James L. Holly, M.D.

SETMA and the Robert Wood Johnson Foundation LEAP Program

We have good news. The Robert Wood Johnson would like to use our LEAP webinars as raw material for blog posts on their website (see http://www.rwjf.org/en/blogs/human-capital-blog.html for where they will be posted).

We are now working on the "**Models of Complex Care Management**" webinar that you presented, and wanted to run the draft prepared by their communication partner by you to see if you see anything that needs changing. Please review the attached draft and let us know by July 18th if changes need to be made. Thanks very much! Sarah and the LEAP team.

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Team-Based Interdisciplinary Care

The Robert Wood Johnson Foundation's (RWJF) **LEAP National Program** is working to create a culture of health by discovering, documenting, and sharing innovations in the primary care workforce. To advance this goal, the program is holding a series of six webinars that highlight best practices. (Read a post summarizing the first of the six webinars.)The second of the webinars in the series focused on team-based care for complex cases. Presenters included leaders from four primary care sites around the country that the LEAP program has deemed exemplars.

Managing Care for the Most Complex Patients

Kathy Bragdon, RN, director of care management at Penobscot Community Health Center in Bangor, Maine, discussed the rapid growth of the health center, and went on to describe its system of care management for the most complex patients.

The center relies on a transitions care manager, who shares information back and forth with the hospital and with patients' medical homes. In addition, the manager meets with patients when they are in the hospital, looking to identify potential barriers to recovery and to provide any needed referrals.

"One of the big roles—we didn't realize how big—was that a tremendous number of patients had no primary care at the time of admission," she said. "We worked really closely with the hospitals trying to provide those services and make that linkage to those patients who needed primary care providers."

Bragdon explained that the center's biggest initiative was to embed care management at its larger facilities, using nurses, medical assistants, health coaches and social workers focused on improving patients' self-management skills, thus reducing the number of hospitalizations and readmissions, and improving the overall quality of care. The initiative is built around face-to-face visits, as well as phone calls with a focus on hospital follow-up. They try to reach every patient within 72 hours after they've been discharged from acute care.

Finally, the center uses a community care team (CCT) to work on its most complex cases. In addition to the supports provided via embedded care management, the CCT conducts a team visit that includes both a social worker and a nurse, meeting the patient where it is convenient for them—at a doughnut shop, a homeless shelter, or wherever else makes sense. "We do this because the RN and the social worker look at the situation through very different eyes in trying to see what is driving that person to the emergency room," she explained, adding that the effort is "focused on the highest utilizers of health care dollars."

The cost savings generated by the CCT program are significant, she said, cutting costs to the state in half.

The Integrated Care Team

From Daughters of Charity Health Centers in New Orleans, Roslyn Arnaud, [RN?], chief nursing officer, and Grace Mena, [RN?], [title] discussed the center's Integrated Care Team. Arnaud began by sketching out the members of the team. They include:

- *An RN Care Manager*, who identifies patients who are not being treated appropriately by a primary care provider, generally at-risk patients with comorbidities. The nurses respond to patients from local safety net hospitals and provide intense follow-up support for them after discharge. They help patients understand what took place and make sure they have medications, and they handle medications reconciliation.
- *A Patient Care Coordinator*, who provides administrative support, including making appointments for patients for services the Health Center does not have provide onsite. Coordinators also make sure patients know about their appointments and work to ensure that they go. They also ensure that preventive care is completed, including mammograms, colonoscopies, pap smears, and other cancer-tracking.
- *A Behavior Health Social Worker,* who serve as a consultant to the patient, helping them identify the need for change, and establishing goals that are appropriate for that patient.

The team members also collaborate with a local university to arrange for the services of a clinical pharmacist and a certified asthma educator.

Mena explained that the center is now testing a team model with a different composition, bringing together a physician, nurse practitioner, medical assistant and care coordinator, with social workers also available for patients. She noted that the nurse practitioner provides patients education and patient engagement. “The key part of this work is communication between the nurse practitioner and RN care manager,” she said.

Continuity and Coordination of Care for Complex Patients

Larry Holly, MD, CEO of Southeast Texas Medical Associates, then discussed his six-site clinic’s efforts to care for complex patients as they transition from one setting to another.

He said that the care transition process begins at hospital admission, when the patient receives a care plan to transition from the ambulatory to in-patient setting. Then, at the end of their hospital care, the patient receives materials that detail necessary follow-up appointments and include a medication reconciliation plan. Associates follow that up with a “care coaching call,” and then the patient completes the process with a follow-up appointment at the clinic.

Associates also uses a Hospital Consumer Assessment Health Care Provider and Systems audit that assesses whether the care provided has been patient-centered and of sufficient quality. It asks whether the physician explained the care plan, answered all of patient’s questions without interrupting, inquired about whether care at home was adequate, and wrote down what potential symptoms would necessitate a return to the hospital. The clinic reviews results of the assessment with the hospital.

Associates also features a Care Coordination Department that identifies and tries to overcome barriers to care, Holly explained. So if patients lack transportation to appointments, can’t afford their medication, or are in need of dental care, the patient is referred to other resources.

Said Holly: “This system has integrated a number of complex problems that have befuddled physicians for years. Now we can easily provide those in the context of continuity of care and transitions of care for complex patients. These are critical parts of a medical home.”

Expanding the Team for Complex Cases

Craig Robinson, MPH, executive director of Cabin Creek Health Systems (CCHS), and Amber Crist, MS, CCHS director of education and program development described their efforts to treat patients with chronic pain using interdisciplinary teams.

CCHS has four sites in rural southern West Virginia, Robinson and Crist explained. The program began with an effort to identify older, frail patients in the area in need of care focused on reducing pain from chronic conditions.

“We quickly realized [such patients] increase the complexity of our system,” Crist said, going on to explain that the system needed to adapt. “We needed to expand our clinical team. It couldn’t just be the medical provider. Accordingly, the team grew to include the MD, a nurse practitioner,

a physician assistant, a medical assistant, a behavioral health coach, a pharmacist, a health coach, and administrators."

"If we can keep these patients out of the hospital, we save the system money. That's where the suffering, is and that's also what's sometimes burning our staff out," she said. "Our providers feel alone in the room. [Otherwise,] they feel they don't have anyone else to turn to and are alone dealing with these complex patients."

The RWJF Human Capital Blog will report on future LEAP webinars in coming weeks.