Multi-Disciplinary Appointments

Kirkland District Family Health Team

Faculty/Presenter Disclosure

- Julie Moody, RPN, QIDSS
- Mandy Weeden, FHT Director

- **Relationships with financial sponsors:**
  - **Other: funding for a Nursing position**

Objectives

- Collaboration between Health Care Providers and the patients to meet the demands of their multiple co-morbidities and assist with the transitions between environments and levels of health:
- Use the Chronic Disease and Prevention Management framework
- Operationalize the principles of Quality Improvement

Origins

- Our FHT initiated the Multi-D appointment approach to utilize the key concepts of the ICCP (integrated co-ordinated care plan), but in a more efficient manner with a broader criterion including psychosocial issues. Sullivan et al (2016) suggest that building successful professional teams includes “re-envisioning goals, promoting shared decision making, communicating effectively and interprofessionally, clarifying roles, learning from failure, and using organizational structures to support multidisciplinary teams.”

Our Determinants of Health

- Higher than the provincial averages of diabetes, CAD, smoking, obesity and an aging population
- Significant co-morbidities
- High unemployment rates
- Lower than provincial average education and literacy levels
- Lower than provincial average income-$21,113 compared to provincial median of $24,604
- 17.8% of earnings from government transfers vs. 9.8% for the province
- Catchment area of 11,000 people

Table 1: Prevalence of selected chronic conditions, self-reported by persons aged 12 years and older, Timiskaming and Ontario, 2009/2010
Adapted from the Timiskaming Health Status Profile, January 2013

	Timiskaming %	Ontario %
High Blood Pressure	27	17.4
Back Problems	24.8	19.4
Arthritis	22.7	17.0
Asthma	9.4	8.3
Diabetes	6.8	6.8

The Chronic Disease and Prevention Management Framework

- Purpose: To provide a common framework to give direction to effective prevention and management of chronic disease.
- The CDPM incorporates the Chronic Disease Model
- This framework drives the quality initiative of our Multi-disciplinary appointments
- The framework includes;
  - Delivery System Design
  - Personal Skills and Self-management Support
  - Provider Decision Support
  - Information Systems

MOHLTC 2005

The Chronic Disease and Prevention Management Framework

- The CDPM Framework's intention is to move health care from:
- Illness oriented to **wellness** oriented
- A solo provider approach to **prevention at all points** along the continuum
- Provider, disease orientated approach to an **integrated, interdisciplinary** care approach
- Reactive and episodic to **proactive**, complex continuing care

The Chronic Disease and Prevention Management Framework

- Moving from a limited role for individuals in self-management to individuals **empowered for self-management** and part of the care team(MOHLTC 2005)

Goals

- Decrease ER visits, hospital admissions and length of stay, but, mostly
- Improved patient and provider understanding of illness and management of their care, and
- Increased confidence of the patient in the Health Care Team and their own ability to understand and contribute to self-management of their illness(es).

Delivery System Design

- The Multi-Disciplinary meeting is a method of operationalizing some of the key concepts of the delivery system design through:
  - Use of the interdisciplinary team
  - Health promotion and disease prevention
  - Planned interactions
  - Information systems

Our Definition of the Complex Patient

Patients with multiple comorbidities and/or complex psychosocial issues requiring multiple professionals to be involved in their plan of care

Challenges of the Complex Patient

These individuals have:

- The potential to become high system users with readmissions related to care gaps, and multiple appointments to allied health care providers
- Multiple chronic disease processes and polypharmacy which challenge treatment planning and delivery
- Complex interpersonal needs/issues that complicate care.

Our Solution to These Issues

The ICCP eligibility criteria is too restrictive and requires too much dedication of unfunded human resources to complete; (COPD, CHF or dementia).

So….

We devised to schedule a multi-disciplinary meeting for any complex patient as we previously described, with all the disciplines involved, pertinent community providers, the patient, and their significant other(s).

Multi-Disciplinary Appointments

Multi-Disciplinary appointments are a collaborative and integrated approach to care planning for patients with chronic disease, complex needs, mental health issues and those who need additional support with a new diagnosis or recent medical event. By utilizing these appointments both patients and providers can work together with the Allied Health Team to address the unique needs of the patient and their specific disease, with the intention of reducing the number of hospital visits and or admissions. This cost effective model has allowed us to meet care planning needs with minimal support and has simplified the care planning process.

Process: 2015-Present

- January 2015, we started a Multi-Disciplinary Project
- FHT pharmacist attended weekly Multi-D at the hospital to identify potential clients
- One clinic appointment weekly reserved for FHT multi-disciplinary meeting to assess patient needs and ensure supports initiated
- All providers have access to daily hospital admissions and discharges

Process: 2015-Present

- Booking referral has evolved from a focus on discharged patients and expanded to include any patient who has complex health issues that require more interventions than the Primary Health Care provider alone can offer.
- In 2016, we opened up the criteria to any patient attending the Family Health Team including unattached clients. The clinical lead took responsibility for attending the meeting and facilitating follow up.

KIRKLAND DISTRICT
Family Health Team

Fax: 705-567-3838 Phone: 705-567-2224

Multi-Disciplinary Appointment Contact Form

This patient requires further follow up in the community.
Please use this form to schedule and for data collection.

Date of request currentDate.default

Patient Name: patName

DOB: patBirthdate.default Preferred phone # patHomePhone.default

Alternate contact person _____ Phone # _____

Is this person: ☐ Next of kin ☐ SDM ☐ POA ☐ Other _____

Does patient have a provider? ☐ Yes _____ ☐ No

Date of discharge: _____

☐ Assessed as frequent ER visits / admissions?

Is this patient on fifteen or more medications? ☐ Yes ☐ No **Please attach discharge med list**

Please check all that apply:

☐ COPD ☐ CHF ☐ Diabetes ☐ CAD

☐ HTN ☐ Mental Health ☐ Other _____

Urgency of Multi-D appointment

☐ <7 days ☐ <14 days ☐ 14-28 days ☐ Other _____

☐ Family support ☐ Community support

Lace score if completed _____

Family Health Team to complete

Date of Multi-Disciplinary Meeting _____

Support Attending ☐ Family ☐ Community ☐ None

Names _____

HCP's to attend ☐ NP ☐ MD ☐ Pharm ☐ RT ☐ SW ☐ RD ☐ RN/RPN ☐ PA ☐ Other

_____

KIRKLAND DISTRICT
Family Health Team

patName's Care Guide

DOB: patBirthdate.default Phone: patHomePhone.default

Date : currentDate.default

What we talked about during your appointment

What's next:

Who to contact for more information

For medication instructions: Christine 705-567-2224

All other questions / concerns: Danielle 705-567-2224 x 3028

Go to the nearest Emergency Department in case of an emergency

FOR OFFICE USE ONLY

Rostered? ...ostered Primary Provider pat.Demographics.Primary_Provider_Name

◯ Consent for Multi-D appointment ◯ Assessed as high risk admissions

◯ Recent Hospital Admissions Discharge Date: ...y.date_of_latest ◯ Multiple ER visits ◯ TDP

In attendance ◯ Pharm ◯ RT ◯ Social Worker ◯ PA ◯ Nursing ◯ CCAC

◯ ...Primary_Provider_Name ◯ Other

Number of medications ..._meds Medication Reconcilliation complete? ◯ Yes ◯ No

Comorbities

◯ CAD ◯ Cancer ◯ COPD ◯ CHF ◯ Diabetes ◯ HTN ◯ Mental Health ◯ Other

Community / Home support arranged

◯ CCAC ◯ CMHA ◯ TDP ◯ Treena Smith ◯ Other

Vignettes

- 41 year old male
- Married, with two adolescent children
- Works underground as a miner
- Smoker of 23 pack years
- Presented at ER with possible pneumonia, weight loss and back pain
- Ct showed left lower lobe lung Ca with mediastinal lymphadenopathy, and sclerotic lesions
- Admitted from ER to floor, and transferred to Sudbury
- Bronchoscopy next day-Non-small cell lung ca with mediastinal nodes showing poorly differentiated adenocarcinoma of primary lung

Quality and Multi-d Appointments

- Quality Improvement and Risk Management purpose:
- To ensure a standard approach for patient management, quality improvement principles are followed. These principles form the foundation of a quality improvement program.
- Their effectiveness may determine the program success or failure.
- Quality improvement programs based on these principles have been shown to have effect on the outcome of medical care.

Quality: Outcomes

- Multi-Professional Appointment Patients:
  - 100% said they found it helpful to have all of the providers attend their appointment together
  - 100% reported the date of their appointment was well-timed after their hospital discharge
  - As a result of the appointment, 100% said they feel very confident at being able to manage their symptoms and their prescriptions

Quality Outcomes Continued

- Patient Testimonials:
  - *"Appreciate that the health care team are all on the same page."*
  - *"Care is well organized."*
  - *Most appreciated that the health care team were all on the same page.*
  - *Two patients were not aware that it was a multi-disciplinary appointment until they arrived and were surprised to see more than one provider attending.*

Multi D Satisfaction Survey Quarter 1-4, 2017.

Questions Asked	Satisfied	Unsatisfied	Unaffected
Was the appointment helpful?	97%	3%	N/A
Well- timed after discharge?	85%	3%	12%
Care and organization?	94% (4-5 on scale of 1/5)	3% (1-2 on scale of 1/5)	3% (3 on the scale of 1/5)
Symptom management post appointment?	83% (3-5 on scale of 0/5)	3% (1-2 on scale of 1/5)	14% (3 on the scale of 1/5)
Rx management post appointment?	79% (3-5 on scale of 0/5)	15% (1-2 on scale of 1/5)	6% (3 on the scale of 1/5)
Provider's familiarity with patient?	94% (3-5 on scale of 0/5)	0%	6% (3 on the scale of 1/5)

Summary of 2018 Q1 Multi-D Encounters

- 17 encounters happened. 10 Female, and 7 male
- 15 were > 65 years of age, 2 were < 65 years of age
- 11 of 17 patients had 4 or more comorbidities
- 6 of those 11 patients had 6 or more comorbidities

Pearls

- Patient/family has to have the cognitive ability and desire to actively participate in the development of the plan
- Need to have a team approach with strong clinical and administrative leadership; the lead has to have the time to initiate and monitor the initiative
- Need a buy in and commitment to the principles of CDPM and quality improvement AND there needs to be accountability back to the Quality Committee for outcome reporting
- Clear communications and a collaborative spirit between Community Health Agencies
- Managing high system users requires human resources not currently funded