Implementing Project ECHO Complex Care Management: Using Technology to Support Primary Care Nurses

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**Problem Statement:**

Patients continue to increase in complexity, requiring significant support, education, coaching, coordination, and care management to achieve an improved health status and ultimately self-management. Primary care nurses are key players in caring for patients, but they need ongoing support to:

- Expand their role to include complex care management
- Enhance their content knowledge
- Enhance their leadership identity within the overall care team
- Improve collaboration among both internal and external health care team members

**Abstract:**

Project ECHO® is a telehealth model of knowledge transfer that connects expert faculty teams with primary care providers. The primary goal of Project ECHO is to improve health care outcomes through case-based learning. It aims to do so by equipping participants with the knowledge and skills needed to care for unique patient populations. While there are several established Project ECHOs specifically addressing the knowledge needs of primary care providers, Project ECHO Complex Care Management (ECCM) is one of the first specifically targeting primary care nurses. It is uniquely designed to build nurse leadership and to directly support nurses as they engage in complex care management. A faculty team of multidisciplinary specialists advise the nurses on how to manage their patients with complex medical, psychiatric, and behavioral issues.

As part of a larger complex care management initiative at the Community Health Center, Inc. (CHC), Project ECHO Complex Care Management (ECCM) was uniquely designed to build nurse leadership skills and experience. The CHC is a one agency with 14 different integrated patient-centered primary care sites across the state of Connecticut. These sites provided care for uninsured and underserved patients. The CHC translated the proven concept design using the Knowledge-to-Action framework to a model centered on nurses. Through twice-monthly didactic and case presentations, nurses from all over CHC’s 14 sites have encountered and learned from CHC’s most complex patients. The faculty team is made up of a nurse practitioner and Chief Nursing Officer, a medical provider, behavioral health provider, pharmacist, registered dietitian, certified diabetes educator, care management specialist, and home-care nurse. The first thirty minutes of a session are focused on didactic education, and the latter fifteen hours on case presentations by nurses. A standard presentation format was designed to support nurses in organizing the case information as well as the questions they are requesting the faculty to address. Through videoconferencing and case-based learning, the faculty lends real-time support and supports nurses as they address the needs of their complex patients. Nurses are empowered to practice to the top of their license and provide patients with high quality, low-cost care. Through case presentations nurses learn valuable care management skills and gain the confidence to develop their roles as leaders on health care teams.

Project ECHO® Complex Care Management: develops nurses and leaders in care management in the primary care setting. It is an effective tool in training both new and experienced nurses as they transition into primary care roles that include a significant amount of care management. Project ECHO® Complex Care Management is an important platform for improving nurse knowledge and self-efficacy and connects every nurse throughout the CHC on a regular basis. It provides them with the chance to learn from one another, creating a knowledge network, and a stronger team dynamic. This technology has the potential to connect nurses without regard to geography, linking teams together to learn from each other, and to share best practices.

Operational data from Project ECHO® Complex Care Management demonstrates the impact through case analyses, and also general metrics of the % of nurses who have presented, as well as the number of continuing nurse education credits granted. As of June 2015, 77% of the nurses who have presented (n=35) have presented with CHC and nurses at CHC were also presented at least one case and 1 nurse having presented ten cases. This number will continue to rise and more and more nurses are likely to follow in this trend in the coming year. Topics covered in the didactic portion of Project ECHO® Complex Care Management have included chronic pain, substance abuse, diabetes, asthma, COPD, self-management goal setting, motivational interviewing, and even medical nutrition therapy to name a few. This poster will be updated with the most current operational data to better describe the overall impact and global implications for Project ECHO® Complex Care Management.

**Project ECHO Origins:**

“The mission of Project ECHO is to develop the capacity to safely and effectively treat chronic, common, and complex diseases in rural and underserved areas and to monitor outcomes.”

—Dr. Sanjeev Arora, University of New Mexico

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**The Project ECHO Model:**

**Benefits:**

- Increased knowledge and confidence to manage complex chronic conditions in primary care
- Increased patient access to evidence-based treatments
- Increased provider satisfaction and retention
- Reduction in unnecessary imaging and other laboratory services
- Reduction in overuse/ misuse of specialty, surgical, and procedural services
- Reduction in inappropriate medication usage

**Common Challenges:**

- Overcoming cultural barriers
- Dealing with patient’s families
- Connecting patients with community resources
- Medication adherence
- Non-compliance with care
- High ER utilization
- Managing transition to new PCP
- High utilization of primary care

**Knowledge-to-Action Framework:**

1. **Pack ECHO® Central to Community Health Centers:**
   - Build and expand Nurse Facilitator Program
   - Develop and implement Community Health Center (CHC) Strategic Plan
   - Develop and implement Community Health Center (CHC) Continuous Quality Improvement Plan

2. **Package ECHO® to CHC Partners:**
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3. **Package ECHO® to CHC Providers:**
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**References:**


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**Project ECHO CCM Satisfaction Scores**

**Question:** How meaningful was today’s Project ECHO CCM session to you?

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<th>2 = Slightly</th>
<th>3 = Moderately</th>
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**Project ECHO CCM Didactic Topics**

**Common Challenges: Complex Care Management**

- Hypertension management
- Obesity management
- Diabetes management
- INR/Coumadin management
- Chronic disease self-management
- Co-management of chronic disease and behavioral health
- Behavioral health management and support
- Substance abuse

**Project ECHO CCM Common Medical Diagnoses**

**Common Challenges: Chronic Disease Management**

- Insomnia
- GERD
- Asthma Management and Medications
- Heart Failure Basics and the Role of Cardiac Rehab
- Asthma Management—Part 2
- Buprenorphine
- Homecare Overview
- Acute Care Management
- Complex Pain Care in a Community Health Center
- Health Information Technology for Complex Care Management
- Motivational Interviewing
- Nursing Guide to Medical Nutrition Therapy and Nutrition Counseling in Cardiology
- PCMH+
- Hepatitis C
- Non-compliance with care
- Inappropriate medication usage
- High ER utilization
- Managing transition to new PCP
- High utilization of primary care

**Action Cycle:**

1. Identify the problem: Nurses need support
2. Review and select the knowledge: Project ECHO Model
3. Adapt to the local context:
   - Provider participants: Nurse participants
   - Integrate into current CHC Project ECHO programming
4. Assess barriers:
   - Academic training
   - Lack of job experience
   - Time
   - Resources
   - Geography
5. Select, tailor, implement:
   - Project ECHO CCM
   - First session on September 24, 2015
6. Monitor use:
   - # of patients enrolled in CCM
   - # of cases presented
   - # of nurses presenting
   - Qualitative evaluation of nurse’s knowledge on topics covered
7. Evaluate outcomes:
   - Impact on patient experience/patient outcomes
   - Impact on nurses’ provider and retention/nurse leadership
8. Sustain knowledge use:
   - Faculty development
   - Quantity/ in-kind or budget neutrality
   - Savings from reduction (both provider and nursing)
   - Spread model

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**Project ECHO CCM Patient Demographics: Age Group**

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**Project ECHO CCM Common Behavioral Health Diagnoses**

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**Project ECHO CCM Common Diabetic Topics**

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For more information, please contact Mary Blankson, APRN, DNP, FNP-C, Chief Nursing Officer, at Mary@chc1.com