

Interdisciplinary Complex Care Planning Project

Presented by:

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Agenda

- Development
 - ❖ Background
 - ❖ Literature Review
- Care Map
 - ❖ Process
- Trial Evaluation Outcomes
 - ❖ Results of survey
 - ❖ Benefits
 - ❖ Workload
 - ❖ Recommendations

Overview of Project and Background

- Roots of the project were derived from a draft created by the SAHCSI Centre Operations Team in 2010.
- Which patients would this serve?
- Developed into a Quality Improvement Project.
 - ❖ The purpose was to improve client outcomes, staff communication, and decrease unnecessary workload to streamline a continuum of care.
 - ❖ Trial Interdisciplinary Complex Care Meetings.

Literature Review

- Found that multidisciplinary team meetings in oncology settings have a positive impact on:
 - ❖ Workload
 - ❖ Staff
 - ❖ Client Outcomes
- Lead to the used of the supportive care framework for helping to identify clients in need of complex care planning

Workload Benefits



- **Improved communication between Health Care Professionals (HCP)**

(Baxter, 2007; Blough & Walrath, 2007; Devitt, Philip & Mclachlan, 2010; Goodman, Penson, Blatman, McIntyre, Gioiella, Chabner, & Lynch, 1999; National Breast and Ovarian Cancer Centre, 2005, 2008; Wiederbolt, Connor, Hartig, & Harari, 2007)

- **Time spent was gained back**

- ❖ Less time was spent tracking down other healthcare professionals (HCP) and having separate discussions.
- ❖ Discussions taking place were more focused
- ❖ The meeting were seen as time efficient in developing care plans

(Devitt et al., 2010; Gallagher, & Forman, 2012; National Breast and Ovarian Cancer Centre, 2005, 2008).

Negative Impact on Workload

- What to Avoid
 - ❖ Unfocused meetings are time wasters
 - ❖ Need to Ensure:
 - ❖ Structure
 - ❖ Start on time
 - ❖ Include appropriate disciplines
 - ❖ Unrealistic demands on staff addressed



<http://jayschroeck.com/blog/wp-content/uploads/2010/12/success-and-failure-sign.jpg>

Impacts on Staff

- Educational benefits
- Improved peer interaction
- Improved mental health
 - ❖ Problem sharing
 - ❖ Joint decision making
 - ❖ A sense of doing a job well and improved patient care



(Haward, Amir, Borrill, Dawson, Scully, West, & Sainsbury, 2003; National Breast and Ovarian Cancer Centre, 2005, 2008, Blough & Walrath, 2007; Devitt, et al., 2010)

Clients

- Improved perception of care and satisfaction
- A more proactive approach to addressing complex supportive care needs using a multidisciplinary team.



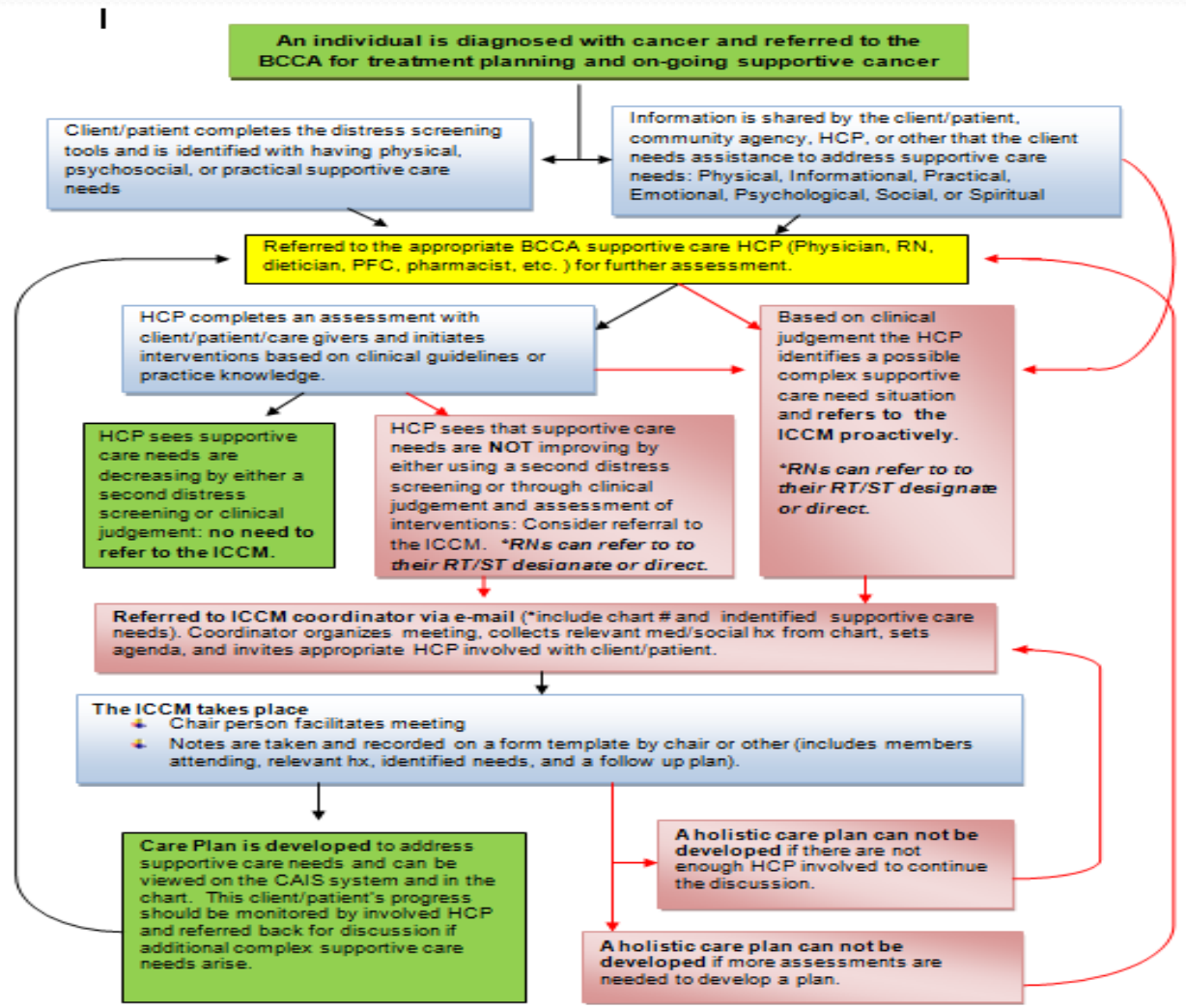
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(National Breast and Ovarian Cancer Centre, 2005, 2008; Goodman et al., 1999).

Supportive Care Framework

- Encompasses domains: physical, informational, practical, emotional, psychological, social, and spiritual.
- Supportive care screening tools can be based on distress and unmet needs.
- BCCA uses the Edmonton Symptom Assessment System (ESAS), Psychosocial Screen for Cancer (PSSCAN) and the Canadian Problem Checklist.
- According to research reviews on the supportive care framework using distress screening tools, 10-15% of clients entering cancer treatment will **require complex support** through the continuum of care (Fitch, et al., 2008; Canadian Partnership Against Cancer, 2009).

Care Map: Interdisciplinary Complex Care Meeting

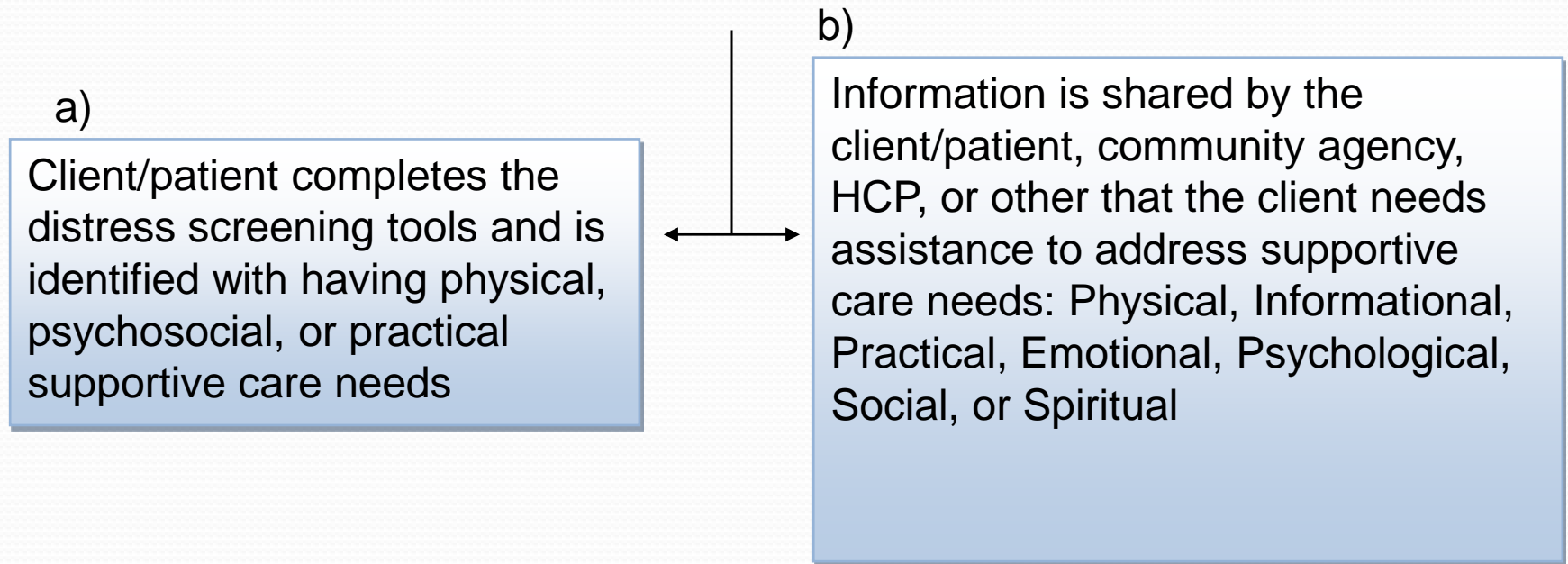


Care Map: Interdisciplinary Complex Care Meeting

STEP 1:

An individual is diagnosed with cancer and referred to the BCCA for treatment planning and on-going supportive cancer care.

Care Map: Interdisciplinary Complex Care Meeting



STEP 2: Supportive care needs are identified either a) or b) or both.

- Distress screening
- Client/HCP/ family/ other

Care Map: Interdisciplinary Complex Care Meeting

STEP 3:

Referred to the appropriate BCCA supportive care HCP (Physician, RN, dietician, PFC, pharmacist, etc.) for further assessment.

Care Map: Interdisciplinary Complex Care Meeting

STEP 4:

a)

HCP completes an assessment with client/patient/care givers and initiates interventions based on clinical guidelines or practice knowledge.

i)

HCP sees supportive care needs are decreasing by either a second distress screening or clinical judgement: **no need to refer to the ICCM.**

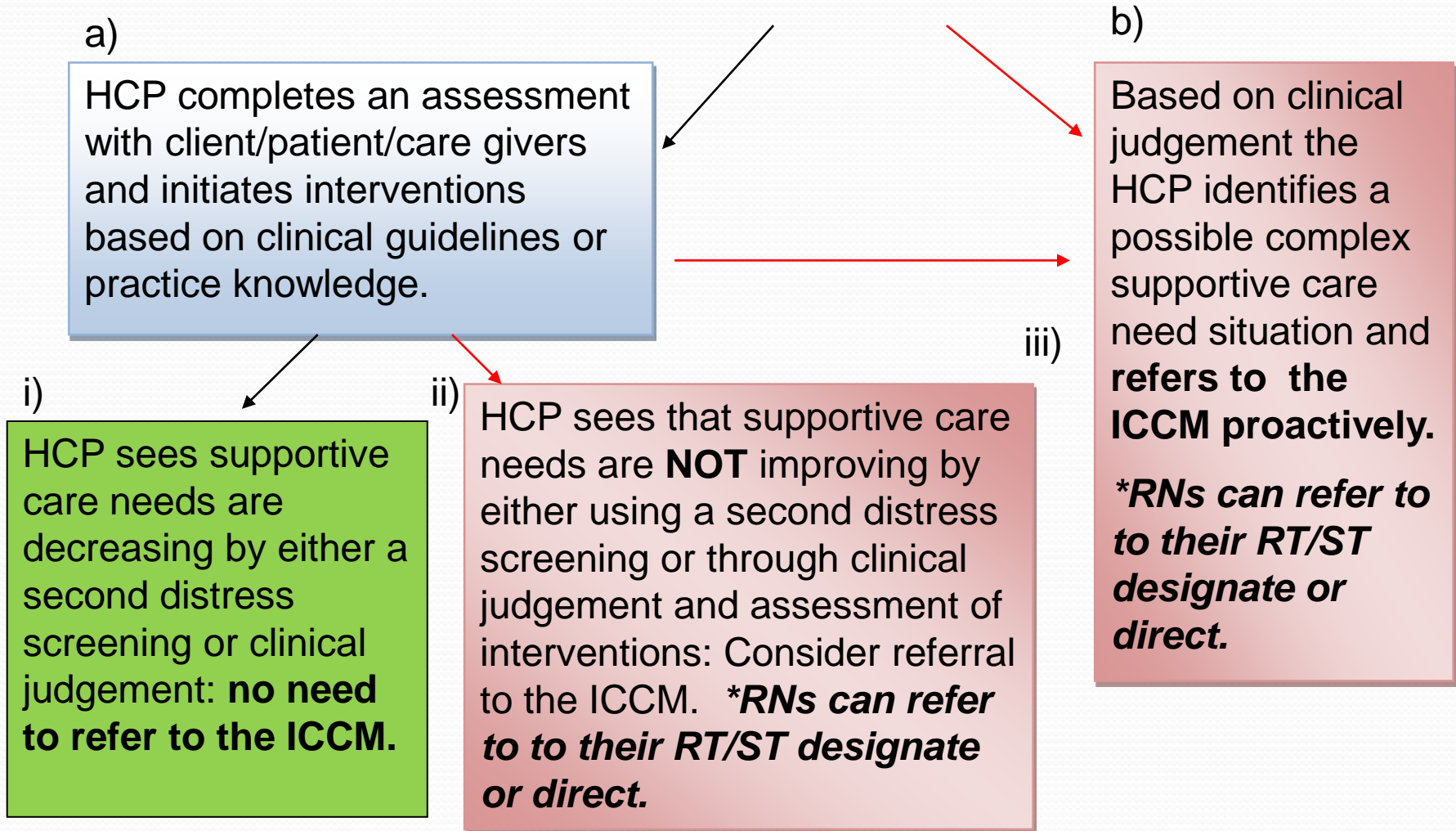
ii)

HCP sees that supportive care needs are **NOT** improving by either using a second distress screening or through clinical judgement and assessment of interventions: Consider referral to the ICCM. ****RNs can refer to to their RT/ST designate or direct.***

b)

Based on clinical judgement the HCP identifies a possible complex supportive care need situation and **refers to the ICCM proactively.**
****RNs can refer to to their RT/ST designate or direct.***

iii)



Care Map: Interdisciplinary Complex Care Meeting

STEP 4: Decision needs to be made to discuss needs at the ICCM.

a) HCP completes an assessment with client/patient/care givers, provides interventions, does a second distress screening and finds:

- i. improvements in supportive care needs (no complex supportive care needs identified) no referral
- ii. HCP completes an assessment with client//patient/care givers, initial interventions result in no improvements to SCN – refers to ICCM. *RNs can refer to RT/ST designate or direct.
- iii. HCP completes an assessment and refers to ICCM based on clinical judgement.

b) HCP receives referral and based on clinical judgement refers to ICCM. *RNs can refer to RT/ST designate or direct.

Care Map: Interdisciplinary Complex Care Meeting

STEP 5:

Referred to ICCM coordinator via e-mail (*include chart # and identified supportive care needs). Coordinator organizes meeting, collects relevant med/social hx from chart, sets agenda, and invites appropriate HCP involved with client/patient.

Care Map: Interdisciplinary Complex Care Meeting

STEP 6:

The ICCM takes place

- ❖ Chair person facilitates meeting
- ❖ Notes are taken and recorded on a form template by chair or other (includes members attending, relevant hx, identified needs, and a follow up plan).

Care Plan is developed to address supportive care needs and can be viewed on the CAIS system and in the chart. This client/patient's progress should be monitored by involved HCP and referred back for discussion if additional complex supportive care needs arise.

A holistic care plan can not be developed if there are not enough HCP involved to continue the discussion.

A holistic care plan can not be developed if more assessments are needed to develop a plan.

Care Map: Interdisciplinary Complex Care Meeting

STEP 6: ICCM takes place (strive for 60 min. or less dependent upon the number of clients to be discussed)

- Chair person facilitates meeting
- Notes are taken and recorded on template by chair or other (includes, members attending, relevant hx, identified needs, and follow up plan).

- a) Care Plan is developed** to address supportive care needs and can be viewed on the CAIS system and in the chart.
- i. This client's progress should be monitored by involved HCP and referred back for discussion if additional complex supportive care needs arise.

Care Map :Interdisciplinary Complex Care Meeting

STEP 6 continued:

b) A holistic care plan can not be developed

- i. client can be referred back to the ICCM to reschedule a discussion if there are not enough HCP involved present at the time of the meeting.
- ii. Client can be referred back to the appropriated BCC HCP for more assessments if they are needed to develop a plan. Sometimes although the referring HCP has completed their assessments others involved may not have been able to fully complete their assessments. By going back to Step 3... HCP may find that they are able to provide an intervention which results in a decrease of the original supportive need in which case they would not need to be referred back again to the ICCM. Alternatively, after all HCP complete their assessments they may be ready to contribute to a holistic care plan.

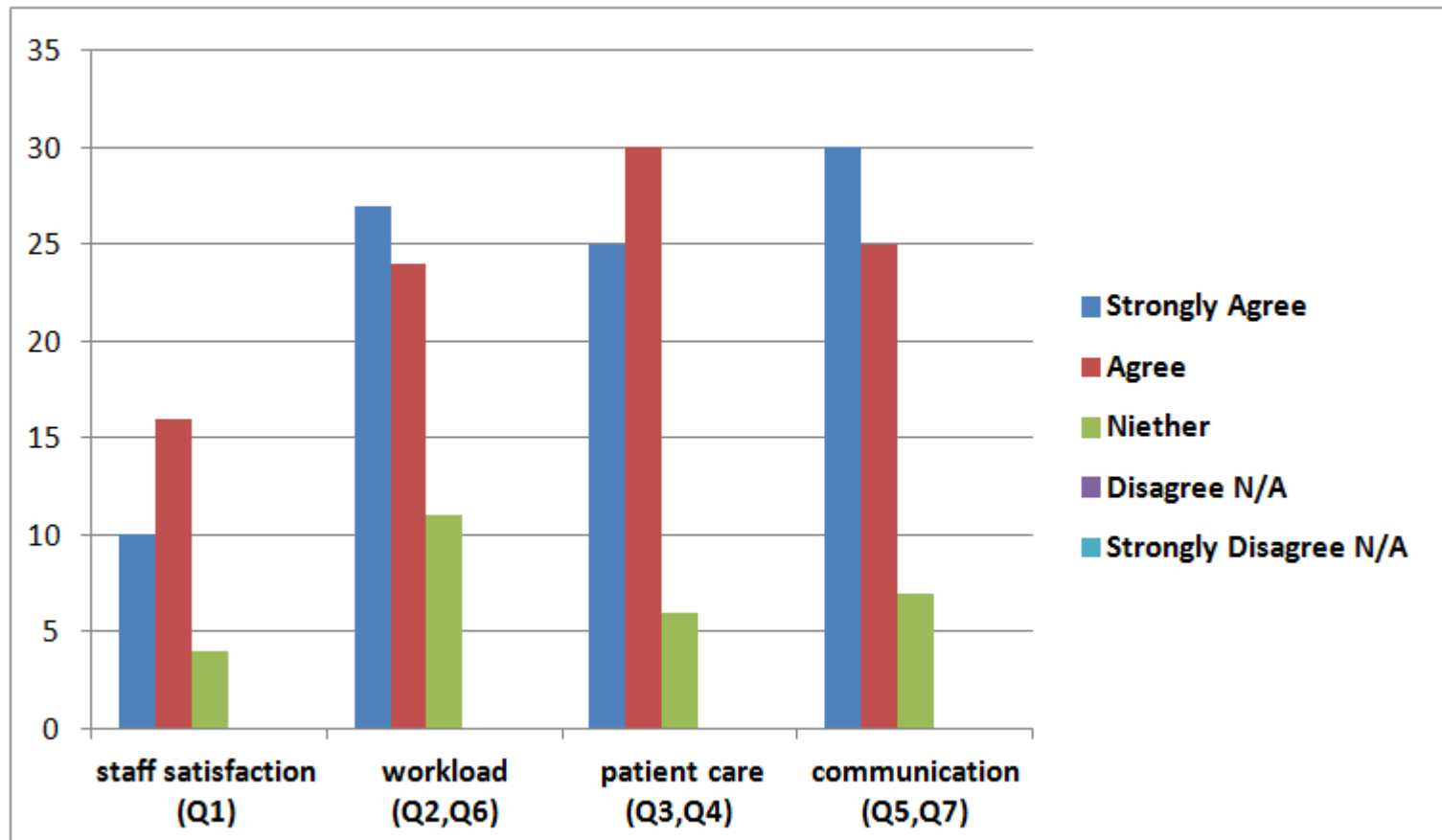
Trial Interdisciplinary Complex Care Meeting (ICCM) Evaluation Outcome Survey

Survey

- Given to attending staff following each meeting
- Focused on:
 - ❖ staff satisfaction of the meeting
 - ❖ perceived benefits to workload
 - ❖ staff agreement with improved patient care
 - ❖ staff communication

Trial ICCM Evaluation Graph

Response to Topics



Trial ICCM Evaluation Outcome Continued

- Benefits identified:
 - ❖ Staff satisfaction with the meeting time and structure
 - ❖ Communication
 - ❖ Care Planning
 - ❖ Education
 - ❖ Care Map



Trial ICCM Evaluation Outcome Continued

- Impact to Workload:
 - ❖ Co-ordinator/ Chair role
 - ❖ Prep time for the involved health care professionals
 - ❖ Elimination of overlaps

Trial ICCM Evaluation Outcome Continued

- Barriers identified:

- ❖ Time
- ❖ Agency Barriers



- Recommendations identified:

- ❖ Meeting room consistency
- ❖ Consider times to enhance physician participation
- ❖ Review time needed for nurses to prepare
- ❖ Communication with outside agencies
- ❖ Develop a document outlining expectations and roles

Summary

- Interdisciplinary Complex Care Team meetings were useful for:
 - ❖ Clarification of plan and medical updates
 - ❖ Sharing information/ concerns
 - ❖ Development of co-ordinated plans



Conducting the Interdisciplinary
Complex Care Team meetings
was Time Well
Spent!

Comments

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