW

- Flags in EMR
- E-mails
- Phone calls
- Warm hand-offs in clinic
- Monthly CC team meetings
- Team Review Sessions

HOW: TEAM MEETING STRUCTURE

1. Introduction to Complexity
   - Models
   - Erie's Initiatives
2. Roles: Scribe, Time-keeper, Facilitator
3. Review of Patients
   - Medical, System fragmentation, Patient engagement, Social
   - Construct Plan and Document
4. Review the Teamwork
   - Team process
   - Follow-up

	Barriers	Assets
Medical Complexity	Diffuse, vague, ill-defined symptoms medications-side effects, interactions, risks and benefits.	Health history Family history Treatment
System Fragmentation	Discontinuity Specialty Referrals and follow-up Self-pay	Continuity of care with Providers EMR shared data base Insurance coverage
Patient Engagement	Substance Use, Mental or Physical Disability ACE, Isolation Burden of Being a Patient:	Family and Social Supports Resiliency Spirituality
Social Determinants	Housing, Transportation, Safety	Access to Community resources

TEAM CASE REVIEW: JR

	Barriers	Assets
Medical	Chronic Pain, multiple medications, undifferentiated dx-fatigue, sleeplessness, falls	Young Adult -27 yo
System Fragmentation	multiple ED visits discontinuity between medical and psychiatric tx	No ER visits in past month Access to Care CC
Patient Engagement	Multiple No Shows Family Stressors/DCFS Substance Use Disorder	Bursts of engagement
Social Determinants	No transportation	Citizen

TEAM PLANS AND FOLLOW-UP CONTINUED

	Discussion	Plan
Medical	unclear etiology of falls and sleepiness, pain	comprehensive, coordinated evaluation
System Fragmentation	Used different portals to coordinate information. DCFS goals	Appt with PCP, Psychiatry Referrals to PT/OP
Patient Engagement	harm reduction options for SUD	Medication Reminders Harm reduction education, resources
Social Determinants	financial, child care and housing stressors	Care manager resources for job and housing

QUALITY IMPROVEMENT PLAN: MEASUREMENTS

	Patient Outcomes
Medical	Health Status; Risk Assessments
System	ED utilization, PCP follow-up
Patient Engagement	BH, Health Educator
Social Determinants	Health Promotion, Care Manager contacts

- Team communication
  - Survey on quality of teamwork
  - Team communications (e.g. flags, e-mails, hand-offs)
  - Follow through with plans

2019-2020 PARTICIPATION GOALS

6 Sessions/year

Participants

10-12 Residents

1 CC RN Manager and CC Care Manager

2-3 Attending Physicians

2-4 case reviews per session

PROCESS MEASURES

5 Conferences

10 patients

Average Patient

# of diagnoses: 21

Age: 44

in the past year

- Erie providers seen: 4.6
- Behavioral Health Visits: 8.4
- Health Education Visits: 1.7
- Care Management Touchpoints: 8.4

RESIDENT EVALUATION: COMPLEXITY CARE KNOWLEDGE AND EFFICACY

	Pre-Evaluation	Post-Evaluation
How confident do you feel in identifying and understanding complex patient care?	3.2	3.75
How confident do you feel in managing care for complex patients in an outpatient primary care setting?	3.1	3.5
How confident are you in collaborating with other team members and services at Erie in your workflow?	2.9	3.7

All questions with Likert scale 1 (Not at All) to 5 (Extremely)

n = 16 compiled over 4 complexity care conferences

RESIDENT EVALUATION: TEAMWORK SURVEY

Question	Likert Scale 1-5
All team members are encouraged to share ideas.	4.3
Facilitators on this team create an environment where things can be accomplished.	4.3
The team has the information and the members it needs to do its job well.	4.2
All team members are able to contribute clinical services tasks that match their abilities and credentials (working at the top of their license).	3.9
Review and discussion of patient care has an effect on the quality of care.	4.2
Resident physicians gain knowledge and skills in managing complex patient populations.	4.2
Resident physicians can coordinate with their interdisciplinary team to strategize, follow-up and proactively manage their panel.	4.2

n = 16 compiled over 4
complexity care conferences

QUALITATIVE EVALUATIONS

- "Other eyes" are helpful
- Opportunity for applied learning of team-based care process
- Excellent team structure, flow and facilitation
- Efficient, high yield
- I think this was a fabulous way to really engage the healthcare team to jointly and comfortably collaborate in real time to help patients get the multidisciplinary comprehensive care they need. Thank you!

QUALITATIVE EVALUATIONS

- Create a "Next Steps" list for each patient at the end of the review for team
- Residents should review patients ahead of time
- Assign separate roles: facilitator, scribe, and time-keeper
- Include informational introduction to care management for interns. Review for current residents
- Include more attendings, behavioral health, RNs, MAs
- Very helpful - I wish we had more frequent and smaller versions of it Like if we could meet regularly before clinic sessions it would be so awesome to help prep, or like maybe for complex patients that are coming in the next week.

DISCUSSION

- Successfully implemented a complexity care curriculum within the Erie HP longitudinal curriculum
- Process measures: overall will meet expected goals by the end of the year
  - Still only reviewing 2 cases per conference
- Resident Knowledge and Efficacy
  - Very limited data to this point
  - Data available show increase in the 3 chosen measures, so trending well
- Teamwork
  - Teamwork questions with relatively high ratings (3.9-4.3)
  - Limited data
- Limitations
  - Low number of respondents
  - Repeat subjects: residents attend multiple sessions

QUESTIONS AND SUGGESTIONS