Taddle Creek
Family Health
Team

It Takes a Team

The Complex Medical Care Clinic

in partnership with

IMPACT: Inter-professional Model of Practice for Aging and Complex Treatments

Objectives

- To communicate scope of and evidence for the initiative
- To discuss history and process
- To demonstrate a clinic in action
- To list intended outcomes
- To review necessary conditions and challenges in implementing such a clinic

Scope

- Patients with complex co-morbidities represent 1-4% of the population but account for 30-60% of health care costs

- They account for 59% of 57 million deaths worldwide and 46% of global burden of disease WHO: Preventing Chronic Diseases: A vital investment 2005.

Empirical Evidence:

Traditionally these patients are managed by serial specialist consultations using single-disease models, inadequate in addressing reinforcing medical conditions, medication interactions, lifestyle factors or co-morbid psychosocial determinants

"Heart-sink" patients typically overwhelm provider who can only manage 1-2 health issues per visit

What is the optimal management of multiple chronic conditions?

- Unknown
- Single provider cannot do it adequately
- Inter-professional approach may be the answer

***Plan:* Bridges Funding to measure a range of outcomes using this model with Family Health Teams**

History of CMCC at Taddle Creek FHT

- Began with traditional GIM consultant seeing referred cases
- Evolved to proactive presentation of cases with whole team present and internist consulting
- Added psychiatrist to case conferencing
- IMPACT: Sunnybrook FPU - Patient and caregiver present with Closed Circuit TV enabling entire team to watch interviews and engage in treatment planning

Clinic Process:

- Case particulars disseminated ahead of time with key questions identified by referring PCP
- 1 team member designated as facilitator
- Case “unpacked” by PCP other than referring PCP
- At least 3 roundtable discussions to allow other providers to offer observations, suggest questions, to return to interview patient
- List of recommendations generated in the EMR
- Copy given to patient with F/u details clarified

Intended outcomes

- **Reduction in Emergency room visits**
- **Reduction in hospital admissions**
- **Reduction in the burden of care:**

For patients: Medication management, comprehensive assessment to address issues in depth, real-time problem solving avoiding multiple referrals, caregiver involvement, feeling valued

For HC providers: Comprehensive chart review, reduction in office visits, enhanced resources to serve patient, clarity in direction and strategies moving forward

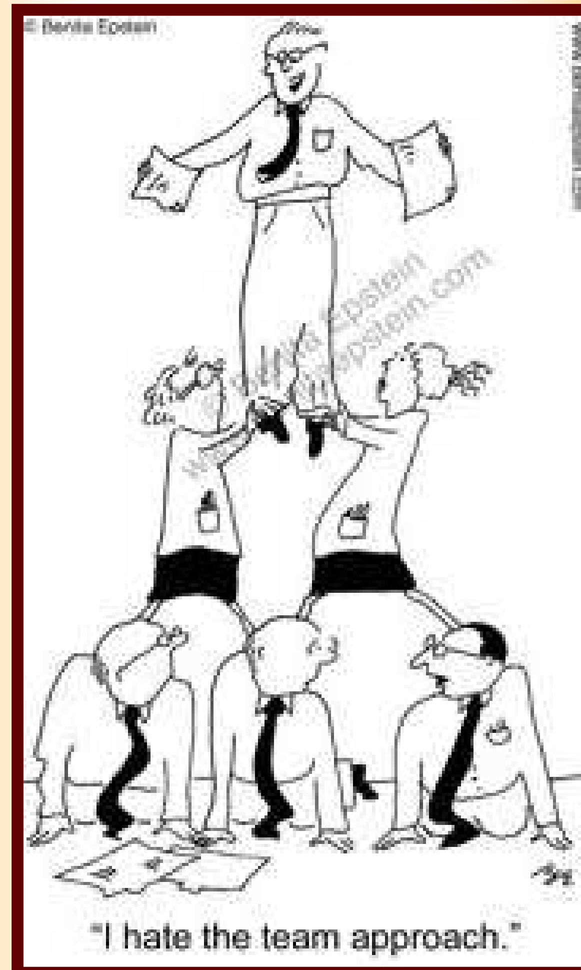
Intended outcomes continued

For the team:

1) Modeling of synergistic problem-solving for all health care providers
2) Building interdisciplinary collaboration

   The DELUXE model of Collaboration
3) Real-time knowledge transfer

Key challenges and conditions for success



Necessary Conditions for Implementation

Mutually respectful working relationships among team members characterized by:

- *Nonhierarchical relationships*
- *M.D. a participating member of the team*
- *Communication to enhance understanding of each other's roles and of the case to be discussed*
- *Facilitated interaction*

Multidisciplinary vs Inter-disciplinary

Multidisciplinary

Communication is generally one-to-one or in report format one-to group

Scope of practice tends to be narrow

Limited knowledge of scope of practice of other disciplines

Physician-centric: M.D. directs discussion

Patient/family goal-setting is done independently by professionals rather than through collaboration

Inter-disciplinary

Communication is among team, fluid and a work in progress

Scope of practice embraces broad range of skills within profession and between professions

Team members understand educational backgrounds, areas of expertise, and pertinent roles of one another

Patient-centric: Patient needs direct discussion

Patient/family goal-setting, planning and implementation undertaken in integrated manner by all team members

Teams (group work)

High performance requires BALANCE

TASK

PROCESS

Task: what is done and the problems associated with completion

Process: how the team functions – what happens between the members, the way decisions are made

PROCESS affects OUTCOME

Lescsz, Richardson & Wagner Module II Ehpic U of T 2008

Necessary Conditions

- Clarity regarding referral process
- Time allotment: 2 hours per patient with most of the team members present
- Clinics need to be pre-scheduled
- Technology: Portable EMR, video camera, CCTV
- Clarity regarding process of the clinic
- Large meeting room & exam room

Challenges

***Time factor*:**

- Investing in time now for returns later
- Time management: getting through the appt.

Confidence factor:

- For team members - volunteering to interview, to share their opinions openly
- For M.D.s - typically these are patients who overwhelm us so showing our less than optimal care takes courage

Challenges

Information transfer:

- How to document clearly
- How to organize implementation plan so this does not also overwhelm the PCP
- How to check back with patient
- How to organize follow-up

Possible Solutions

Need a champion(s) of the model, provide regular updates, show evidence

Pre-schedule - everyone booked out ahead of time

Regular meeting time

Search EMR for patients with 3-5 co-morbid conditions and/or on >5 meds

Find creative ways to support PCP to present cases