

Complexity in Primary Care: Evaluation of Team-Based Complexity Care

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Abstract:

Providing effective care to complex patients within primary care is a critical component of a healthcare system that addresses the goals of the quadruple aims. Yet, teams struggle to effectively identify and manage these patients. While there are a variety of models of complexity that incorporate social determinant of health into biopsychosocial models of complexity, few of these models have been adapted to educational and service oriented goals of a primary care residency clinic.

Goals: The purpose of this study is to evaluate the team process and patient outcomes of a residency specific-complexity care initiative. We will describe the structure, process, resources and evaluation of a bimonthly multidisciplinary case conference in a Family Medicine residency clinic. This clinic incorporates foundational concepts from population health and complexity care to both improve care for complex patients and increase resident knowledge of and ability to identify and care for complex patients. We will also evaluate the team process and the patient outcomes.

Design: This is a quality improvement project—PDSA design.

Participants: The complexity care team participants will include 8-16 R2 and R3 Family Medicine residents, 2-3 Family Medicine attendings, 1-2 nurses, 1-2 medical assistants, 1-2 behavioral health providers, and 1-2 care managers.

Measurements: Teamwork survey; patient characteristics and outcomes, including number of diagnoses, number of providers, number of behavioral health visits, number of health education visits, number of care management touch points, number of ED visits, and age.

Protocol: Our protocol includes bi-monthly multidisciplinary case conference review for patients who have been identified from MHN's (Medical Home Network) ED patient visit algorithm and provider identified complex patients. During each session, the multiprofessional team reviews complex patient issues (medical, systems, and social determinant), barriers, and assets. The team then creates and documents strategies to address those issues through coordinated treatment plans.

Results: We will generate process improvement measures on the number of conferences, team attendance, quality of team communication, and resident confidence in caring for complex patients in a team based setting. We will also describe patient characteristics and outcomes (including number of diagnoses, number of providers, number of behavioral health visits, number of health education visits, number of care management touch points, number of ED visits, and age). We will focus on analyzing teamwork responses, describing characteristics of reviewed patient care, and identify structural and systemic obstacles in implementing this model. The results will help identify the organizational structures, team communication and patient care strategies and recommendations that support complexity care initiatives in medical residencies.