Session # A5

Harmonizing Clinical, Research, and Teaching Aims: Team Care for Patients with Complex Needs

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

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Learning Objectives

At the conclusion of this session, the participants will be able to:

1. Describe a team-based approach to addressing complex patients' needs.
2. Develop engaged and experiential methods for teaching interprofessional learners about team-care for complex patients.
3. Demonstrate familiarity with an evaluation strategy and preliminary outcomes data for a team approach for complex patients.

Harmonizing

- Team-based approaches accelerating in use (clinical care)

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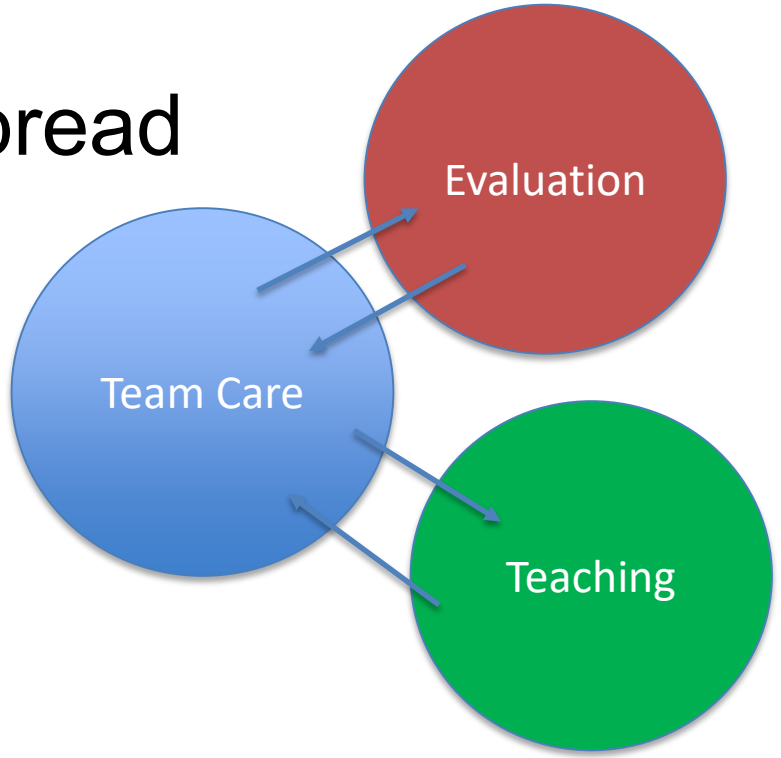
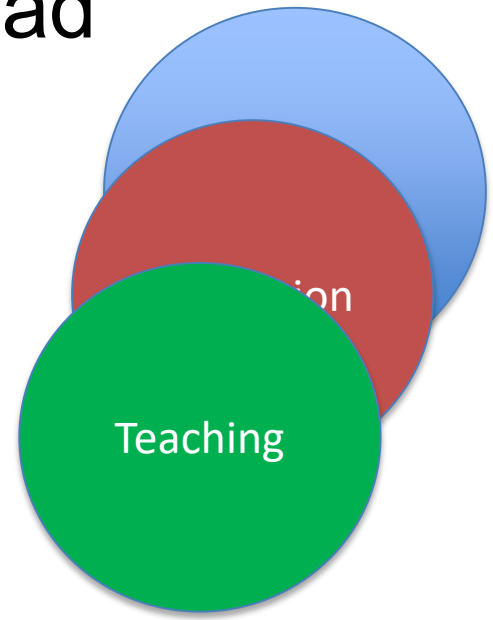
- Opportunities to share/spread innovations (research and teaching)



Peek, C.J., Cohen, D.J.,& DeGruy, F.J. (2014). Research and evaluation in the transformation of primary care. American Psychological Association, 69(4), 430 – 442.

Harmonizing

- Team-based approaches accelerating in use (clinical care)
- Opportunities to share/spread innovations (research and teaching)
- Efficiency in harmonizing those efforts



Team Based Approach to Patients with Complex Health and Social Health Needs

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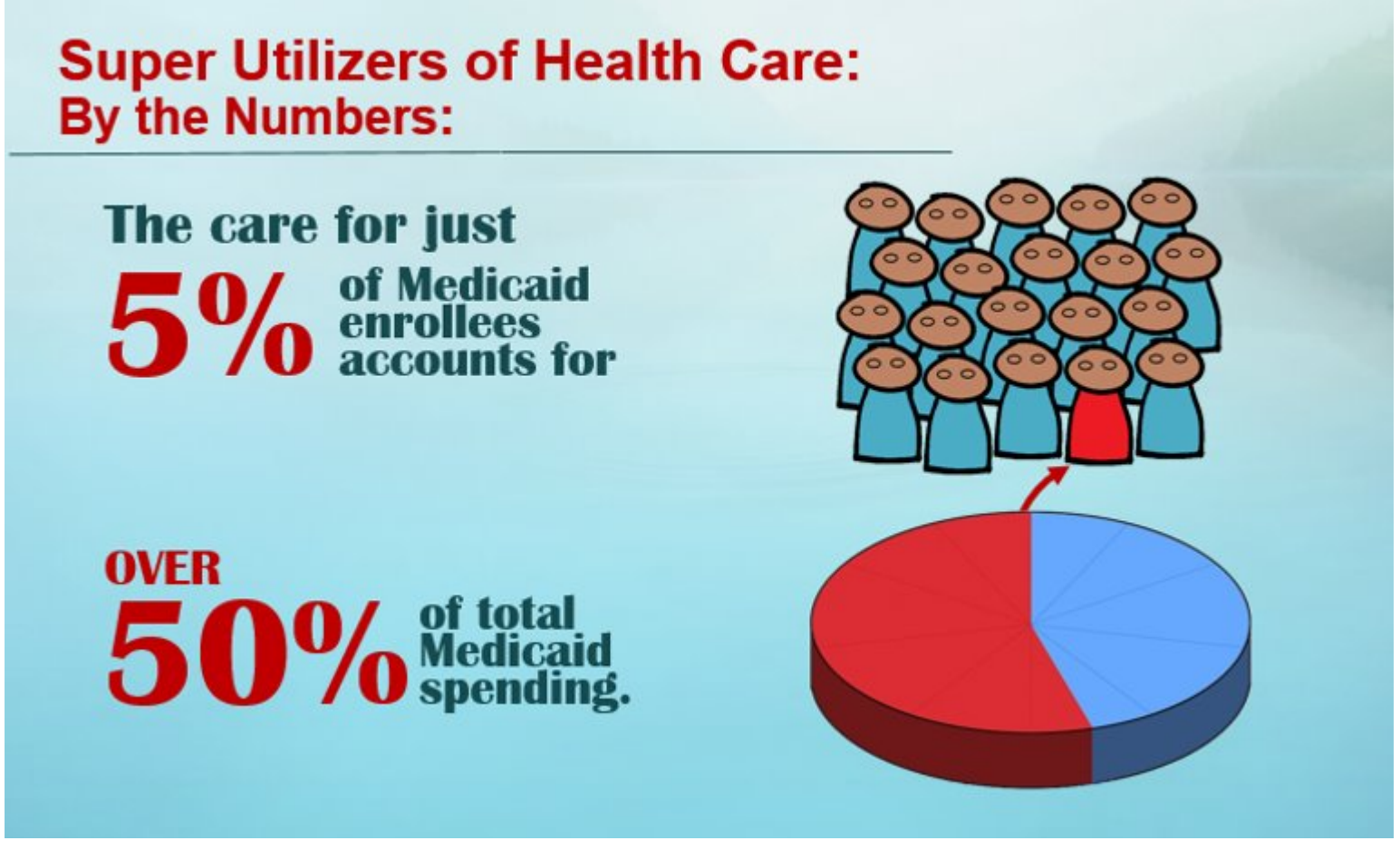
Patients with Complex Health and Social Health Needs

- Multiple chronic medical conditions
- Social support/determinants needs
- Polypharmacy
- Poor health-related behaviors
- Limited treatment recommendation adherence
- Multiple hospitalizations
- Guarded to poor prognosis without significant intervention

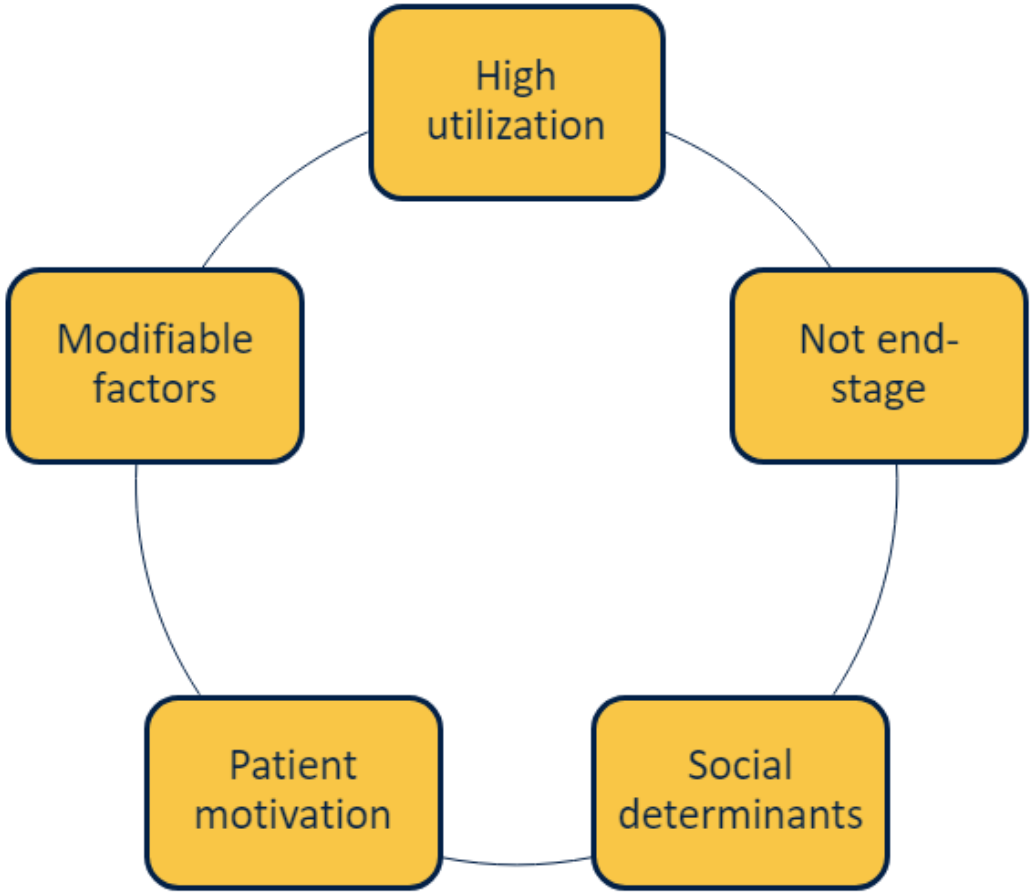
Patients with Complex Health and Social Health Needs



Effect of Complex Needs on Quality of Life

Enter… The Team

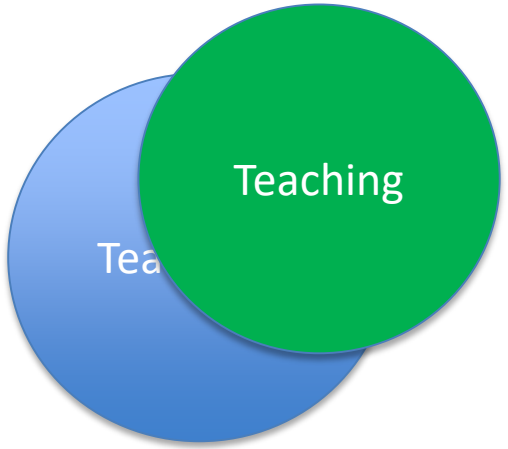
Identifying Patients



Enhanced Care Treatment Approach

- Screening
- Pre-visit interprofessional huddle
- Interprofessional clinic visit (all members)
- Goal setting
- Follow-up (phone, visits)
- Registry
- Monthly collaborative team meetings

Teaching Activity



Activity

- Anticipate barriers and potential solutions to implementation of an interprofessional team-care approach

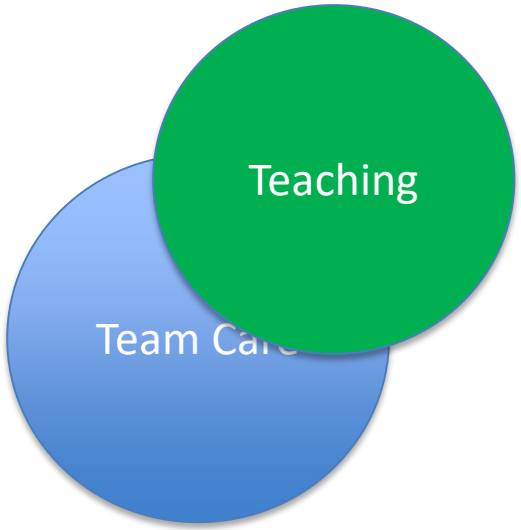
Enhanced Care Treatment Approach

- Screening
- Pre-visit interprofessional huddle
- Interprofessional clinic visit (all members)
- Goal setting
- Follow-up
  - Phone
  - Visits
- Registry
- Monthly collaborative team meetings

Challenges and Solutions

Barriers and Opportunities

Harmonizing Teaching



Harmonizing Teaching

Learning In Vivo

- Medical residents/students
- Pharmacy residents/students
- Behavioral health:
  - Psychology externs
  - MSW students
  - Counseling students

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Harmonizing Teaching

Learning in Didactics

- Third Year Medical Students
- New Residents and Students (across disciplines)
- New Faculty

Institutional Teaching: IPE Grand Rounds

First IPE Grand Rounds audience comprised of:

- The VP for Health Sciences and the Dean of Quillen COM
- Faculty and residents from Family Medicine and Pediatrics
- Faculty and students from the College of Medicine
- Faculty and students from the College of Pharmacy
- Faculty and students from Psychology
- Faculty and students from the College of Clinical and Rehabilitative Sciences
- Faculty from the College of Nursing
- Faculty and students from the College of Public Health

Harmonizing Evaluation

Hospitalizations

8

hospitalizations in 2016-2017

- Unhealthy diet
- Complex social determinants
- Medication non-adherence

56 Total Medication Bottles

Patient Example

HPI

- 50-year-old white male
- CC: establishment with the enhanced care team.
- Fluctuations in blood sugar, weakness, persistent SOB, and occasional chest pain, which is relieved with nitroglycerin.
- Patient goal: lose weight.
    - Currently eating two large plates of carb-heavy foods for three meals per day.
- Personal stressors at home (social and financial)
- Hospitalized eight times in the past two years

Specialists on Board

- Allergy/Immunology
- Cardiology
- Endocrinology
- Family Medicine
- Infectious disease
- Orthopedic surgery
- Ophthalmology
- Podiatry

PMH

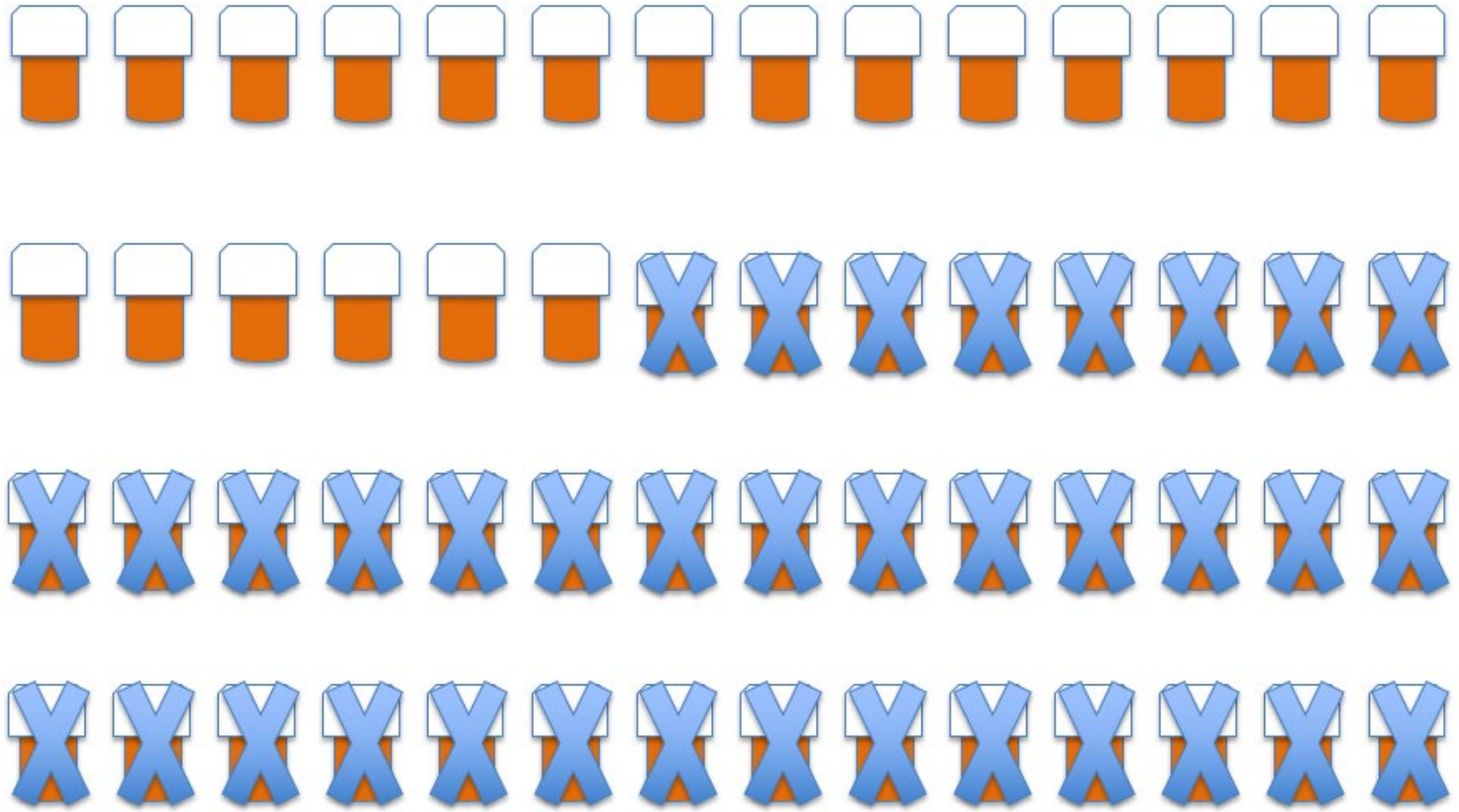
Angina pectoris
Anxiety/Depression
Coronary artery disease s/p stent x10 and CABG
Cardiomyopathy
COPD
Heart failure with preserved ejection fraction
Chronic urinary retention with self- catheterization
Hyperlipidemia
Hyperparathyroidism
Hypertension
Insomnia
Type 2 diabetes mellitus
Albuminuria
Obstructive sleep apnea

Patient Example

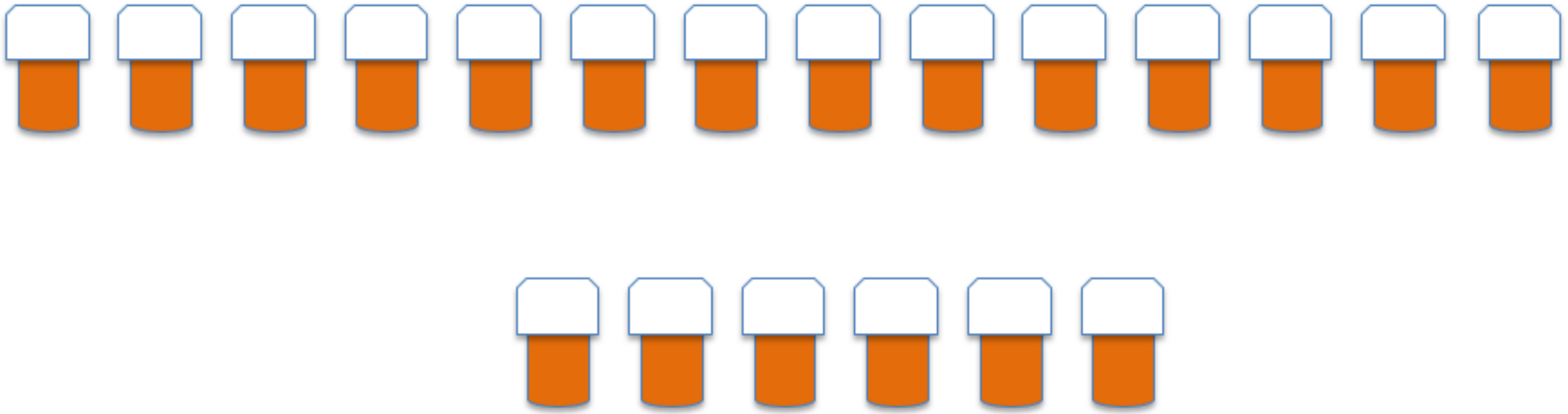
- Send home with only medications patient should take
- Calorie counting with My Fitness Pal app
- Patient to attend health coaching/healthy living support group
- Plan to adjust medications at future visits – to see pharmacist each week after health coaching
- Meetings with behavioral health consultants to improve coping
- Tracking visits/goals in registry

Total Number of Med Bottles = 56

Decreased Number of Medications by 36



Result 20 medications vs 56



Hospitalizations

8

hospitalizations in 2016-2017

- Unhealthy diet
- Complex social determinants
- Medication non-adherence

ZERO

hospitalizations in 2018!!

- Healthier diet and 30 lbs lost!
- Stable home situation
- Adherent to meds

Improved Quality of Life

Harmonizing Evaluation

- Strong Quality Improvement Process
- Clinical Intervention based on literature
- Baked measures into clinical process

Harmonizing Evaluation

- Pre/Post Measures
  - ED/hospital visits
  - Patient Centered Assessment Method (PCAM)
  - Patient Activation Measure (PAM)
  - Patient Health Status (SF-36)
- Process Measures
  - Sessions
  - Types of visits
  - Goals

PCAM

Health and Well-being			
None 1	Mild/vague but no impact 5	Moderate to severe 12	Severe needs with significant impact 6
Social Environment			
None 0	Some inconsistency and dissatisfaction 1	Some concerns about safety, security, and restrictions 17	Unsafe, unstable environment with significant impact on mood and social functioning 3
Health Literacy and Communication			
None 2	Good communication but with barriers 6	Difficulties with communication 3	Serious difficulties 1
Service Coordination			
None 0	Services in place 2	Gaps in care 8	Significant fragmentation and missing care 2

Patient Visits

- Number of visits per patient:

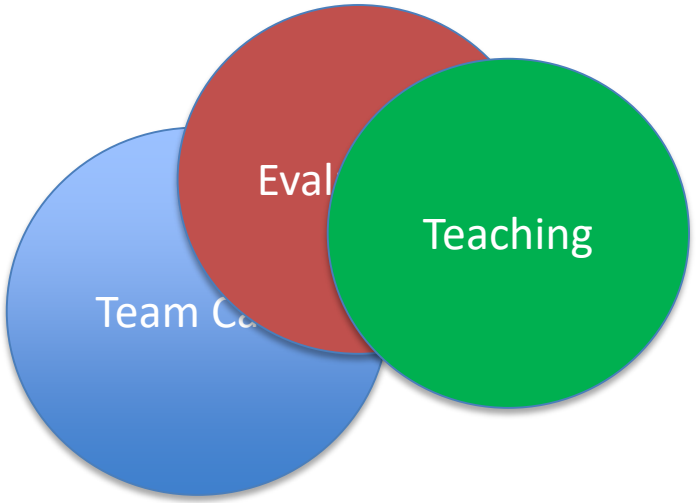
  Range: 1-21; Average: 13

Patient Goals

- Actively participate in care/goals and will attend all appointments
- Put self first, example: spa days twice a week
- Increase social activities
- Apply for resources-gas voucher and utility assistance
- Meet with BH at every visit
- Stop drinking
- Healthier food choices and increase energy-eat more veggies
- Increase energy-be able to play with grandchildren and go fishing
- I will keep all of my appointments-recording in planner.
- Increase social interaction by visiting friends
- Increase food supply by utilizing food pantries in area
- Increase socialization; get more comfortable getting out and going places alone
- Patient willing for additional assistance within home, apply for Choices
- Home visit to be done and meds to be limited and reviewed for better understanding.
- Manage DM better
- Manage Pain

Presentations

- Williams, S., Tewell, R., Wykoff, M. Holt, J., & Polaha, J., (October, 2019). Harmonizing clinical, teaching, & research aims: Team care for complex patients. Presentation accepted to the annual conference of the Collaborative Family Healthcare Association. Denver, Colorado.
- Williams, A., Holt, J., Wykoff, M., Metzger, K., Tewell, R., (January, 2019). IPE Grand Rounds Presentation. East Tennessee State University. Johnson City, TN.
- Buselmeier, B., Highsmith, M., Gilreath, J., Porambo, M., Smith, C, & Polaha, J. (December, 2018). *A team approach to patients with complex health and social needs in primary care.* Paper presented at the Society for Teachers of Family Medicine Practice Improvement Conference. Tampa, FL.



Questions

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Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

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Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

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6. Sunderji, N. (2018). A vision for the future of *Families, Systems, & Health*: Focusing on science at the point of care delivery. *Families, Systems, & Health, 36(4),* 423-426.

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