The Complex Care Program, a new federally-funded University of New Mexico initiative, will use the Project ECHO model of multi-disciplinary consultations through weekly telehealth clinics to assist teams of providers in managing publicly-insured patients with socio-economic, behavioral, and medical needs.

The project is creating Outpatient Intensivist Teams (OITs) to provide comprehensive care with the goals of improving care coordination and quality, and reducing costs.

- **Population:** 5,000 publicly insured patients with complex socio-economic, behavioral, and medical needs in New Mexico and Washington state.

- **Delivery Model:** Based in primary care sites throughout the two states, each OIT will provide comprehensive care to 200-250 patients enrolled in the Complex Care Program. OITs are composed of: one nurse practitioner (lead), one registered nurse, one counselor, and two community health workers. These teams will receive support from specialists through the ECHO Complex Care Clinic, which will provide real-time, virtual access to hospital-based specialists who relay best practices and effective care management strategies, as well as help to co-manage teams’ complex patients.

- **Financing:** Project ECHO received an $8.5 million Health Care Innovation grant from the Center for Medicare and Medicaid Innovation for the implementation and evaluation of the Complex Care Program over the next three years. Support for the OITs will come from participating Medicaid managed care organizations, which will share the cost of the OITs in proportion to the number of beneficiaries served.

**KEYS TO SUCCESS**

The foundation of the Complex Care Program is the Project ECHO model, which has improved patient care and increased provider capacity in many underserved communities. Key success factors include:

1. **Using technology to leverage resources** that would otherwise be available only in academic medical centers;
2. **Sharing and implementing only best practices** that have been proven effective;
3. **Engaging in case-based learning** rather than just lectures, so that community-based provider teams become experts, and can manage patients in real-time through a guided practice model; and
4. **Diligently tracking outcomes** to identify successes and gaps, and inform best practices.
Spotlight: ECHO Community Health Worker Training Program

To extend the medical knowledge transfer gained from Project ECHO further into rural communities, Dr. Sanjeev Arora and colleagues developed the ECHO Community Health Worker (CHW) training program. In developing the Project ECHO clinic for patients with diabetes, ECHO faculty learned that rural areas often lacked trained diabetes educators and nurses who could supplement the work of primary care physicians, and work with people in the community to manage their conditions. Since diabetes care involves extensive patient education, self-management, and behavior modification, it is nearly impossible to ensure that patients are getting what they need in a 15-minute visit. Diabetes educators and nurses are able to have in-depth meetings with patients, meet with them in their homes, and better understand how to tailor care to address each patient’s unique situation.

To develop this workforce, Project ECHO designed a program to train clinic staff in managing patients with diabetes. Eligible trainees must have at least a high-school diploma, and may include medical assistants, community health workers, and others. Participants are brought to Albuquerque for a three-day intensive program that provides training in all aspects of diabetes care, including diet, exercise, foot exams, finger sticks, motivational interviewing, history taking, and more. Upon returning to their clinics, participants take part in weekly telehealth clinics with Project ECHO staff to continue learning and co-managing patients. The program has been expanded to include specialized CHW training in addiction and preventive care. Trained CHWs can partner with physicians in caring for patients with chronic conditions, and they also become experts in managing care for particular conditions.

BEHIND THE INNOVATION

Sanjeev Arora, MD is creator and director of Project ECHO, an innovative model that leverages telehealth technologies to improve access to care for patients with complex and chronic conditions. He is also a professor of medicine in the Department of Internal Medicine at the University of New Mexico’s Health Sciences Center.

Miriam Komaromy, MD, is an associate director of the ECHO Institute at the University of New Mexico Health Sciences Center, where she leads the Complex Care Initiative (called ECHO Care), as well as the addictions and psychiatry and community health worker programs. An internal medicine physician and addiction specialist, she served as a faculty member in the Department of Internal Medicine and residency director for the Primary Care Internal Medicine Residency program at the University of California, San Francisco/San Francisco General Hospital. Dr. Komaromy has also practiced medicine in a federally qualified health center and served as medical director of New Mexico’s state-funded addiction treatment hospital.

PROFILES IN INNOVATION SERIES FROM THE COMPLEX CARE INNOVATION LAB

These profiles highlight the organizations and individuals participating in the Center for Health Care Strategies’ Complex Care Innovation Lab. The Innovation Lab, made possible by Kaiser Permanente Community Benefit, is bringing together innovative organizations from across the country working to improve care for vulnerable populations with complex medical and social needs. Participants are exploring new ways to advance complex care delivery at the local, state, and national level. For more information, visit www.chcs.org.