

# Interdisciplinary Approach to Complex Patient Care

McKenzie C. Highsmith\*\*†, PharmD, BC-ADM, William Buselmeier†, MD, Jesse Gilreath, DSW, LCSW†, Jodi Polaha, PhD†  
\*Gatton College of Pharmacy; †Quillen College of Medicine; East Tennessee State University

Since the implementation of the Affordable Care Act in 2010, the number of patients previously uninsured or under insured has declined significantly. The U.S. healthcare system remains largely fragmented, inefficient and largely not cost-effective. With the influx of patients entering the system, there is an increasingly critical need for coordination of care, especially for patients with multiple chronic conditions and increased complexity.

We aim to describe one practice's quality improvement efforts to increase the quality of care for complex patients, many with a combination of multiple chronic conditions, polypharmacy, social and behavioral health needs and multiple providers involved in their care.

The **Champion Team (CT) Model** is an evidence-based process of engaging various members of the healthcare team to address a quality initiative or need. The Champion Team Model was utilized to involve an interprofessional team in creating a process to improve the care provided to complex patients. Professions represented include pharmacy, medicine, behavioral health, nursing and administrative staff. As an interprofessional approach was already being utilized in an **interprofessional transitions of care (IPTC) clinic**, the creation of a dedicated complex patient clinic, later named "**VIP clinic**", had a strong foundation to be built upon. This clinic provides time and resources to high risk, complex patients from an interdisciplinary team. A third interdisciplinary clinic, **Medication Management clinic**, is also utilized for complex patients to participate in, specifically if they have a complicated medication regimen. For patients that may not need an interprofessional clinic, but could benefit from **case management**, a patient health manager is also able to provide that service.

## VIP Clinic

- True team-based care
  - Intake home visit (PHM and LCSW)
  - Team huddle to review goals
  - Report from each team member
  - Patient interviewed by whole team
  - Plan development and education includes entire team
- Patient graduates from VIP clinic when all pre-specified goals met or team agrees the patient has received maximum benefit.
- Emphasizes successful care models

## Medication Management Clinic

- Interprofessional team model
  - PharmD
  - MD/DO
- Half day clinic, every other week
- Appropriate patients referred
  - Polypharmacy
  - Several chronic diseases or treatment resistance

Patients are identified as "complex" by risk scoring analysis and also by the patient's primary care physician. The patient is then screened by a patient health manager to determine if they meet criteria for VIP Clinic or if another program or service will best fit their needs. The interprofessional team then gives input and the patient is contacted. Choice to participate in any interprofessional program is ultimately the patient's choice. If they choose to proceed with enrolling in the VIP Clinic, a home visit is conducted by the patient health manager and licensed clinical social worker. At this visit, they complete a Patient Centered Assessment Method (PCAM) to help identify needs, patient perceptions, barriers and goals.

The IPTC clinic, VIP clinic and Medication Management clinic function as three tools available to the interprofessional healthcare providers in a residency teaching practice.